Table 5.13.1 : Lissue Hospital - Workload Trends in Medical Paediatrics

Year	INPATIENTS					
	Available Beds	Admissions	Throughput	Average Length of Stay	Occupancy %	Waiting List 31 Dec.
1974	38	227	6.0	28.4	46.4	-
1975	38	164	4.3	37.2	44.0	-
1976	38	154	4.1	39.4	43.6	-
1977	38	178	4.7	38.6	49.6	-
1978	38	203	5.3	31.3	45.9	-
1979	38	135	3.6	43.2	42.0	-
1980	38	119	3.1	44.2	37.8	-
1981	21	185	8.8	27.5	66.5	-
1982	20	251	12.5	21.1	72.6	-
1983	20	251	12.5	19.3	66.4	-

The workload trends in Child Psychiatry are summarised in Table 5.13.2. The number of beds has remained constant since 1973. The number of discharges reached peaks in 1980 and 1983. The average length of stay decreased in the years when the level of admissions was high although no clear trend is discernable from the data. A high level of bed occupancy has been maintained. A day patient service is also provided in this specialty.

Table 5.13.2 : Lissue Hospital - Workload Trends in Child Psychiatry

Year	INPATIENTS					
	Available Beds	Admissions	Throughput	Average Length of Stay	Occupancy %	Waiting List 31 Dec.
1973	20	48	2.4	147	96.4	-
1974	20	52	2.6	132	94.0	-
1975	20	49	2.5	146	98.0	-
1976	20	60	3.0	114	93.1	-
1977	20	95	4.8	67	88.0	-
1978	20	73	3.7	87	88.9	-
1979	20	73	3.7	91	91.2	-
1980	20	144	7.2	46	91.0	-
1981	20	98	4.9	60	80.8	-
1982	21	78	3.8	78	80.8	-
1983	20	130	6.5	47	83.2	-

Staffing Levels. Consultant medical staff responsibility for both specialties is provided by consultants with commitments both at this hospital and at The Royal Belfast Hospital for Sick Children. In addition, general practitioners have sessional commitments. Of the 39 nursing staff in post at 31st December, 1983, 24 (61.5%) were trained nurses. There were 30 ancillary and general staff, 2 professional and technical staff and 2 clerical staff, making a staff complement for the hospital of 73 persons.

Analysis of Costs. The gross revenue expenditure of Lissue Hospital for the year ended 31st March, 1984, amounted to £716,373. Of this the Direct Treatment and Ancillary Departments accounted for £334,921 (46.8%), Specialists' Remuneration and Expenses for £25,168 (3.5%) and total Service Departments for £356,284 (49.7%).

The cost per inpatient per week for 1983/84 was £449.87.

[redacted]

2 In so far as possible, facilities within the Area of the Board should be administered by that Board. This is important, as it makes for clear definition of managerial responsibility and avoids confusion in the minds of the public and Staff alike. Only exceptionally will there be a case for breaching this principle.

In the appendix, cases of overlap between Districts in an Area were set forth, with Lissue being quoted as an example:

> Lissue Hospital, Lisburn Health and Social Services District. Beds 58, type: Convalescent and Child Psychiatry.
>
> Hospital Management Committee: Belfast associations – is an annexe of the Royal Belfast Hospital for Sick Children.
>
> Catchment area is predominantly greater Belfast. Comparatively few patients are normally resident in the Lisburn Health and Social Services District.
>
> FUTURE ROLE: In view of its current links in the catchment area, there is a good case for this hospital to be administered and staffed by North and West Belfast Health and Social Services District, rather than Lisburn Health and Social Services District.

The Ministry's position was stated further in a letter, dated 31 May 1973, from Dr T.T. Baird, chief medical officer, to Dr J.M. Beare, chairman of the RBHSC Medical Staff Committee:

> We have given considerable thought to this question of overlap between Districts within an Area and have recently issued a circular [the aforementioned R16/73] to Area Boards, giving guidance on this subject. Basically, we feel that in general, Area Boards should be responsible administratively for all the 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 that it would be very easy for the Eastern Health and Social Services Board to resolve it this way.

The Board did not agree and ignored this nudge from Dundonald House – Lissue Hospital was hived off to the Lisburn District. Staff concern that nursing and administrative posts would be downgraded and that laboratory services, records, X-rays and so on would suffer went unheeded, and repeated representations to have the decision reversed were of no avail. The Board continued to hold the view that no post would be reduced in status by this administrative change and that the function of the clinical nurses, and other staff associated with Lissue, would in no way be disturbed.

[redacted]

In Confidence
(For Official Use Only)

Paper No. EB 26/76

EASTERN HEALTH AND SOCIAL SERVICES BOARD -

Lisburn District

Report on visit by members of the Board and co-opted members of Committees to Lisburn District on 20th May, 1976.

Members Present

Sister Genevieve
Professor M. J. Brown
Mr. J. Dorrian
Mr. F. Kane
Mr. D. R. S. Kingan

District Representatives

Dr. W. J. McLeod - District Administrative Medical Officer
Miss B. J. Miller - District Administrative Nursing Officer
Mr. R. B. Stevens - District Administrative Officer

Miss A. J. Scandrett - Board's Headquarters

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

LISSUE HOSPITAL

Paediatric Unit

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

Psychiatric Unit

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

Dry Rot

It was noted that the remedial work had commenced on the rot at the top of the main staircase.

KILLOWEN HOSPITAL

The members inspected the adaptations and fire precaution work, and were of the opinion that the money for these projects had been well spent. The patients who had been transferred from the old Lisburn Hospital were now accommodated in more pleasant surroundings, and were much more comfortable. The staff had integrated very well with the existing staff at Killowen. It was felt that the installation of a lift would be of great assistance in the movement of patients.

MENTAL HEALTH COMMISSION FOR NORTHERN IRELAND

HOSPITAL REPORT (Confidential)

Future Visits Recommendation

regular visit	1
visit in 6 mths	2
visit in 3 mths	3
urgent revisit	4

Future visit: 1

Board Area

Northern	1
Southern	2
Eastern	3
Western	4

Board: 3

Date 5 January 1987

Date: 0 5 0 1 8 7

Hospital/~~unit~~ Lissue

Hospital (code):

Type of provision:

mental illness	1
mental handicap	2
mixed	3

Type pt: 2

hospital 500+ beds	1
hospital 500 beds	2
unit 100+ beds	3
unit 50 - 100 beds	4
unit - 50 beds	5

Size: 5

hospital	1
nursing home	2
home for person in need	3
other	4

Type Hospital: 1

statutory	1
voluntary	2
private	3

Status hospital: 1

Total number of patients 17 + 3 day patients

No pts: 0 1 7

Total number of detained patients Nil

Names of Visiting Commissioners

Dr Scally (Team Leader) Mrs Eve

(Reporter)

No det pts: 0 0 0

Time of visit: from 9.30 am to 2.45 pm

Type of visit:

day	1
early morning	2
night	3

Visit: 1

announced	1
unannounced	2

Announced: 1

REPORT

1. Detention of in-patients for 48 hours (art 7(2))

Comments on use/policy:

N/A

2. Is the availability of Pt II Doctors always satisfactory?

Always	1
Usually	2
Not often	3
Never	4
N/A	5

Pt II [1]

If no, please specify:

3. Admissions from courts

(1) Number of art 42 remands for report etc — No/42 [ ]

(2) Number of art 43 remands for treatment — No/43 [ ]

(3) Number of convicted persons subject to hospital order under art 44 — No/44 [ ]

(4) Number of convicted persons subject to interim hospital order under art 45 — No/45 [ ]

The only 'court' admissions are of children who are subject to a fit person or place of safety order under the Children and Young Persons legislation.

4. **Use of guardianship**

Comments:

N/A.

5. Consent to treatment

(1) Arts 63 and 64 N/A

Is there (if appropriate) a form 21 or 22 for each detained patient?

Yes	1
No	2
N/A	3

Consent 1

Are all the forms completed satisfactorily?

Yes	1
No	2
N/A	3

Consent 2

Is there an adequate flagging system for renewal/Art 67 review reports?

Yes	1
No	2

Consent 3

Comments:

N/A - except where parental rights have been removed and authority given to social services.

(2) Urgent treatment (art 68)

Is a complete/accurate central record kept and monitored?

Yes	1
No	2

Art 68

If yes, who monitors:

If no, comments:

6. Treatment plans for patients

Is there a written multi-disciplinary programme for each patient?

A formal written plan is not kept. The MD team keeps notes based on discussion at 2 x ½ day ward rounds each week. The MD team comprises medical, psychology, nursing, teaching and social work staff.

Always 1
Sometimes 2
Never 3

3

Is there a nursing process for each patient?

This emanates from ward rounds.

Always 1
Sometimes 2
Never 3

1

Is there a medical formulation recorded in a clear and explicit form for each patient?

Always 1
Sometimes 2
Never 3

1

Does the unit operate a "key worker" system to co-ordinate the individual's programme of care?

Keyworker is not always medical.

Always 1
Sometimes 2
Never 3

1

Are treatments which could be distressing for patients and which are not specified under Article 64 eg Time Out, Aversion Therapy, Behaviour Modification Programmes carefully monitored and understood by staff?

BMP - modified by the full time clinical psychologist - always written.
TO - used by nursing staff/corridor (not room) for a few minutes.

Always 1
Sometimes 2
Never 3

1

7. After-care plans for patients

Are individual follow-up treatment plans clearly specified prior to discharge?

The inpatient unit usually follows up patients for a month. They may be referred to an outpatient unit for child psychiatric guidance. There is extensive liaison with various outside bodies, eg social services.

Yes 1
No 2

Is there a written policy/set of procedures?

Yes 1
No 2

Comments:

8. Patients' money

Are capable detained patients allowed to handle money?

Yes	1
No	2
N/A	3

Money: 3

Comments on administration/policy/use of rewards:

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

9. Seclusion policy

Is seclusion used

Yes	1
No	2

Seclusion 1: 2

There is a seclusion policy laid down by the Area Nursing Team but seclusion is never used.

If yes,

Are instances of seclusion recorded on the wards:

Always	1
Usually	2
Not often	3
Never	4
N/A	5

Seclusion 2:

centrally recorded accurately

Always	1
Usually	2
Not often	3
Never	4
N/A	5

Seclusion 3:

monitored adequately

Always	1
Usually	2
Not often	3
Never	4
N/A	5

Seclusion 4:

Comments on seclusion policy/practice:

Comments on seclusion rooms:

10. **Are voluntary patients nursed on locked wards?**

Yes	1
No	2

Locked

If yes - give names of wards

Does the hospital have a written policy for nursing informal patients in secure provisions?

Yes	1
No	2
N/A	3

Secure policy

Comments on use of de facto detention etc:

Some wards are lockable to keep children out at certain times. Absconders are catered for by staff reallocation.

11. Mental Health Review Tribunals

Are patients aware of and do they exercise their right of appeal?

12. Staff training re Mental Health Order

Are staff given satisfactory training

satisfactory	1
not satisfactory	2
not covered	3

Staff training: 1

Comments:

Nursing staff - 2 x ½ day study sessions. They can also attend weekly training sessions run by the child psychiatrist for medical/nursing staff.

Social workers - were given opportunity to attend training courses.

13. Patients Rights (art 27)

Was a notice concerning the visit on display on the wards?

Yes	1
No	2

Notice:

Were leaflets on patients' rights available, if so where?

Yes	1
No	2

From nurses.

Leaflets: 1.

Were patients advised of the Commissioners' visit?

orally	1
in writing	2
both	3
not informed	4
N/A	5

All parents were informed.

Pt advised:

To whom has the duty for informing patients orally of their rights been delegated?

nurses	1
admin	2
other (specify)	3
more than 1	4
no policy	5

Inf rights

Were ward staff seen to be aware of patients' rights?

all	1
most	2
some	3
few	4
none	5

Staff/rights

Is patients' state of understanding and need for possible further action recorded?

Always	1
Mostly	2
Occasionally	3
Never	4
N/A	5

Pt understands

Comments on patients' awareness of rights, particularly those who have communication difficulties:

Ward Visits

name of ward	type of ward	locked/unlocked*

* at time of visit please state L of U

Number of detained patients interviewed

- at patients' request:

- at Commissioners' request:

Total patients interviewed:

Number of complaints received:

How many voluntary patients interviewed:

Pt

1			
2			
3			
4			
5			

Were any patients unavailable during the visit?

Yes	1
No	2
N/A	3

Det pt

If yes, give reasons:

General Comments on Interviews

(Please list separately the names of patients seen, with notes on individual interviews. In the case of a complaint, complete a separate complaint form for each).

General Comments on Ward Visits

1. The Psychiatric Unit

The unit is small, having 2 seating areas, a dining-room, some 4-bedded wards and some single rooms. Children are encouraged to bring their possessions and to put up pictures etc. Many go home alternate weekends, therefore, not as much use is made of this facility as might be.

There are 2 family flats with cooking facilities. These are used in particular for non-accidental injury cases.

A school with 4 classrooms and 5 teachers is attached to the unit and caters for children from 5-13, usually in conjunction with the child's own school.

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

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

2. Paediatric Unit

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

Assessment and Treatment

Some of the children are admitted for assessment and stay for a short period only at Lissue. Others are there on a longer-term basis for treatment. The average stay is 2 months; some are less than 2 weeks, some over one year. The majority are boys.

General Comments on Wards Visits continued

The emphasis is on involving the whole family, including parents, siblings, grand-parents, uncles and aunts, as appropriate. The unit has a closed circuit video unit which is used to record interviews with families. One member of the multi-disciplinary team conducts the interview which can be watched then, or later, by the others so that a co-ordinated approach can be planned.

One psychiatrist insists that parents give an undertaking of regular contact and participation (see copy attached of relevant form) on a weekly basis at the least.

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

FINAL MEETING BETWEEN COMMISSIONERS AND SENIOR STAFF

(All the points raised should be recorded and included in the subsequent letter to the hospital).

Issues raised by Commissioners

The Commissioners commented favourably on the multi-disciplinary approach and on the obvious harmony between the various professional disciplines.

The only doubt raised concerned the adequacy of staffing in view of the high turnover and high occupancy rates (see figures provided in advance).

Issues raised by staff

1. The role of nursing staff when apprehending absconders.

   Children do run away from time to time. The doors are not locked. It is hoped to contain such children by maintaining close supervision but this is not always possible. Nursing staff queried whether it should not be the responsibility of social workers to look for the children and bring them back. It appears that, at present, whoever is available is used.

2. The future of the paediatric unit

   A decision is expected in mid-February on the future of the unit which tends to be used for mental handicap cases though not designated as such. The staff share parental concern that respite facilities may not be so freely available when the unit is moved to Purdysburn (probably).

3. Similar doubts exist about the future of the school as a result of the move.

Issues to be checked on next visit

Signed J Eve

LISSUE HOSPITAL

CHILD PSYCHIATRY UNIT

CONTRACT

I/We, the undersigned, the parents of ..... request that he/she be admitted to Lissue Hospital, Child Psychiatry Unit. *We have visited the unit and we have had explained to us the way in which it is run.

*

We agree to spend at least one afternoon or evening per week on the unit, and to attend once per week for family meetings. We understand that the whole family is required to attend these meetings unless the therapist requests otherwise and that these family meetings may be observed through a one-way screen or closed circuit video by other members of the staff of the unit.

We understand that this unit is open seven days per week, but that ..... may spend some weekends at home.

We accept these conditions and understand that if we are unable to fulfil them that the staff at Lissue Hospital reserves the right to discharge .....

Signed: Father ..... Mother .....

Date .....

* Delete as appropriate

Name of Child ..... Date .....

I (we) hereby give permission to Department of Child Psychiatry (Lissue Hospital) to obtain information about my (our) child pertaining to his/her treatment from:

The Child's School(s)
The Educational Psychologist
The General Practitioner
The Family's Social Worker

Delete which is not applicable

Signed Father .....
Mother .....
Guardian .....

Name of Child ..... Date .....

I (we) give permission to use any audiovisual recordings made at Lissue Hospital of myself (us) and my (our) family for the purpose of (a) research by professionals; (b) teaching to professional workers only with the approval of the Medical Director. I (we) understand that if I (we) wish to withdraw my (our) permission I (we) may do so in writing.

Signed Father .....
Mother .....
Guardians .....

[redacted]

[redacted].

[redacted]

Q24. Any other relevant information you wish to make the HIA Inquiry aware of in respect of Lissue.

144. During their training, doctors seeking to specialise in Child Psychiatry and working towards a Consultant's post would almost certainly have spent periods of time in the Child Psychiatry Unit at Lissue Hospital during its years of operation. It has come to the Boards attention that Dr Roderick Morrison Fraser ("Dr Morris Fraser") was a Senior Registrar in the Royal Belfast Hospital for Sick Children and is described as having been employed by the Northern Ireland Hospital Authority as a child psychiatrist from 1 August 1970. Drs Nelson and McAuley recall that as part of his work Dr Fraser would have spent periods at Lissue. The Inquiry may wish to note:

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

b. On 17 May 1972 Dr Fraser pleaded guilty to a charge of indecent assault at Bow Street Magistrates' Court in London;
c. This was referred to the General Medical Council where Dr Fraser was found guilty of serious professional misconduct. In determining what sanction to employ the GMC considered the circumstances during sittings on 16-21 July 1973, 11-13 March 1974, 15-18 July 1974 and 14-16 July 1975. It appears that the matter was subsequently concluded without sanction. [redacted]
d. During this period it is believed that Dr Morris continued to work in Belfast. Recollections from staff at the time suggest that the Northern Ireland Hospital Authority was not aware of the allegation or conviction in 1972;
e. In or around May 1973 Dr Fraser was charged as one of eight people connected to the abuse of boys on an international scale. This was reported in the local press and came to the attention of the Northern Ireland Hospital Authority on the same day that Dr Fraser was due to interview for a post as Consultant in Child Psychiatry. The interview was cancelled. Dr Fraser did not work within Child Psychiatry in Northern Ireland or at Lissue hospital following this.

[redacted]

[redacted]

[redacted]

Child FF 11 year old girl admitted to Lissue from 10. 03.88 to 23.03.89.

This child was described as being in need of constant / strict supervision. Restraint was used on 3 occasions as follows:

10. 05. 88 - accused staff of twisting her arm yesterday. Staff spoken to by Nurse L who was told that her behaviour was unreasonable yesterday and was restrained and twisted her own arm (23)

07. 06. 88 – Note: this incident was not recorded in the Nursing notes until12.06.88. While being restrained Child FF sustained a black eye on 7June. When mum visited on 9th very annoyed, verbally abusive spoken to by Mr. BB, Mr. C and Charge Nurse J (8). In other notes it is recorded on 07.06,88." Verbally abusive and non-compliant and restrained by staff as she was loosing control" (30).

A Body Chart Form was completed by Nurse CC on 8th, June showing a left black eye. On 09. 06. 88. S/N J spoke to the child's mother and told her that he had had to restrain her. A detailed explanation was given of the restraint used and an explanation given of how Child FF sustained the injury by the upper part of Nurse J arm hitting her on the head (30) (31).

FROM FAMILY AND CHILD CARE NOTES:

At a Child Protection Review 23.09.88. Mr. D described the incident on 7th June thus:- " an attempt had been made to physically hold Child FF in a chair to calm her down and in so doing a member of staff accidentally hit her on the eye " (4)

Mr. D completed an Untoward Incident Report on 30.6.88 in which it was stated:
"Mr. BB investigated the matter from the nursing side and was satisfied from the reports from other nursing staff that Nurse. J's account was trustworthy" (5).

12/13.07.88 - would not settle despite being given several chances to do so and eventually had to be physically restrained (2).

Issues

(a) The absence of an Independent element to the Nursing investigation into the injuries sustained.
(b) There is no information to show that the enquiry considered the reason for the time lag between her injury being sustained on 7th, June and the record in the Nursing Notes made on 12th June three days later. The child's mother complained on 9th, June. There is no information about what prompted Nurse L to complete the Body Chart Form on 8th, June.
(c) The Family and Child Care Records indicate that the Untoward Incident Report was not completed until 30.06.88 by Mr.D. Why was there a delay of 23 days and why was it completed by Mr.D?

[redacted]

Q16. Is the Board aware of any contemporaneous complaints made of abuse in Lissue?

82. The Board is aware that in March 1983, LS71 alleged buggery by another patient in the Child Psychiatry Unit. The following chronology summarises the steps taken:
    a. LS71 was an inpatient in Lissue from 19 August 1982 to 24 September 1982;
    b. LS71 was subsequently placed in Marmion Children's Home. In February 1983 consideration was being given to a further admission to Lissue, which upset LS71. Over the course of discussion with his Social Worker, [redacted] LS114, on 25 and 28 February 1983, he disclosed sexual abuse by a peer (whose name he did not know) within the unit during his previous admission;
    c. This matter was immediately reported to police. The Social Worker accompanied LS71 to the police station on 1 March 1983. On that date he

was medically examined. It is recorded that: “the doctor stated that in his opinion (despite the time elapsed since alleged incident) that sexual interference may have taken place”. The Social Worker returned to the police station with LS71 on 2 March 1983 when a statement of complaint was taken. The Assistant Director of Social Services, EHSSB, Mr Bunting, was also advised of the complaint by telephone on 2 March 1983;

d. The allegation was also reported to the Child Administrative Nursing Officer (“CANO”) at EHSSB. On 3 March 1983 the CANO made contact with the District Administrative Nursing Officer (“DANO”). The DANO undertook an investigation and provided a written report dated 16 March 1983. The conclusion was, in summary, that policies were sound and there was adequate provision for the nursing care of all children brought into the Unit; that an element of risk did exist within the philosophy which had to be accepted; that the recent tendency to admit children over 14 years was stretching the Unit beyond that with which it could cope; and that in completing the investigations, DANO had sought to ensure that nursing staff fully understood their role and responsibilities. The investigation concluded that staff were fully aware of all procedures and there was no indication of any staff negligence. It was held that, given the risk element and the large number of children over 14 years, it was difficult for staff to manage and supervise them and manage their care because of the manty difficult needs of the various groups.

e. This report was provided to the CANO. Following discussion with Consultant Medical Staff, it was agreed to institute a change in admission policy so as to ensure that children over 13 would not be admitted from 29 March 1983. 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.

f. By 8 March 1983 the fact of the police investigation had been reported in the press (Irish News).

g. On 21 July 1983 the Child Administrative Officer advised the Department in writing of the untoward incident. This followed correspondence from the Department commencing 26 March 1983 in light of the press report. The Department sought information as to which the incident had not been dealt

with in accordance with the relevant circular (HSS 4 (OS) 1/73, dated 30 October 1973). The EHSSB advised in July 1983 that some confusion had arisen form the fact this was an allegation being investigated, but accepted that the Department should have been notified and an apology was given for the oversight.

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

[redacted]

EHSSB

INDEPENDENT REPORT LISSUE & FORSTER GREEN HOSPITALS HISTORIC CASE REVIEW

Final Draft

RS STINSON

January 2009

This report is an independent review of Lissue and Forster Green Hospitals case records augmented as appropriate with Family and Child Care records for children admitted to either facility between 1975 & 1995. Not all records were complete, comment is restricted to information available by January 2009

Contents **Page**

1. Background

1.1 Lissue and Forster Green Hospitals were directly managed services within the Eastern Health and Social Services Board (EHSSB) until the establishment of Health and Social Services Trusts in 1994. The relevant units of each hospital were managed within the Child Psychiatric Service based at the Royal Group of Hospitals. The review has clarified that while both units operated as hospitals, neither was registered as such. Both units provided inpatient care of children with a range of mental health difficulties including anorexia, enuresis, encopresis, depressive type illnesses, suicidal and self-harming behaviours, obsessive compulsive disorder, Tourettes syndrome, and a range of conduct and behavioural problems. Some children and young people were also treated on an out-patient basis. The units also had facilities to admit children with their families for assessment and family therapy. Two consultant psychiatrists were responsible for the service and provided cover from their base at the Child Psychiatry Unit based on the RVH site as the services provided were Consultant-led. Both units treated children across the full age range. Lissue Hospital, in addition to its child psychiatry unit, also provided a service for infants with serious congenital issues. Lissue Hospital ceased operation as a Child Psychiatry Unit in the early 1990s.

1.2 Referrals for treatment were made from the out-patient specialist service based at the RVH site, from General Practitioners and by Social Services. A considerable number of the children referred had significant conduct and behavioural problems arising from their family and social environment prior to admission; this was particularly noteworthy in children who were either in the care of Social Services or in contact with Social Services due to either their own or their parents' emotional, social and psychological situations. The nature of children's problems, whether strictly clinical or social in origin, meant that they had a complexity of needs which within a group living context would have posed significant management problems on those charged with caring for them.

1.3 Following an allegation made by a previous patient regarding her care at Lissue a Serious Adverse Incident Report (SAI 0336) was received on 2 May 2008 by the EHSSB from the Belfast Trust stating that an internal review was being conducted in respect of the allegations made about staff previously employed in Lissue and Forster Green Hospitals reportedly between 1985 and 1991. The allegations related to physical, mental and sexual abuse. The Belfast Trust has led on work to investigate the allegations in relation to this complainant. The DHSSPS was aware of 2 previous allegations made in respect of Lissue in 1993 and 1994 and on receipt of the SAI Report it brought this information to the attention of the Belfast Trust and EHSSB to assist with the present investigations.

1.4 Six staff members were named by the complainant. Preliminary enquires indicated that two of these individuals were currently employed within the HPSS; one of these members of staff was named in the 1993 complaint which was investigated by the RUC. Both Trusts were tasked to review staff case files to ensure that no current employee posed a safeguarding risk for children and/or vulnerable adults

and to investigate the situation in relation to the staff member named by the complainant.

1.5 As the EHSSB was directly accountable for service provision at Lissue and Forster Green Hospitals at the time of the alleged abuse it has led on an investigation of the historic aspects of the abuse allegation. The EHSSB decided to sample 30 children's case files to elicit information relating to their care. The focus of the EHSSB's Historic Case Review is on safeguarding issues relating to the care of children. This report sets out the findings of the Board's historic review of cases.

1.6 The remit of the Review limited it to examining case records to identify child safeguarding issues. Wider issues relating to the professional practice of staff, or the nature of the therapeutic environment at either unit, which may arise require to be addressed by the appropriate authorities to ensure both the safety of current patients and that legacy care or treatment practices are not carried forward into inpatient Child and Adolescent Mental Health Services (CAMHS).

1.7 The Review's findings will require to be considered by the Board and its Trusts in the wider context of the Belfast Trust's review of the case specific aspects of the allegations made by a services user (see Para 1.3) and both Trusts' review of relevant staff files (Para 1.4).

2. Review's Terms of Reference (TOR) & Methodology

2.1 To assist the EHSSB in the examination of children's case files as part of an initial scoping exercise designed to ascertain what, if any, further action should be taken in relation to reported issues at Lissue or Forster Green Hospitals the following Terms of Reference were established:

Phase 1

To conduct an initial sift of 30 children's case files to identify potential areas of concern. The criteria employed at this stage were:

i. information suggestive of physical and/or sexual abuse between peers;
ii. information suggestive of physical and/ or sexual abuse of children by staff;
iii. information suggestive of grooming activity

Any information of a *harsh regime* would also be documented in this sift.

Phase 2

The information obtained from Phase 1 to be collated to inform a Report to the EHSSB highlighting any areas of concern and indicating what, if any, further action should be taken.

Methodology

2.2 A sample of 30 children's CAMHS case file were selected, 10 of the children were named in previous allegations (see Para 1.3) while the remainder were selected randomly from the Admissions Register. On the basis of information forthcoming from the review of the 30 CAMHS files 4 additional files were accessed resulting in 34 CAMHS files being examined. Where children had a care background the review also sought access to their Family and Child Care (F&CC) case files following their discharge from either unit to assess if any reference was subsequently made to any untoward event at Lissue or FGH. Accessing these files proved problematic and often no files or partial files were provided for review. As most of these children had been in the care of HSS Trusts which have a statutory duty to maintain case files for 75 years from the child's date of birth this is a matter which the EHSSB and Trusts should consider to ensure full compliance with their statutory duties in relation to the safe storage of children's case files.

2.3 All incidents from the 34 case files identified at the Phase 1 stage were referenced and the same reference number is used in this Report. For ease of reference, details of incidents highlighted in Phase 1 have been transcribed directly into this Report.

3. Definitions

3.1 The following definitions have been used:

Child: a person under the age of eighteen.

Sexual Abuse: forcing or enticing a child to take part in sexual activities. The activities may involve physical contact including penetrative or non-penetrative acts. They may include non-contact activities such as involving children to look at, or the production of pornographic material or watching sexual activities or encouraging children to behave in sexual inappropriate ways. Sexual activity involving a child who is capable of giving informal consent while illegal, may not necessarily constitute sexual abuse as defined above. The decision to initiate protection action in such cases is a matter for professional judgment and each case should be considered individually.

Physical Abuse: deliberate physical injury to a child or the willful or neglectful failure to prevent physical injury or suffering. This may include:

- hitting
- shaking
- throwing
- poisoning
- burning or scalding
- drowning
- suffocating
- confining to a room or cot
- inappropriately giving drugs to control behaviour.

Bullying: a child who is bullied may suffer from any of the types of abuse defined above. It can take many forms but the main are:

physical e.g. hitting, kicking

verbal e.g. sectarian / racial remarks, name calling, threats

indirect e g. spreading rumours

The above definitions are taken from *Cooperating to Safeguard Children*, DHSSPS (May 2003). The following definitions have been taken from Wikipedia.

Harassment:	a hostile or offensive act or expression against a person. It includes: o derogatory name calling o insults or racist jokes o verbal abuse ranging from belittling or suggestive remarks to threats, physical attack and ridicule of an individual.
Sexual Harassment:	always involves unwanted attention or treatment which emphasizes sexual status or which has a sexual element. It can be physical, ranging from suggestive looks to indecent assault or rape ; or verbal ranging from belittling or suggestive remarks and compromising invitations to aggressively foul language or unwanted demands for sex, or displays of sexually suggestive or degrading pictures or displays. The effect of such behaviour on the recipient is to create an intimidating, hostile or offensive environment.

4. Index

4.1 The following is a glossary of the children whose case files were reviewed and the reference letter used to refer to each within the Report. The Category number relates to the nature of the incident; see Key below. A separate index links the child's referencing system to the name of the individual child.

Child	DOB	Categories 1	2	3	4	5	6	7
A.	[redacted]	√		√				√
B			√					
C								
D							√	√
E				√			√	
F								
G								
H								√
I								√
J							√	√
L								
M								√
N								
O								
P			√					√
Q								
R		√						
S		√						√
T		√						
U		√						
V								
W			√					

Child	DOB	Category
X	[redacted]	
Y		√ √
Z		√
AA		√
BB		√ √ √ √
CC		√
DD		√ √
EE		√ √ √
FF		√
GG		√ √
HH		

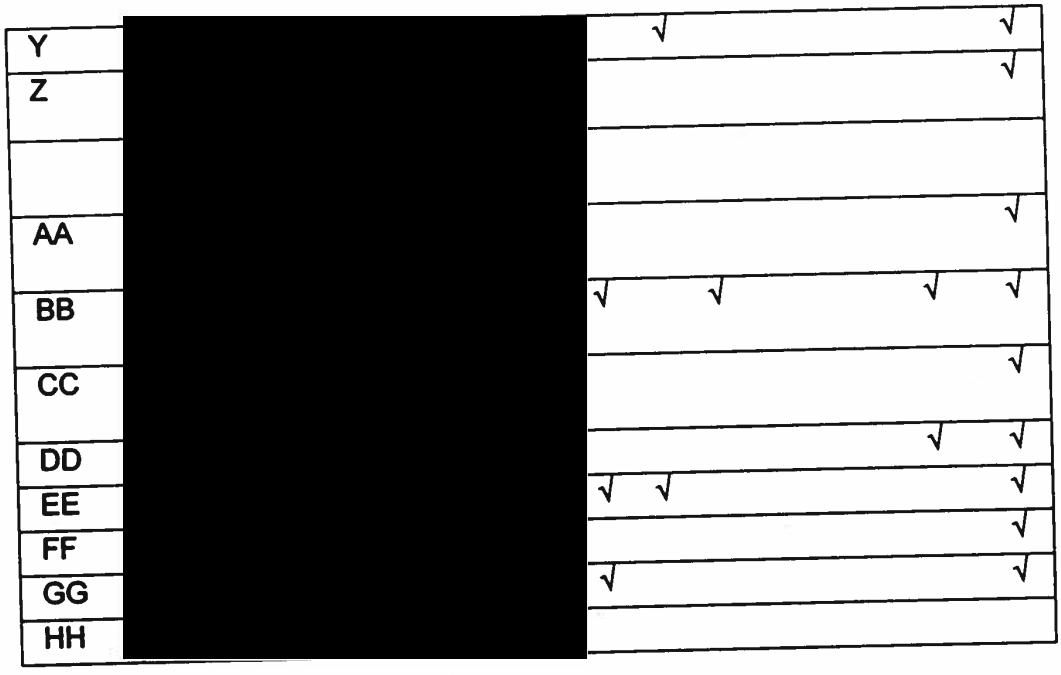
Key:
1. Sexual Abuse by Peers
2. Sexual Abuse against Peers
3. Sexual Abuse by Staff
4. Physical Abuse by Peers
5. Physical Abuse against Peers
6. Physical Abuse by Staff
7. Care Management

Note. Individual incidents are not recorded

Children's Index

4.1 The following is a glossary of the children whose case files were reviewed and the reference letter used to refer to each within the Report. The Category number relates to the nature of the incident; see Key below.

Child	Name	DOB	Categories 1	2	3	4	5	6	7
A.	[redacted]	[redacted]	√		√				√
B				√					
C									
D								√	√
E					√			√	
F									
G									
H									√
I									√
J								√	√
L									
M									√
N									
O									
P				√					√
Q									
R			√						
S			√						√
T			√						
U			√						
V									
W				√					
Child			Category						
X									



Key:
1. Sexual Abuse by Peers
2. Sexual Abuse against Peers
3. Sexual Abuse by Staff
4. Physical Abuse by Peers
5. Physical Abuse against Peers
6. Physical Abuse by Staff
7. Care Management

Note. Individual incidents are not recorded

5. FINDINGS

5.1 This section sets out the findings under the following heading:

5.1.1 allegations of sexual abuse by peers
5.1.2 allegations of sexual abuse against peers
5.1.3 allegations of sexual abuse by staff
5.1.4 allegations of physical abuse by peers
5.1.5 allegations of physical abuse against peers
5.1.6 allegations of physical abuse by staff
5.1.7 grooming.

Details in relation to children are provided using the reference letter from Table 1. Peer sexual activities are considered under 2 headings: *allegations of sexual abuse by peers* and *allegations of sexual abuse against peers,* the former are allegations made by children while the latter are third party allegations of observations recorded by staff.

5.1.1 Allegations of Sexual Abuse by Peers (Category 1)

Total number of children abuse 8

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

- fondling other children e.g. breasts/testicles (6)
- alleged sexual intercourse (1)
- kissing private parts (1)
- exposing body parts (1)

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

5.1.2 Allegations of Sexual Abuse Against Peers (Category 2)

Total number of abusing children: 6

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

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

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

5.1.3 Allegation of Sexual Abuse by Staff (Category 3)

Total number of incidents: 3

The 3 allegations within this category related to girls whose ages ranged from 8 to 13 years (average age 10 years). Two of the allegations relate to unnamed staff, while one named a staff member. One of the former and the latter were referred to the Police Service for investigation. In one case, as the 8 year old could not name the staff member, no outcome was recorded. There is also no evidence of a review of the case files when the allegation was first made in 1990 to seek to identify any potential untoward event. In the latter case, relating to a 13 year old girl, the absence of corroborating evidence when a disclosure was made some 15 years following her discharge from Lissue meant there was no police action. The absence of a criminal charge does not, however, obviate the need for consideration at employer level using the balance of probability associated with safeguarding of children.

The remaining allegation related to an 8 year old girl whose mother alleged that a doll's arm had been put up her daughter's bottom by staff in July 1993. This matter appears to have been resolved to the satisfaction of the parent, however, the records do not specify how.

Appendix 3 provides details on these 3 incidents.

5.1.4 Allegations of Physical Abuse by Peers (Category 4)

The file extracts made available contain many references to named children being

physically abused or bullied by named or unnamed peers. There is, however, no information to suggest systematic or sustained attacks on any particular child and what did take place amounted to spontaneous adolescent brawls which developed out of some degree of provocation or acts of misplaced bravado.

5.1.5 Allegations of Physical Abuse against Peers (Category 5)

While the above may also be said about allegations of physical abuse against peers, one child, Child BB was noted as having committed 42 assaults on a number of named children

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

5.1.6 Allegations of Physical Abuse by staff (Category 6)

Total number of incidents:	2 (recorded in Files) 2 (in Patients' written statements or transcriptions of conversations with Police)

A total of 4 allegations were made against staff, 3 of whom were based in Lissue, the other was a visiting social worker. Three of the allegations were made by girls who ranged in age from 6 to 13 years (average age 10 years), the boy was 12 years of age.

The nature of the allegations included staff allegedly hitting a child, being given "an awful kick up the behind"; this complainant alleged that 2 named members of staff were "always violent with the children". This complainant made a written statement to the Police Service in 1993 detailing her allegations (see Appendix 3).

A further complaint was made to the Police in 2008 by Child J who alleged physical abuse by teaching and insensitive handling by nursing staff (see Appendix 4). The complaint regarding the visiting social worker was that a child was grabbed by the arm.

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

Appendix 4 provides further details.

5.1.7 Grooming (Category 7)

In the present context, Grooming is taken to mean the cultivation of a relationship by a stronger person with a weaker person for some ulterior motive. In the course of this review it was found that older children formed relationships with younger more vulnerable children but no motive was ascertained from the records, other than to help staff or to get personal satisfaction. The history of some of the children involved in assisting younger children raises questions about this practice from a management perspective. The Board should check that such practices are no longer extant. Some of the issues which emerged from this practice are set out below under the following headings:

(a) child/child;
(b) staff/child.

Child / Child

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

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

Another note referring to the same patient states:

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

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

Staff / Child

Incidents involving two children **Child A and Child H** were considered for inclusion in this category but due to the difficulty in discovering any positive evidence of intent in both cases, they have been included in the section **Staff / Child relationships at Section 6 sub-section (v).**

6. CARE MANAGEMENT REGIME

6.1 In the course of this review the following issues in respect of the care received by some children have been identified:

6.1.1 Restraint

6.1.2 Sanctions

6.1.3 Victimisation

6.1.4 Humiliation

6.1.5 Supervision / Staffing Levels

6.1.6 Staff / Child Relationships

- Child A
- Child H.

6.1.7 Child J

6.1.1 Restraint

Restraint is considered in some detail to assess to what degree it was part of the therapeutic culture of Lissue and Forster Green Hospitals. Restraints which were clearly used to prevent injury to self or others are not recorded in the cases discussed. A total of 6 children were the subject of restraint.

The following section considers restraint used in these 6 children's cases, and concludes with a section on the issues arising. Details relating to these cases are available at Appendix 5.

The incidents relate to 3 boys aged from 7 to 12 years of age (average age 10 years) and 3 girls aged from 11 to 13 years (average age 12 years). Issues arising related to:

- restraint being used when a child threatened or attempted an action, rather than poses a risk to self or others;
- involvement of patient's relative, bus driver or student nurses in restraint;
- injury to children, one child sustained a black eye, another friction burns, while one complained of her arm being twisted;

- use of restraint when in pre-admission reports Social Services noted that it was counter-productive as the child sought any attention whether positive or negative;
- the limited staffing resources which were at times diverted to restraining children and the number of staff employed to restrain individual children;
- restraint used to achieve compliance regarding, for example, refusing to go to Time Out, or take a shower or change clothing or bedding;
- the length of time for which restraint was employed;
- use of a blanket to restrain a child;
- restraining a child in her bed; particularly of concern with one 11 year old girl with a previous history of being sexually abused;
- refusing to settle.

In one case, there was a delay in recording that Child FF sustained a black eye until after the mother complained about the injury. An Untoward Incident Report to Social Services who held a Fit Person Order in respect of Child FF was dated 18 days after the event and had to be requested by Social Services. The investigation of the mother's complaint had no independent element which would have been both possible, given that the child was in care, and desirable. The delay in making this record raises questions regarding the comprehensiveness of file recording in general.

Issues Arising from use of Restraint

The restraint incidents, reviewed as part of this work, took place between 1988 and 1995. It is unclear whether or not there was a policy in place in respect of the application of restraint to guide staff's practice or to monitor practice in this area, at that time. While care must be taken to avoid historical events being judged against contemporary standards there are nevertheless, expectations that vulnerable children should be treated with sympathy, respect, and understanding and that their dignity should be protected at all times irrespective of whether or not a policy is in operation. While understanding the difficulties which staff had to face in managing a group of children with complex needs, the following questions emerge:

- what guidance, supervision and support had staff access to when employing restraint?
- was it considered appropriate for restraint to be applied for non- compliance?
- was it always applied as a last resort?
- was it always applied in the best interests of the child involved or for the protection of other children or staff?
- were there arrangements for management oversight of its use to inform training or developing other responses?
- were staff appropriately trained and accredited to use restraint?
- when it was appropriate, were Untoward Incident Reports completed on time?

6.7 In 2005 the DHSSPS issued Guidance on the use of Restraint and Seclusion to the HPSS family; the Board should ensure that its inpatient CAMHS facilities have

policies and procedures to implement this guidance.

6.1.2 Sanctions

The use of sanctions to influence children's behaviour is acknowledged as one means of influencing acceptable behaviours. In the following the threat of sanctions was used by staff on a small number of occasions to encourage compliance which impacted negatively on children's contact with important others, or on the whole group. A total of 4 children's experiences are considered. Appendix 6 provides a summary of the events.

The four incidents relate to 3 girls aged from 11-15 years (average age 13 years) and one 7 year old boy. In 2 cases children were not permitted a visit home due to failure to comply. One of these was in respect of an anorexic teenage girl who had failed to gain a kilogram in weight. The other was in relation to a 7 year old boy with a history of encopresis and nocturnal eneuresis. This event occurred when he had spent more than 2 months away from home, given his age, sanctions other than restricting his home visits would have appeared more appropriate. The third child for whom denial of leave was used as a sanction was in respect of a child in care who was refused an overnight stay at her children's home.

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

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

6.1.3 Victimisation

From the information provided it is clear that staff were faced with a wide range of challenging behaviour, some of which were tolerated and some of which were punished with a range of sanctions. Again, based on the information provided, there was only one boy who was put to bed early as punishment for his series of misdemeanours. See Appendix 7.

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

6.1.4 Humiliation

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

The review identified 11 children's cases where humiliation appears to have been used, 3 boys and 9 girls. The boys ranged in age from 6 to 13 (average 9 years), much younger than the girls who ranged in age from 4 to15 (average age 12 years). With the exception of a 4 and 10 year old girl the remainder were teenage girls. Details are available of the incidents set out in Appendix 8.

Issues arising fell within the following broad categories:

- showering and bathing of older patients, including removal of sanitary towel;
- strip searching
- insensitivity to symptoms of illness and housing of children
- standing a child against wall for 1½ hours;
- forcing a child to bed

General Issues arising regarding Bathing and Showering

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

6.1.5 Supervision / Staffing Levels

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

The Review examined the records of children cared for over a period extending from 1979 to 1995. Thirteen children were noted as needing varying levels of supervision over this period, but they were not all in residence at the same time. It is, therefore, not possible to detect retrospectively any sustained period of children requiring supervision at the same time, not getting the care they needed. However, the notes made on individual children provide an indication of the concerns felt by

nursing staff and the impact on children may be assessed by the level of misbehaviour and gratuitous violence noted during the Review of their case records. Further details are provided at Appendix 9.

The following addresses issues relating to staffing and supervision levels from the 4 cases within this category. Two girls aged 10 and 13 and two boys aged 9 and 14 were identified by staff as requiring higher levels of supervision than staffing levels permitted. The implication for the supervision of children and their care are evident from these records, which may not fully reflect the position given that only a small sample of cases was reviewed:

Issues

Apart from being noted on the files was any recognition given by management to the concerns raised by staff in 1979 and 1980 regarding staffing levels? When one considers the high level of restraint used at time which took up considerable staffing resources and the complexity of children's needs the staffing complement needs to be given particular attention when considering the overall findings of this review.

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

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

6.1.6 Staff / Child Relationships.

There were 2 girls aged 8 and 14 (Child A and Child H) about whom the records suggested issues relating to the appropriateness of the staff/child relationship (see Appendix 10). These are set out below in some detail. There is no indication of management oversight of case files which potentially would have brought the potential risks associated with the situations to the attention of the staff member so that safer practices could be promoted to minimize the risk of complaint.

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

6.1.7 Child J

A separate section has been provided in respect of this child as she as an adult made a complaint about her treatment at Lissue. It is this complaint which triggered the review of children's case records as set out in Section 1.

Child J was first admitted to Lissue in1987 suffering from Tourette's Syndrome when she was 12 years old. In 2008 at the age of 33 years she described her treatment at Lissue to the Police and Appendix 11 is based on a transcription of two interviews she had with Detective Constable B attached to the Child Abuse Investigation Unit at Antrim Police Station and Ms C, Assistant Manager Community Mental Health Teams, Belfast Health and Social Care Trust on:

1. 23rd May 2008
2. 3rd June 2008

Details, contained in Appendix 11, should be considered with caution as at this time it amounts to a series of uncorroborated allegations.

General Issues Arising from Child J's case

Child J's interview with the police alleged an institution at Lissue and Forster Green Hospitals run on the basis of threat, the installation of fear among vulnerable children, the deliberate deprivation of their dignity and bullying by senior staff. While I have cautioned about the need for corroboration, a significant number of the issues raised by Child J also emerges from the review of the file notes submitted as the basis for this review. The Board and Belfast Trust should take action to ensure that current practice in impatient child and adolescent facilities is to a high professional standard and that all staff are trained on child protection matters.

7. CONCLUSION & RECOMMENDATIONS

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

- children admitted to Lissue with their range of complex and at times competing needs;
- the challenges arising from the structure of the institutions; and
- the risk of judging practice by today's standards.

7.2 To assist the Board and its Trusts the following recommendations are made:

1. Trusts Directors of Social Work should ensure that Family and Childcare files are stored in such a manner that they can be readily accessed given the statutory duty to retain for 75 years.

2. The EHSSB and its successor body should seek from its inpatient child and adolescent mental health facilities copies of their Restraint Policies and Procedures to ensure they are informed by DHSSPS Guidance on the use of Restraint and Seclusion (2005).

3. The PSNI should provide in writing to the EHSSB and its successor body its conclusions on which, if any, cases could be progressed under the criminal law.

4. The practice of the range of professionals who comprised the multi-professional team working at Lissue and FGH should be reviewed by medical, nursing and social work professionals based at the EHSSB through detailed consideration of collated data acquired through the sift of case files and this report.

5. The EHSSB and its successor body should seek from the Belfast Trust assurance that its CAMHS facilities operate to high professional standards.

6. The EHSSB and its successor body should seek from Belfast Trust details relating to the Child Protection training provided to its CAMHS staff with details on the number of staff trained.

7. The EHSSB and its successor body should ensure that CAMHS staff have guidance on case recordings and that there is management review and oversight of these records.

8. The staffing complement of CAMHS inpatient facilities should be reviewed by the Belfast Trust to ensure its adequacy; and that all staff have regular access to support, supervision and training.

9. The EHSSB and its successor body should ensure that the Trusts have robust systems for recording and managing all complaints received from children resident in Mental Health facilities and for the provision of Annual reports on these and their outcomes.

10. The EHSSB and its successor body should ensure that the Trusts have robust policies for monitoring and assessing abscondings and for the independent debriefing of patients on their return.

11. The EHSSB and its successor body should consider the finding of this review and agree whether or not there are further actions which it wishes to take in relation to pursuing further those incidents deemed to require further follow up.

7.3 The EHSSB and its Trusts should prepare an Action Plan with timescales to implement these recommendations by the 31 March 2009.

APPENDIX 1: DETAILS OF ALLEGATIONS OF SEXUAL ABUSE BY PEERS

Child A - 8 year old girl admitted to Lissue from 23.06.86 to 07.08.86

Child A complained that a named male child had kissed her in the private parts (5). She reported this to staff; then told them that it was all lies (11). It had been recorded earlier that she was constantly telling tales against the same boy. (8)

In out-patient patient notes it is recorded that this child was raped while at home by a friend's uncle (14). There is no indication in the notes supplied that this allegation was referred to the police.

Child R - 9 year old girl admitted to Lissue from 27.02.93 to 27.08.93

Child R complained to her mother that another female child had touched her on her private parts. The alleged incident had been witnessed by a third party (another child) and reported to staff who were said not to have believed her. Her mother was assured by Staff Nurse Darragh that the incident would be fully investigated but the mother later said that R was probably telling lies and the matter was to be forgotten (1)

Issue

If the above incident was witnessed by a third party it is a matter of some concern that the mother's assertion was accepted as a reason for dropping any further enquiry by staff and that the witness was not interviewed.

Child S - 11 year old girl admitted to Forster Green Hospital from 06.01.95 to 26.06.95

Child S alleged that a named male child had touched her on the breasts whilst at the unit's school (1). It is recorded that she told the teacher but as the teacher had not observed the incident, it was seen as a matter of one child's word against that of another. There is no indication of any further action taken about this allegation apart from the incident being included in the school records for 19.06.95

Issue

Did the teacher make any attempt to investigate this incident by asking other pupils in the class about it? The incident appears not to have been taken seriously as a matter requiring to be investigated. There is no reference to whether or not a referral under the *Joint Protocol for the Joint Investigation by Social Workers and Police of Alleged or Suspected Cases of Child Abuse* was considered.

Child T - 13 year old girl admitted to FGH from 06.06.95 to 17.11.95

Child T alleged that a named male child had touched her breasts and later exposed himself to her (34). She was upset by this incident but was assured by staff that they would seek to ensure that it would not happen again (31). The boy was described as having physical and learning disabilities (25). In her discharge letter dated 23.12.94, it is recorded that Child T dealt with this incident herself, but it was reported to Social Services. However at her request any further investigation was dropped (32). The incident had also been reported when Child T was at school and was included in school records (40)

Issue

It was unclear what action was taken with the boy regarding his behaviour or whether there no response as the incident was dropped when Child T requested no further investigation..

Child U - 14 year old girl admitted to Lissue from 04.11.89 to 08.12.89.

Child U was sitting beside a named male child who rubbed his hand up and down her leg. She allowed him to do this for about 10 minutes. She was asked by staff did she fancy him and said no. She was then asked why she let him rub her leg. She became angry and accused staff of trying to get her a bad name (2).

Issue

While this child may not have objected to what happened to her, it is a matter of concern that a staff member observed the boy's behaviour (which amounted to an assault) for 10 minutes without intervention and then humiliated the child by asking if she fancied him. The staff member can be identified.

Child BB - 13 year old girl admitted to Lissue from 06.04.79 to 17.03.80
Day Patient 06.11.80 to 12.10.81

Child BB complained about a named peer feeling around her breasts (49),

Issue

It is not apparent from the records what action was taken by staff in relation to this incident.

Child GG - 9 year old girl admitted to Lissue from 28.10.87 to 22.12. 87.

On 7th January 1988 a male patient, Child EE, a 10 year old, admitted to staff that he

had had sexual intercourse with her before her discharge on 22nd December 1987. There was no knowledge of this incident prior to that date. The discharge letter to her GP (05. 01. 87.) stated:

"No evidence of sexualised behaviour while she was a patient " (1)

Child BB was considered to be in need of a high level of supervision (8). On 04.11.87 it was recorded:

"...inclined to wander off and do her own thing if not closely supervised." (15)

Issue

The problem of supervising children at Lissue should not be underestimated given:

a. the logistics of the layout of the building and the size of the surrounding estate
b. available number of staff
c. the number of children requiring high levels of supervision at any one time.

The potential to avert this incident had Child GG been under the supervision she was assessed as requiring needs considered.

(See also Child EE - Sexual Abuse Against Peers)

Child EE - 10 year old boy admitted to Lissue from 12.11.87 to 21.01.88
Day Patient 04.02.88 to 11.04.88
Re-admitted 11.04.88 to 30.05.88

Child F an 11 year old boy sexually assaulted Child EE by squeezing his testicles and penis (30).

Issue

Records on what, if any, action was taken by staff in respect of Child F's behaviour were not available, therefore, the appropriateness of the response is unknown.

APPENDIX 2: DETAILS OF ALLEGATIONS OF SEXUAL ABUSE AGAINST PEERS

Child B - 11 year old girl admitted to Lissue from 17.09.80 to 13.04.81

The records show that Child B had no hesitation in removing her clothing (2) (3). She also accosted boys feeling their penis irrespective of their age (6), fondled male peers (7) and on the first night of her admission she was reprimanded by staff on three occasions for lying around on the floor with boys (22). She required constant supervision and to be watched at bed time but staff noted that this was difficult to ensure as she could outwit most staff (49). She was found playing strip poker with boys (50) and on two occasions she was found touching the breasts of another female child. (59) (63)

Child X - 14 years boy admitted to FGH from 30.05.93 to 07.10.93

On one occasion Child X was found "constantly pawing at a female child" (42) It was noted that this boy was strong and aggressive and on a previous admission he was out of control (36) The same note also shows that staffing levels "were not adequate at the moment" (07.12.93.)

Child Y - 14 years boy admitted to Lissue from 03.07.81 to 25.08.82

The records show that Child Y persistently fondled other male children, including younger peers throughout the time he spent at Lissue. It was acknowledged by staff that he needed constant supervision but the records indicate that staff potentially colluded with him in presenting him with the opportunities to be alone with other male children.

For the purposes of this review only a specimen list of his contacts with other boys is included but it serves to show how Child Y presented a risk to his peers and how he needed to be kept under constant supervision. His behaviour provoked verbal and physical retaliation. The notes show:

- Child Y is encouraging ** to fondle him and he is doing likewise to *** (2) (this record also refers to him fondling a 5 year old boy)
- observed fondling over older peers, also masturbates in front of peers (9)
- will touch peers male peers in an inappropriate manner (21)
- spent this night in ****'s company under constant observation (30)
- seen rubbing his legs against ****'s, corrected but when staff's back turned he reverted to this behaviour (31)
- spent the night in *****'s company under observation (40)

- found to be fondling ****** around ******'s bottom, given a good talking to by myself and lost privileges (42)

In all, some sixteen incidents of a homosexual nature were recorded against this boy. He was also recorded as having grabbed a female child by the breast on two occasions (64).

Issue

Staff acknowledged that this boy was devious and underhand and in need of constant supervision it is difficult, therefore, to understand why staff permitted him to be alone all night with other male children even under supervision (30) (40) (77). Other children were afraid of him and on 17.11.81 they decided that he should be isolated and staff agreed (72). The boy's behaviour extended to younger peers also resident in Lissue; the wide age range of residents places particular challenges on staff.

The difficulty in providing effective controls on this boy in a location as open as Lissue should not be underestimated but given the emphasis on his need for control, and his devious nature the adequacy of supervision provided needs to be considered?

Child P - 9 year old boy admitted to Lissue from 29.04.86 to 01.08.86
Re-admitted 28.10.86 to 22.06.87 but continued on day patient basis until early 1988

When Child P was resident in Lissue, allegations had been made that when he was resident at Somerton Children's Home in 1986 he had an ongoing sexual relationship with a 13 year old girl which included vaginal and anal intercourse. Details of this relationship were made known prior to a Child Protection Case Conference in August 1987 when Mr D was asked for his opinion. In his view, Child P "could be capable of sexual experimentation morally having few constraints on his behaviour". However Lissue had no concerns about his sexual behaviour during his previous admission. He indulged in a lot of crude talk and could relate very explicitly sexual acts but he was vulnerable and easily led (1).

The Case Conference was of the view that there was a good chance the girl was covering for another perpetrator, and it was decided that he should be interviewed about the incident by social workers as RUC involvement could de-stabilize the placement.

There was no record on the files submitted to this review about the outcome of the interview nor how this information was used to manage Child P safely in Lissue. The complaint referred to at Para 1.2 above includes reference to Child P.

The records also indicate that on one occasion while resident in a children's home, Child P and his brother were found in a tent in a state of undress in the company of two girls. On that occasion there was not the same reluctance to involve the police.

While at Lissue there were concerns about his sexualized language and knowledge. He was noted to be vulnerable and was a frequent absconder with peers.

Issue

Questions arise as to the competence of social workers to determine whether or not child P had sexual intercourse as alleged. While it is unlikely that any prosecution would have taken place, police involvement may have had a better chance of determining whether or not there was any substance to the allegation. Was the matter ever directly discussed with him or, if there was substance to the allegation, was it accepted as a matter of fact and no further action taken?

There is no information to ascertain how this boy was so sexually aware nor how the information used to inform Child P's treatment plan particularly in the context of his known vulnerability to older peers. The frequency of his absconding and the need for debriefing was also not seen to be addressed within the records, as often absconding can be linked with a range of exploitative and/or anti-social behaviours.

Child FF - 11 year old girl admitted to Lissue from 10. 03. 88 to 23. 03. 89 (See also File on Child DD)

Child DD reported to a nurse on 21.03.88 that he told S/N E that Child EE had told him that he had had sex with Child FF on 16.03.1988 (8). There is no indication in any of the records available about what action was taken with this information. For example, was Child EE or Child FF spoken with to ascertain whether or not the reported assault had taken place? Was the information given by Child DD ignored and if so on what basis?

In the file extract for Child FF it is recorded (16.03.88) that she absconded at about 3pm and that, "this child needs constant supervision all the time" There is no record as to whom she might have absconded with (9). In the file extract for Child EE it is recorded, however, in Daily Inpatient notes on 16.03.88 that he absconded from the classroom today at 3.00pm (38). The next entry dated 16/17/03 88 for Child FF records that she requested a shower that evening which she took under supervision when it was noted that she "Has a large bruise on the R? thigh."

Issue

It would appear that no connection was made between the two children absconding at the same time and the information allegedly given to S/N E by Child DD that Child EE had claimed that he had sex with Child FF. There is also no record made of the observed injury on Child FF's thigh and her being questioned about how she acquired it.

Child EE - 10 year old boy admitted to Lissue from 12. 11. 87 to 21. 01. 88
09. 02. 88 to 11.04.88 (Day Patient)
11.04.88 to 30.05.88

On 07.01 88 Child EE reported to one of the ward staff that he had had sexual intercourse with one of the other patients (unnamed)(4) He was to be interviewed about this matter by Mr. D and it was reported to Dr. A. The Social Work Notes show that he admitted to having a sexual relationship on one occasion with this patient who was identified as Child GG who had been discharged on 22.12. 87 and on two other occasions one with a named child (who was not a patient) at the Ice Bowl (9).

Child EE had previously been sexually assaulted by another male patient (Child F) on 04.01 88; Daily In Patient Notes (30).

Issues

No reasons are recorded for not reporting the incident with Child GG to the police.

Given that Child EE admitted to having a sexual relationship at Dundonald Ice Bowl with a girl who was not a patient was any consideration given to her position and again there is no explanation as to the lack of Police involvement; Lissue staff had only Child EE's word that she was a first year pupil at Methody; the school attended by his older brother. Was any consideration given to the possibility that she could have been much older and been abusive of Child EE.

There is also no indication of attempts to ascertain from Child EE how he had acquired the degree of sexual knowledge which he was able to display in discussion with staff.

APPENDIX 3: DETAILS OF SEXUAL ABUSE BY STAFF

Child A - 8 year old girl admitted to Lissue from 23.06.86 to 07.08.86

Child A was admitted to Lissue on 23.06.86 with other members of her family and remained there for some weeks after their discharge on 12.07.86.

In 1990 when a resident of Firbeck Children's Home, she alleged that in June 1986 when she had been in Lissue, she was approached by a male member of staff in her bedroom and inappropriately touched in the vaginal area. (Buff Folder B Incident 2)

Her allegation was initially referred to RUC Dunmurry for investigation. The matter was the subject of a Child Protection Case Conference on 11.10.90 by which time she was a resident at Adelaide Park Children's Home. The Police investigation had not yet begun. No further information had become available for a second Case Conference on 30.11.90 although the records show that the investigation was to continue at her pace.

Child A claimed that she did not know the name of the alleged staff member.

18.2.91 "Child A needs to give fuller details re the incident and a statement - police to consider going ahead with this anyway."

25.2.91 "No Police interview yet re the incident at Lissue as no further info or details as to perpetrator"

The minutes of a meeting at Adelaide Park Children's Home on 25.2.91 record,

"Child A made an allegation about a staff member at Lissue - unable to give a description or name. Reluctant to give Social Services any information. She did not tell anyone in the Unit or at home about the incident."

In a letter from APSW to the Police dated 30.7.92 information was sought as to the DPP's decision inferring that the matter had been investigated and advice sought.

Child A again repeated her allegation while a resident of Sharonmore Children's Home in 1994. In 1995, Child A was reluctant to take the issue any further. A Sergeant F had apparently carried out investigations in1994 during which he had hoped to interview Child A. In May 1995, plans to interview her were cancelled as she no longer wished to make a statement.

The minutes of a Case Review held at Sharonmore on 30.5.95 states:

"Child A recorded as not wishing to pursue the allegations about a staff member - will do so when she feels ready ".

On 10.04.97 it was recorded "M Mc M (social worker) advised Inspector H by 'phone that

Child A now wishes to make a statement regarding her earlier complaint relating to inappropriate touching by a nurse at Lissue".

To date there is no record of Child A ever making a formal statement of complaint.

On 12.04.91. Social Worker I recorded that Child A's sister who had been in Lissue at the same time told her mother that she had been in the room when a staff member had come in and lain on top of Child A and Child A asked her to go for help.

Issues

There is no information that Child A's sister was ever asked to confirm that the alleged incident took place. Or if it did take place, did she go to for help, and was any record made of the request?

After Child A made the allegation (some years after it had allegedly taken place) there is no information about what support she received from residential or fieldwork staff to enable her to pursue a formal complaint.

When the allegation was first made, was EHSSB Management informed about it and what, if any, internal investigation of the facts ensued?

Was the management at Lissue ever asked for or did they offer to produce the staff duty rota for the relevant period with the view to narrowing down the list of possible suspects or was a review undertaken of the file records in an effort to ascertain any incident which might be associated with the allegation?

Was the case referred, as Social Services, though to the DPP and what advice was given?

Child E - 8 year old girl admitted to FGH from 04.05.93 to 23.09.93

In Social Work notes dated 08.09.95, reference is made to a complaint by Child E's mother and cohabitee that she had been woken up by staff on 08.07.91 (sic) and that a doll's arm had been put up her bum. Child E was interviewed in the presence of her mother and her cohabitee and the matter was resolved to their satisfaction (20).

Issue

There is no indication as to what constituted Child E's mother's and cohabitee's satisfaction. From the recording it is not possible to determine whether or not the assault took place or whether the child made up the story.

Child BB - 13 year old girl admitted to Lissue from 06.04.79 to 17.03.80
06.11.80 to 12.10.81 (Day Patient)

Child BB was admitted to Lissue when she was 13 years of age. She had an unsettled history while she was there. From the file notes examined during this review, it was noted that she had been involved in 42 incidents of physical violence with other patients.

In 1993, when she was 28 years of age, she made a written statement to the police about several aspects of her experiences at Lissue. **Caution: There is no corroboration of any of the following allegations.**

On her second day at Lissue when she was feeling weak due to sedation, she fell or fainted and in the process she was grabbed by the hair by Nurse J. Prior to the fall she alleges that Nurse J was staring at her.

Issue

Under the circumstances, it would be expected that Nurse J would say that he was acting in the girl's interests by preventing her from receiving injuries in the fall.

She continues:

"A number of weeks after I had arrived in Lissue, I was lying on a bed in the first dormitory. ...I remember Nurse J coming into the dormitory and he lay down on top of me. I was wearing my day clothes. While Nurse J was lying on top of me, he gave me a passionate kiss on the lips. I remember him touching my chest. This was on top of my clothes. I remember these things through a haze because of the tablets I was on. Nurse J was always hanging about the girls' dormitory.

She recalls another occasion when she was heavily sedated:

"I was lying on the floor and Nurse J was lying beside me. He opened the zip on his trousers and took out his penis. He made me touch it. Because of the medication I was on I was unable to control my hands to masturbate him. I just fondled him. I had never seen a penis before that day. He had an erection. At first when I thought back I thought Nurse J may have been wearing a Durex because of a knob at the end of his penis but now that I know the difference, I think Nurse J may be circumcised. I remember that there was semen so I take it he must have came. I then went to the toilet. ...Again because of the medication I couldn't do up my trousers when I had been to the toilet. I remember standing at the door and Nurse J fixing my trousers."

Issue

While accepting Child BB's allegations, it should be kept in mind that she acknowledges that she was under medication at the time of the above incident and her recollection of events was not disclosed until some 15 years after the event.

Child BB was discharged but returned to Lissue as an inpatient when she was 15 years

old in 1980. She was one of three patients who remained in hospital that year over the Christmas holiday period and consequently was feeling very sad.

In her statement she continues:

"I remember giving Nurse J a hug. I know it was stupid but I just felt so terrible. Nurse J then picked me up and carried me into the observation room and lay me on the bed. Nurse J lay on top of me. He put his hand up my skirt. I had tights on. He put his hand inside my tights and touched me between the legs. I had my period at the time and was wearing a sanitary towel. When he felt me between the legs he must have felt the towel and this must have put him off. He kissed me at least once. Then he got up and washed his hands. I remember times when Nurse J would put his penis between my legs. It wasn't inside my clothes.

He never penetrated me. I remember it felt hard and was sore pressing against me. I don't remember any particular incident that this happened. I told Staff Z about Nurse J kissing me. I told her on the day after Boxing Day. I didn't tell her anything else. I remember Staff Z kept asking for details. I told her because I knew it wasn't right what Nurse J had done to me I remember that there was a girl called "Child B". She was from Unity Flats. She was eleven. One day I saw her in the middle dormitory with Nurse J. She was pulling up her skirt in front of him. I was always suspicious of what he had done to that girl. There was another girl called "Child N". ...I fell out with her because I remember her telling me one night that she "had done it "with Nurse J. I knew she was talking about having sex with Nurse J. I didn't believe her. Nurse J is an attractive looking fellow. Some of the girls would have referred to him as their boyfriend. ...My medication changed last August and now I can think back quite clearly to what happened during my two stays in Lissue.

Issue

Child BB now refers to a person called LS25 Was she a member of staff? Can she be traced with a view to her being asked about Child BB's allegation? Can Child B and Child N be traced? Would Lissue records be available to prove that Child BB was one of three residents over the Christmas period? Why had she to spend Christmas in hospital? Had her parents anything to say about that?

Although it is no excuse for Nurse J's alleged behaviour, was Child BB infatuated with him? She seemed to be offended at the thought of another child allegedly having sex with him .

Child BB has also alleged that she was physically abused by staff at Lissue. In her statement she says:

"I remember one day "Nurse K" gave me an awful kick up the behind. I knew I had done wrong by scribbling on the table. ..."Nurse J" and another nurse "Nurse K" were always violent with the children. Especially with children over six years of age. If they done anything wrong "Nurse J" or "Nurse K" would grab them by the hair and pull them down

the corridor. There were times when other staff were present when "Nurse K" or "Nurse J" would grab the children by the hair. The staff never ever done anything about it. During this stay at Lissue I got injections. Usually "Nurse J" gave me them but sometimes "Nurse K" gave me the injection. I always got the injection on the hip. One day "Nurse J" was taking me to school. I said to him about how violent he was to the younger children. I will always remember his answer. "I'm sure I'll be forgiven for that". There was no need for the violence "Nurse J" and "Nurse K" used especially on children as young as six. ... "Nurse L" was a nurse at Lissue. She would have seen "Nurse K" and "Nurse J" being violent. She was very hurtful to me. She would make comments about me looking pregnant...."

Issue

This alleged treatment amounts to the crime of common assault. Is Nurse L still available for interview?

APPENDIX 4: DETAILS OF ALLEGATIONS OF PHYSICAL ABUSE BY STAFF

Child D - 12 year old boy admitted to Lissue from 23.01.92 to 06.03.92

On the night 12/13.02.92 Child D accused staff of hitting him (6) & (7)

Issue

No staff member was named by the complainant.

Child E - 6 year old girl admitted to Lissue from 04.05.93 to 23.09.93

On 27.07.93 Child E's mother reported to Nurse Auxiliary M that she (Child E) alleged Social Worker M, had pulled her by the arm. Nurse M is recorded as reporting the matter to Staff Nurse O on 24.07.93 (inpatient nursing notes) (4).

Issue

Apart from reporting the above incident to a more senior member of staff there is no record on Child E's file about how it was investigated and what was the outcome.

Child J - 12 year old girl

Refer to for fuller detail: **Care Management Section 7 Child J.**

Child BB 13 year old Female

Refer to for fuller detail: **Sexual abuse by staff Child BB.**

APPENDIX 5: RESTRAINT

Child D - 12 year boy admitted 19.01.80 to 06.03.92

Restraint was used on 2 occasions as follows:

10/11. 02. 92 - after threatening another child, Child D "had to be physically restrained for half an hour." (3)

17. 02. 92 - I found Mrs. P (patient's mother) and a student nurse restraining Child D. Physically escorted Child D back to the ward where he had to be restrained initially for 15 minutes by myself P. and post reg. Student R. Restrained for another 15 minutes for not doing time out (8).

Child M - 13 year old girl admitted 20.03.90 to 06.04.90
21.06.90 to 29.09.90
19.03.91 to 25.03.91

Restraint was used on 2 occasions as follows:

06.04.90 - held in bed for 30 minutes for disobeying instructions to stay in bed(18).

09.07.90 - held for 45 minutes wrapped in a blanket during a temper tantrum.

Child S - 11 year old girl admitted 06.01.95 to 26.09.95

In a pre admission social work report dated 01.06.93 (26), it was stated that the use of restraint was not advisable as it would be counterproductive. Restraint was, however, used on 14 occasions (between 29.01.95 and 31.05.95) as follows:

29.01.95 - restraint used 3x for damaging door of bedroom; non-compliance: and niggling peers (4)

23.02.95 - being physically aggressive, required restraint x 2 for 10 minutes minutes each (9)

22/23.02.95 - was being restrained on the floor by three members of day staff. Details of restraint not known....After bath reported having red patches on each shoulder. Would appear to have been caused by friction burns while being restrained, (S/N S) (9)

22/23.02.95 - disruptive defiant behaviour continued so brought downstairs

by myself and Staff Nurse T. Held on the bed while struggling (10)

17. 03. 95 - for refusing to walk to Time Out, S/N E, Staff Nurse U and Staff Nurse V attempted to carry her to TO room. Hit out and S/N V kicked in back. Other staff had to assist S/N M[1] and bus driver X. Had to be restrained on the corridor for 2-3 minutes. In time out bit her arms same reported to Dr. Y (13)

19/20.03.95 - had to be carried upstairs by 2 staff. Cheeky towards staff attempting to kick and bite staff...(14)

20. 03. 95 - removed from school....as refused to do 100 lines for wearing earrings to school. Lost her temper and had to be brought back by 2 staff and had to be restrained by 3 members of staff for 20 minutes. (14)

28/29.03.95 – after...making a nuisance of herself...and being rowdy, became cheeky when staff intervened. Resulted in restraint for 10-15 minutes. Fought with staff the whole time. Belongings removed from room and told she would have to earn them back (15)

29/30.03.95 - taken to bathroom as refused to shower. Situation escalated until 2 staff had to restrain her for 10 minutes (15)

03. 04. 95 - refused time out . When staff took her by the arm hit out en route to TO on going through a doorway caught her chin on the door due to level of aggression. Seen by Dr. AA[1] accident form completed (16)

16. 05. 95 - was restrained outside school as she was physically aggressive to staff. Restrained again indoors as a danger to staff and others (20)

18. 05. 95 - had to be removed from classroom for non compliance --restrained on 2 occasions by 4 members of staff (21)

29. 05. 95 - TO for slapping younger peer across the face. Had to be physically taken to TO (22)

31. 05. 95 - restraint used for non- compliance 2 periods involving 3 members of staff lasting 10 minutes each time.

Child CC 7 year old boy admitted to Lissue 13.04.82 to 29.06.89

Restraint was used on 2 occasions as follows:

10. 05. 89 - was put to bed this morning for non compliance and generally

disruptive behaviour. When on TO he began to kick the doors and scream and required some restraint (10)

11. O5. 89 - put in TO in corner refused to do was taken up to bedroom where he had to be restrained

Child FF 11 year old girl admitted to Lissue from 10. 03.88 to 23.03.89.

This child was described as being in need of constant / strict supervision. Restraint was used on 3 occasions as follows:

10. 05. 88 - accused staff of twisting her arm yesterday. Staff spoken to by Nurse L who was told that her behaviour was unreasonable yesterday and was restrained and twisted her own arm (23)

07. 06. 88 – Note: this incident was not recorded in the Nursing notes until12.06.88. While being restrained Child FF sustained a black eye on 7June. When mum visited on 9th very annoyed, verbally abusive spoken to by Mr. BB, Mr. C and Charge Nurse J (8). In other notes it is recorded on 07.06,88." Verbally abusive and non-compliant and restrained by staff as she was loosing control" (30).

A Body Chart Form was completed by Nurse CC on 8th, June showing a left black eye. On 09. 06. 88. S/N J spoke to the child's mother and told her that he had had to restrain her. A detailed explanation was given of the restraint used and an explanation given of how Child FF sustained the injury by the upper part of Nurse J arm hitting her on the head (30) (31).

FROM FAMILY AND CHILD CARE NOTES:

At a Child Protection Review 23.09.88. Mr. D described the incident on 7th June thus:- " an attempt had been made to physically hold Child FF in a chair to calm her down and in so doing a member of staff accidentally hit her on the eye " (4)

Mr. D completed an Untoward Incident Report on 30.6.88 in which it was stated:
"Mr. BB investigated the matter from the nursing side and was satisfied from the reports from other nursing staff that Nurse. J's account was trustworthy" (5).

12/13.07.88 - would not settle despite being given several chances to do so and eventually had to be physically restrained (2).

Issues

(a) The absence of an Independent element to the Nursing investigation into the injuries sustained.
(b) There is no information to show that the enquiry considered the reason for the time lag between her injury being sustained on 7th, June and the record in the Nursing Notes made on 12th June three days later. The child's mother complained on 9th, June. There is no information about what prompted Nurse L to complete the Body Chart Form on 8th, June.
(c) The Family and Child Care Records indicate that the Untoward Incident Report was not completed until 30.06.88 by Mr.D. Why was there a delay of 23 days and why was it completed by Mr.D?

Child EE - 10 year old boy admitted to Lissue 12.11.87 to 21.01.88
09.02.88 to 11.04.88 (Day patient)
11.04.88 to 30.05.88

Restraint was used on 4 occasions as follows:

04.01.88 - Body Chart showing mark on eye--self abuse and old bruise on thigh fell at ice hockey note states "child had to be restrained by clothing due to aggressive self abuse and injury to others" (21)

11.12.87 - Child EE isolated from peers when he attempted to hit out. Restrained for his own safety and that of staff and peers (28)

04. 01.88 - got aggressive to staff and became a danger to himself and others. He physically abused himself by scratching his face and attempted to bang head off wall. Restrained for 15 minutes (30).

06/07 01.88 - became physically aggressive towards ** eventually had to be restrained and put to bed (32).

APPENDIX 6: SANCTIONS

Child I - 15 year old girl admitted to Lissue from 18.09.89 to 26.07.91

This child had a history of Eating Disorder

01. 03. 91 - Told not getting home on pass as hadn't put on 1kg.....became physically abusive to staff and refused to join her peer group "we had to physically escort her back to her peer group (46)

Child S 11 year old girl admitted to Lissue from 06.01.95 to 26.09.95

18. 05. 95 Not allowed an overnight at Bawnmore due to bad behaviour

Child J - 13 year old girl admitted to Lissue from 23.03.87 to 27.03.87
Re-admitted 17.09.87 to 23.10.87
09.02.88 to 31.03.88
20.07.89 to 12.08.89
12.08.89 (Day Patient)
30.04.91 to 17.05.91

Following Child J's return to Lissue after being treated at another hospital for a drugs overdose, her room was searched by two members of staff (V and EE) who told her that other children would not be allowed to go swimming unless she told them where she had hidden the drugs she overdosed on. (Transcription 2)

Child CC - 7 year old boy admitted from 13.04.89 to 29.06.89

This child had a history of encopresis and nocturnal enuresis.

15/16.06.89 - told he would not get home if he did not comply with a request to put on a pad or buzzer on his bed....(16)

19. 06. 91 - due to the incident at 16 above wasn't allowed home on Friday evening as planned. "Was given an opportunity to redeem himself i.e. given certain tasks to complete which if he completed he would have been allowed home, he refused to comply (18).

Child Y - 14 year old boy admitted to Lissue from 03.07.81 to 25.08.82

11/12.02.82 - Complaining to night staff that only he is ever sent to bed early for bad behaviour. Night staff records: "would appear to be true because other peers never in bed when night staff come on".

APPENDIX 8: HUMILIATION

Child CC - 6 year old boy admitted 3.04.89 to 29.06.89. (See also section on Restraint)

15/16.06.89 - at 6am the child was denied the opportunity to return to bed after a toileting episode because he refused to put on a pad or clean pants/ pajamas. He was stood against a wall for 1½ hours and was told he would not get home if he did not comply.

Child DD - 13 year old boy admitted to Lissue from 26.08.87 to 27.05.88. This boy suffered from Tourette's Syndrome

Tourette's syndrome is a neurological disorder characterised by repetitive stereotypical involuntary movements and vocalisations e.g. facial grimacing, shoulder shrugging, head and shoulder jerking, repetitive throat clearing, grunting sounds. It can also involve self harm. In an interim report for Lissue written by Senior Registrar Dr. FF it was stated:

"family therapy has aimed chiefly at supporting the family and helping them to identify those behaviours which appear due to illness and those which should be addressed as badness " (1).

His school report for week commencing 04.01.88 states:

"Very laid back today. Increase in jerks and verbal utterances. Had a good talk with him on several occasions. He does not listen....Poor interaction with me (teacher) until he was pressurised to answer me (17).

His school report for week commencing 1. 2. 88 states:

"was reprimanded many times and he was furious with me for hounding him..."

The report for week commencing X states:

"Non compliant and dumbly defiant. Several approaches tried - no success. Put him in corner where he begins to self abuse" (11).

When Child DD was seen to show the symptoms of his illness, he was sometimes put in the corner or given lines to write out as a punishment.

Issue

While the difficulties in caring for this child should be appreciated and not under-estimated it has to be asked if the teacher was sufficiently briefed about his symptoms and if he (the teacher) was as sensitive to the boy's needs as he should have been. If the boy's behaviour was affected by the provocation of other pupils, what alternative arrangements were considered to address his needs?

Child J - 12 year old girl

See separate Section at (vii) below

Child V - 13 year old girl admitted to Lissue from 28.03.83 to 10.10.83

18. 08. 83 - yesterday was asked to strip in the office though she had already handed over cigarettes and matches. No cigs found when she stripped (11). The girl's father was annoyed about the searching and the matter was discussed with Charge Nurse J when he visited the Unit. It is not clear if her father discussed his complaint with [redacted] or if staff brought it to his attention. There is no record of C/N J's response.

Issues

The following questions arise:

- Did a policy exist on strip searching of children?
- What authority did hospital staff have to authorize strip searches?
- Was the search carried out by male or female staff?
- Was there a complaints procedure?
- What was Charge Nurse J's response to the complaint?

Child Z - 13 year old girl admitted from 03.01.90 to 11.05.90

05. 04. 90 - Today DD and EE went into Child Z's bedroom, foul smelling-stained knickers found in soap bag dirty socks lying on top of radiator- towels in a plastic bag smelling++. These were taken into girls' only group to ask their opinion, child did not blush or appear embarrassed but was affected by same in her own way---appeared hurt (18).

Issue

This seemed to be a recurring problem with this child and no doubt the staff were exasperated but was it part of the therapeutic process to bring about change by hurting her in this way.

Child AA - 4 year old girl admitted from 29.03.84 to 29.06.80

14. 06. 84 At times has to be forced to eat (4)

Issue

A possible interpretation of this comment could constitute an assault.

Child BB - 13 year old girl admitted to Lissue from 06.04.79 to 17.03.80 06.11.80 to 12.10.81 (Day Patient)

15. 04. 79 - Refused to shower herself so was washed by staff. (1)
Staff removed soiled sanitary towel (2)

21. 04. 79 - Wouldn't get out of bed lifted out against her will "led to shower refused to remove nightdress & bra but no resistance when I removed same like a limp doll. Staff member washed and dressed her (3).

25. 04. 79 - Staff observed Child BB in bath & washed her vagina as she hadn't washed same when washing herself (5).

27. 04. 79 - Washed against her wishes "had to be put in bath & washed....(6)

28/29.04.79- Undressed by staff as she refused to undress... (7)

Issue

Practices in relation to this child raises he following questions:

- What was the policy in relation to undressing adolescents and observing them in the bath?
- How was this practice monitored b y management?
- Was it part of the child's treatment plan?
- Were male staff involved in any of the above operations with a female patient?

Child H - 15 year old girl admitted from 10.01.91 to 13.08.91 Sulcidal

15/16.03.91- Child H on constant observation therefore staff observe her at all times. Had a bath and hair washed (13).

Issue

This record in the file was made by a male member of staff (Staff Nurse E). It is unclear whether or not he was responsible for observing Child H in the bath If he did, should he have done so or should he have sought assistance from a female member of staff? Again it would be helpful to ascertain if a policy was in place to direct staff's action.

Child I - 15 year old girl admitted from 13.11.89 to 26.07.91 Suicidal

06. 09. 89 - Supervised having a bath as on caution card. (7)

20. 11. 89 - Refused to undress at bedtime nursing staff " had to physically take her clothes off she was very resistive to this... (16).

Issue

The file records do not specify whether male or female staff were involved?

Child FF - 11 year old girl admitted from 10.03.88 to 23.03.89
(Needs constant supervision)

16/17.03.88 - requested a shower given under supervision (10)

Issue

What is the policy relating to the supervision of children bathing and who should supervised?

Child GG - 10 year old girl admitted from 28.10.87 to 22.12.87
(Needs Supervision)

05.06.87 - Had shower...supervised by S/N GG[1](15)

Issue

What is the policy regarding one staff member supervising bathing and recording of the gender of supervising staff?

Child P - 9 year old boy admitted to Lissue 29.04.86 to 01.08.86
28.10.86 to 22.06.87 [continued as day patient until early 1988]

06. 10. 87 - Staff Nurse L(staff nurse) explained that Child P " being forced to have bath" was all part of the self - hygiene programme in Lissue (3).

a

Issue

Was there such a policy? If there was, would precedence not be given to a child's right not to be coerced?

APPENDIX 9: DETAILS OF SUPERVISION/

Child BB - 13 year old girl admitted to Lissue from 06.04.79 to 17.03.80 06.11.80 to 12.10.81 (Day Patient)

12. 6. 79 - required to be supervised in isolation due to insufficient number of Staff to provide more adequate management (26).

Child B - 10 year old girl admitted to Lissue from 17.09.80 to 13.04.81

19/20.10.80 - Impossible for staff to give her the constant observations she needs as only 2 staff on (28).

Child P - 9 year old boy admitted to Lissue 29.04.86 to 01.08.86 28.10.86 to 22.06.87 [continued as day patient until early 1988]

11. 04. 87 - Letter from Dr. A to Director of Nursing EHSSB flagging up nursing shortage and impact on supervision of children (29).

Child X - 14 year old boy admitted to FGH from 30.05.93 to 07.10.93

07. 12. 93 - Letter from Ward Sister CC to Dr. HH expressing her own and staff's concerns should Child X be readmitted...Staffing levels not adequate at the moment (36).

APPENDIX 10: DETAILS OF STAFF/CHILD RELATIONSHIPS

Child A - 8 year old girl

Included below is the full text of a record made by Staff Nurse E on the file of Child A on 27/28. 06. 86.

"Extremely friendly towards male staff. Wanted to sit on my knee all evening appears very mature for her age (NB age 8) making comments suggesting that I should put my hand on her bottom and tickle her--to use her own words. At times holds unto me in a very mature way and wanted to be taken up to bed alone asked why alone she said we could talk together without being disturbed. When she was being put to bed she asked for a good night kiss. When this was being given she held firmly to my neck and pulled herself tight against me giving me a kiss on the lips and held on so that I had to pull away she smiled and said she enjoyed that then settled down to sleep. It would appear that Child A knows quite a lot for her age acts in a very mature way at times. She appears to enjoy attention and does what she is told" (3).

Issue

Is the above a true record of what took place could it be an attempt by a member of staff, who behaved in an improper manner by taking advantage of a child and writing it up in a manner which transfers the responsibility away from himself to the child, to ensure that the attention of any person reading the file was directed to the child ?

What directives / guidance in respect of staff / child contact were in operation at the time? Was Nurse E's Line manager aware of the entry he had made on the file?

Did Staff Nurse E report his experience to a colleague after it happened? To do so would have been a more immediate response than writing up the file, if only to protect himself from serious allegations which the child might have made.

Given the subsequent allegations made by Child A in 1990 and 1994 regarding her care at Lissue were her case records examined to ascertain the possibility of anything Untowards having been recorded on her case file.

Child H - 14 year old girl admitted to FGH 10.0.91 to 13.08.91

Child H was admitted to Forster Green Hospital on 10.01.91and discharged on 13.08.91 as a day patient. Staff Nurse E, Nurse V and Doctor DD were named as key therapy workers and were confirmed in this role on 12.04 91. It was recorded that she needed close supervision.

Staff Nurse E is recorded as talking to her in her bedroom on:

10/11.03.91 (she told Nurse E she felt suicidal)
16/17.05.91
03/04.05.91 (underlying suicidal tendencies prevalent)
24/25.05.91 (Nurse E spent 1½ hours with her as she said she was feeling suicidal)

He talked to her at bedtime (location not stated) on:

16/17.03.91
17/18. 03.91
22/23. 03.91 (Nurse E felt she was suicidal)

Nurse E is recorded as listening to Child H talk about her family history and feelings over a period of 10 nights between 22/23.03.91 and 25/26.04.91. Neither of the other key workers are shown to have spent the same amount of time with her or spent time with her at bedtime or in her bedroom talking about these matters.

On 08.05.91 Child H's mother received an anonymous telephone call. The caller however left his telephone number and when she phoned back it was to Staff Nurse E's home number. He is recorded as knowing nothing about the matter

Issue

The records show that Nurse E was the only Key Therapy Worker to note that Child H had expressed suicidal tendencies and that she was in need of constant supervision. The nurse on duty 03.05.91 felt that constant supervision placed pressure on her. Given that Nurse V was involved with Child H in disclosure work presumably during the day, what was the policy for a male member of staff to be alone with Child H in her bedroom for such long periods during the dead of night when there was no record of such need made by any other member of staff when he was not on duty?

Were Nurse E's line managers aware that he was the only member of staff spending time at night alone with Child H in her bedroom? Were they aware of the potential risk to Nurse E and did they discuss this with him?

What attempts were made to ascertain how the alleged father of an ex-patient could make a telephone call to Child H's mother and leave a number which was Nurse E's home telephone? Was consideration given to this being the action of a staff member?

APPENDIX 11: Child J

Transcription 1- Page 8

One of the symptoms of Child J's Tourette's Syndrome was a constant sore throat as a result of the involuntary noises she made. She drank to ease the pain, but on her first night at Lissue, her drinks bottle was confiscated. Like many children on their first night in a strange place, she had difficulty in sleeping. Night staff showed no sensitivity to her situation, denied her request for a drink, and threatened to lock her door if she did not be quiet.

She was discharged after four days but had several subsequent admissions.

Control of Patients

Page10

Bad behaviour by the children was dealt with by awarding TIME OUT which amounted to them being locked in a room. In some cases they were removed to a sparsely furnished dormitory and had their shoes removed.

Page12

Going to the toilet at night was discouraged. An unnamed male member of staff is alleged to have told new patients a horror story involving ghosts and the murder of a girl who lived at Lissue before it was a hospital. Children would seek to accompany each other to the toilet during the night but when the lights went out (presumably they were on a time switch) the children squelled and were admonished for making a noise.

Page16

The punishment for running away amounted to children being stripped naked on their return and confined to a dormitory for 2 weeks. There were no pillows or blankets on the beds. Staff remained outside the locked doors. If a girl ran away with a boy she would have been subject to an internal medical examination. A special regime was in place when children needed to go to the toilet. Boys had to wear pyjama tops, the girls were given bottoms. (Note - there is a slight contradiction here. She states that children were stripped naked but she also says that they were allowed to keep wearing the parts of the pyjamas they were given to go to the toilet

Issue

Consideration should be given to the possibility of the above alleged actions being seen as child cruelty

Child / Child Relationships

Page 13

On one occasion when she went to the toilet the door was opened when she was in a state of undress and was threatened by two boys, one of whom, wanted sexual intercourse with her. Despite her protests, they only desisted when they heard someone approaching.

Staff / Child Relationships

Page 14

Child J alleged that a male member of staff would get her to sit on his knee while he stroked her hair which she described as long and curly. At the same time he allowed another female patient to comb his hair.

Page 14

One night as she was undressing for bed, a male member of staff entered her bedroom asking the whereabouts of a named boy. Unknown to her, the boy got out from under her bed. The member of staff accused her of regularly allowing the boy to see her undress.

Page 15

She named the member of staff as a CC.

Page 18

Child J had a history of bedwetting which continued when she was in hospital after each incident she had to take a shower or bath. She alleged that Staff Nurse CC would always go with her to the shower and watch while she undressed / dressed. She became so embarrassed that began to undress/dress in a wardrobe.

Issue

While the act of stroking Child J's hair may at best be described as inappropriate. The alleged acts of voyeurism constitute sexual abuse.

Page 18

She then refers to an incident involving Child Q. She was reluctant at first to go into this in any detail because Child Q now lived in London and was not aware that Child J was talking to the Police. However she went on to describe

her friend hammering on the inside of the pool room door trying to get out after being alone inside with, allegedly, Staff CC.
She never discussed this incident with Child Q who was the same child as the other child in the hair combing incident (Page 14).

Page 22

In talking about her friend Child Q, Child J said that Staff CC would spend hours in her bedroom at night.

Issue

In the absence of more detail it would be difficult to pursue the matters alleged by this adult. Checks of staff employed at the hospital identify only the first name as probably accurate; additionally, the surname is inaccurate for any male staff member.

She then goes on to describe in some detail the treatment received by Child DD who like herself suffered from Tourette's Syndrome

Page 23

His condition was worse than hers and she states that he was given a very bad time and that staff gave him lots of punishments. She alleges that in group exercises he was made to stand on a chair while the others were seated and was chided about the symptoms of his illness.

She describes another incident when she and Child DD were in the television room. A member of staff whom she named as: Staff Nurse or Senior Staff Nurse II.

> *"grabbed both of them by the back of their necks and by the jumper and collar and ran them down the corridor...and threw Child DD into one of the dining room tables and her into another".*

In the second transcription, she acknowledges that the name might have been II[a].

Issue

This alleged action clearly constitutes an assault.

Page 24

Child J goes on to describe the treatment which she alleges that she and Child DD received in what she described as the Monday Group, which was organised by R[1] and KK where she alleges that they were picked on. At one session, JJ shouted at Child DD and made him sit in a corner with his face to the wall
until he apologised to the group before being allowed readmission .

Issue

The treatment allegedly experienced by Child DD was void of humanity, degrading and could be considered as victimisation and cruelty. The full case records should be reviewed by nursing professionals to ensure that professional codes of conduct were not breached.

Page 24

Child J describes the treatment she alleges that Child DD received when he was at school in Lissue. She alleges that Mr. LL, the teacher would punish him if he wasn't concentrating by making him stand in the corner and on occasions would bang his head off the wall. The child could have stood in the corner for up to an hour and was denied the opportunity to go to the toilet.

If her symptoms were bad she alleges that she got a bad report which meant that she was denied the opportunity to go swimming.

Issue

Mr. LL's insensitivity has already been referred to and Child J's independent account of the treatment which she and Child DD received would tend to support the claim that he was not as aware as he should have been of the symptoms of Tourette's Syndrome. His alleged behaviour in relation to Child DD clearly constitutes an assault and stands in marked contrast to the way other children (in this review) were treated at School.

Transcription 2

The first 7 pages consist of confirmation of what Child j said in her first interview. She then continues:

Page 7

A nurse called MM told her that she would be locked up for life in lunatic asylum. After a bath, a nurse called L had her lying naked on the bathroom floor while she applied cream without her consent to her vaginal area Child J
wanted to apply the cream herself, but the nurse said she wouldn't do it right.

Issue

Nurse MM's alleged remarks are not what one expect from a nurse to a twelve/thirteen year old child and given the lack of consent, Nurse MM's alleged actions constitute an assault.

After describing the facilities at Forster Green to which she was admitted following the closure of Lissue she describes how she was treated:

Page 17

She describes how she could be quite noisy at night in bed because of her Tourette's Syndrome. Staff shouted at her and threatened that she would be locked up for life in a lunatic asylum if she didn't keep quiet . She became frightened of staff. She feared being shouted at or having her room door closed tight and she was afraid of the dark. On one occasion she had to go to the toilet three times On the third time she was told if she came out (Page 18) of her room again she would be locked in. She resorted to using a waste paper bin in her room as a toilet and throwing the contents out of the window before day staff came on duty. Her parents noticed the smell in her room, but she was afraid to give them the reason as she feared they would complain to staff who would then give her a bad time.

When she was in Forster Green, she had occasion to be on suicide caution which meant that she had to be accompanied by a member of staff at all times. This denied her all privacy especially when she was accompanied to the toilet or shower at night by a male member of staff.

She also refers to being watched from behind a two way screen by Nurse CC while she dressed and undressed. She says she could see him when the light was on.

Page 19

It was allegedly the practice of Charge Nurse J to have meetings with older children and at one such meeting she decided to complain about Nurse CC walking into the rooms without knocking when she was getting dressed or undressed. Nurse J she claims immediately rounded on her for daring to mention a member of staff's name without any evidence or proof of anything happening. She broke down in tears. As a result of her complaint, however, the children were told to make signs for their doors but staff ignored them. Nurse CC allegedly continued to walk into her room unannounced.

Page 20

Child J then referred to Nurse CC allegedly being in some rooms for two hours at a time. He was never in her room for such long periods, but she was satisfied that he was in other rooms because she could see him through the open bedroom and corridor doors. He went up the corridor but he wouldn't come back down. She confirmed that she was referring to Nurse CC a permanent night shift worker.

Page 23

She was particularly concerned about Nurse CC's alleged early morning visits to the room of her friend Child Q.

Issues

The issues are very much the same as already noted for example children allegedly being controlled to the extent of being afraid to go to the toilet during the night; being deprived of their dignity; and being rounded on by Charge Nurse J when she responded to his invitation to make a complaint.

Page 26

Child J took an overdose and was admitted to another hospital. On her return to Forster Green she alleges she was taken to her bedroom by V and EE who wanted to search her room for drugs which they alleged she was selling to other children. They threatened to deprive other children of their swimming sessions if she didn't tell them where she had hidden drugs. In their search they trashed her room and when they found nothing they ordered her to put everything back in place.

Issue

From the allegations made there was very little empathy shown to Child J when she returned from hospital and it was totally unprofessional to resort to emotional blackmail in the attempt by the two members of staff to find drugs in her room.

4.1.3 MANAGING CHALLENGING BEHAVIOUR

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

During the period of review it is evident from the records examined that patient's behaviours provoked nursing responses which were punitive in nature such as the use of restraint or sanctions. Whilst it is acknowledged that this was accepted practice at that time there is evidence that even within this context some nursing practice moved beyond the boundaries of reasonableness. Examples include the withdrawal of permission for family contact or home leave, withholding food, and the strip searching of adolescents.

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

CONCLUDING REMARKS

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

Matters of professional concerns in respect of the care of children at both units have, however, been identified over the period reviewed. The review found high levels of peer abusive behaviours and a regime which was at times harsh and punitive. There are also instances of staff care of children which gave rise to concern. Three allegations were made to the Police of which two were investigated. In respect of LS66 no corroborating evidence meant the case could not be progressed; on the balance of probability it is, however, likely that her complaint had a basis. The 2008 complaint by LS69 is now being considered by the PPS.

The PSNI has confirmed that in relation to the children's abusive behaviours it is unlikely that any further action can be taken due both to children's age at the time of the incidents and also as many of the allegations are now statute barred.

In relation to the current practice within the inpatient CAMHS facilities the Belfast Trust requested that these be reviewed by QNIC; the resulting report was viewed by the Trust as a positive comment on its current care practices.

A review of the practice from a nursing perspective has been completed by an Independent Nurse Consultant who has commented negatively on the standard of practice when judged against the standards extant at that time. A recommendation has been made that one member of staff's HR file should be sent to the NMC for its consideration. A similar review of professional practice is awaited from a medical perspective.

Recommendations have been made in the attached report of the Independent Consultant which are to be taken forward by the HSC Board.

Marion Reynolds

July 2009

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February 7, 2010

Commentary Report on: **INDEPENDENT REPORT LISSUE & FORSTER GREEN HOSPITALS HISTORIC CASE REVIEW** author: RS Stinson (January 2009)

I am a Consultant Child & Adolescent Psychiatrist working for the South London & Maudsley NHS Foundation Trust. I have run inpatient child psychiatry services for children under 13 years old for a total of 23 years, firstly in South-West London for six years and then for seventeen years in this Trust. I have also worked in outpatient specialist child and adolescent psychiatry throughout this time both at tier three and tier four levels.

I was approached by Mr Declan Carvill by email on 4th August 2009 (see Appendix 2). The task has been to:

"The aim is to consider the report by Bob Stinson having access as needed to the sift material and all case files to provide a view on the standard of medical intervention expected at that point in time rather than judging by today's standards."

In further discussion with Ms Reynolds this was further clarified as follows:

I was asked to provide an independent child psychiatry commentary on the "Independent Report Lissue & Forster Green Hospitals Historic Case Review" produced for the Eastern Health and Social Services Board (EHSSB) by RS Stinson in January 2009. In particular, I was asked to comment on whether the services provided by the child psychiatrists at the time to the two hospitals, Lissue and Forster Green, were adequate in the light of subsequent complaints detailed in the above report.

In carrying out this task, I have had made available to me the documents listed in appendix 1. I have not attempted to interview anybody concerned, so that this report is purely based on the paperwork and a telephone conversation with Marion Reynolds. There were delays in making notes available to me.

Mr Stinson indicates that his review is "limited to examining case records to identify safeguarding issues" (para1.6). In an effort to be useful to the boards that will consider this report, I have taken a slightly wider brief and allowed myself to comment on pointers to good practice for the future.

I have assumed that the information quoted in the Stinson report does not need further verification.

Mr Stinson's report indicates that both Forster Green and Lissue "were directly managed services within the Eastern Health and Social Services Board" in the late 1980's and early 1990's. Ms Reynolds described the context of the two child and adolescent psychiatric units at that time indicating that the consultant child and adolescent psychiatrists responsible for the units were based elsewhere and had a number of other responsibilities. The size and age range of each unit is not specified in the report. Unfortunately, from the information available to me, I cannot tell the ages of the patients at the time of their admission other than for the few cases whose records I have seen.

From the notes I have been sent, it is clear that a series of senior trainees, Senior Registrars, made regular notes in the children's medical records and that direct entries to the notes by the consultants were largely absent in the notes I examined. However, there were regular references in the Senior Registrars' handwriting to telephone conversations with the consultant and to other discussions with them.

There were also notes made at ward rounds. As far as I could tell each of the patients on the ward would have been discussed at every ward round. Unfortunately, the written record does not indicate who was present at each ward round. On only a few occasions was there a specific note that the consultant made a comment. This does not mean that the consultant was not present at most, if not all the ward rounds. It only indicates that there is no positive record of the matter. It is equally unclear what other members of the nursing team and the multi-disciplinary team were present.

Advice: It is important to record the names of those present at ward rounds and their professional roles as well as keeping a clear record of case discussions. This was <u>not</u> a universal expectation at the time and is not now but it would be helpful.

Commentary on Lissue Historic Case Review

I will go through Mr Stinson's report commenting on particular points. I will make general observations at the end of this commentary. For each section (sections 5, 6 and 7) of the report dealing with allegations of abuse or mistreatment, I will refer immediately to the relevant appendix of Mr Stinson's report and give my views on the information documented there.

1. Paragraph 4.1: Mr Stinson's report includes the names of each of the children whose files he has examined. This is a breach of the children's confidentiality. They should only be referred to in a report such as this by anonymous identifiers and their ages at the times of their admissions.

2. Section 5.1.1 and Appendix 1 – Allegations of sexual abuse by peers

   2.1.1. Child A: Mr Stinson points out that there was no indication in the clinical notes that an allegation that the child was raped at home by a friend's uncle was referred to the police. Comment: Before this is taken as any evidence of poor practice by health workers, you would need to be sure that the matter was not already known to the police or to social services and that the nurse concerned was aware of this.

   2.1.2. I do note that this girl had alleged sexual abuse before she was admitted, and that she behaved in a sexualised way with peers and with adults, both of which are recorded. I also note (from the F & CC Files in the list of cases I was sent) that Child A seems to have spoken to social workers or police about seven or eight times between 1986 and 1996 about the allegation but declined to give a formal interview. Whilst I do not think that this detracts from the seriousness of the allegation I do wonder if she was obtaining attention through her distance regulating behaviour. I note that she was said to have come from quite an emotionally deprived background.

   2.1.3. In terms of the allegation about the friends uncle raping her, this information was told to the first interviewer (I cannot be sure of this because the file note is unsigned but it occurs at the beginning of the file before further outpatient records dated 7/10/85. That would mean that her disclosure to the nurse would not have taken the matter any further forward; that might explain why there is no note of it having been reported again to social services.

   2.1.4. With the information available it is not possible to come to any conclusion about her allegations.

   2.1.5. LS79 appears to have placed himself in a vulnerable position with Child A. I note that he appears to have carefully recorded what happened although I cannot be sure it is a complete account. In terms of practice in 1986, his recorded behaviour in putting this child to bed would not be exceptional.

Today, a male nurse would not be put in that position with a young female patient.

2.2. Child R: I agree that each of the three children should have been interviewed by senior clinical staff at the time. I think that would have been good practice at that time, though not universal.

2.3. Child S: I am unsure whether it would have been appropriate to ask fellow pupils about this. It would depend on the situation, the girl's previous behaviour etc. I do not think it is the sort of incident that should have elicited external referral to police and social services unless there were rather more evidence of interference. At that time, such allegations in other inpatient units would have been assessed by staff on their merits. A record of such discussions and their outcome would ideally have been kept but I know that would not always have happened because of pressure of work, staffing levels etc. Good practice today would require careful note taking of such incidents and interviewing each child. An assessment by the unit social worker would be made with the consultant as to whether this should be referred on to social services. I note that there was a unit social worker as part of the multi-disciplinary team at Forster Green. I do not know if this also applied to Lissue.

2.4. Child T: I agree with Mr Stinson. To resolve whether further action, e.g. psychosexual education were undertaken with this boy with learning difficulties, his clinical (medical, nursing and education) notes would have to be examined. That was apparently not done by Mr Stinson.

2.5. Child U: I agree with Mr Stinson's assessment of the issues here. I was very worried by the staff member's failure to intervene early and stop the boy concerned. Did (s)he give any consideration as to the effect on the girl of the staff member observing this behaviour passively and then making a comment that obviously upset the girl? This would not have been acceptable behaviour from the staff member at the time. Before being too critical, one would have to ask whether the staff member were very junior and this was a matter for education rather than censure.

2.6. Child BB: It is not possible to comment usefully as there is no information on the staff response.

2.7. Child GG: I have had the opportunity to examine this girl's medical notes but the nursing notes were not part of that record. I have not been sent child EE's records. Assuming that Mr Stinson has accurately summarised the situation, I can comment. Child GG's behaviour deteriorated as recorded in her notes in the second half of November 1977. She was admitted as being out of control in ORANA, I assume a social services children's home, with "highly sexualised language and drawings". It was noted that she was showing "no overt sexual problems" on 11th November; by 25th November she was much more consistently oppositional and had thrown a knife at a peer. There is no reference to sexual behaviour as a part of this.

Comments: Her deterioration of behaviour is consistent with the allegation, though it does not prove it. I was unsure whether it was very safe to take the word of a 10 year-old boy that he had had sexual intercourse with a girl of 9 years 11 months. It may be true but it could also be bravado. Only careful interview by senior members of staff, preferably the consultant psychiatrist and senior nurse would give a guide to this. There is no evidence that was the policy in such situations on these units. By the time the allegation came to light, child GG had been discharged. In that circumstance, the information should have been passed on to social services for their decision as to whether to interview her.

I also agree with the issues raised by Mr Stinson (a,b and c). They are crucial before criticism can be levelled against individual members of staff. They lead on to questions as to whether the consultant psychiatrist, the senior nurse and other members of the MDT including the social worker for the unit had raised with management the issues of staffing and the suitability of the building. To manage children that are described in this report, high levels of staffing and appropriate facilities are absolutely necessary. Otherwise it is unsafe for the children and for the staff.

It illustrates a further issue to which I will return. Is the purpose of a child psychiatry inpatient unit to manage children whose behaviour becomes out of control or is it to manage those with severe mental health difficulties? There is some overlap but they are not the same.

2.8. Child EE: A failure to record the response to child F's behaviour is a fault and would have been in that era if the assault had been observed by adults. Were EEs parents contacted? What did they want to do? What discussions were had with child F? What actions to safeguard them both were taken? If the alleged assault was not observed then it would have been appropriate to interview the children. Given the nature of this alleged assault, this could have been done by a senior nurse or the Senior Registrar. Had it been more serious, I would have expected the consultant to be directly involved.

3. <u>Section 5.1.2 and Appendix 2 – Allegations of sexual abuse against peers</u>

3.1. In the third paragraph of 5.1.2, Mr Stinson makes some general observations about the allegations of sexual abuse against peers. It is very unclear whether the clinicians felt supported by management during this era. Was there a pressure to keep beds filled? Decisions as to whether to report peer to peer sexual activity would have been taken by the clinical team with the advice of the social worker attached to the unit at that time. The threshold for reporting such behaviour has reduced over the years quite markedly. Some units would have reported the matters to parents and would have supported them in their decision of reporting to

social services or not doing so, unless the situation were serious. Allegations involving sexual intercourse would have been reported.

3.2. Child B: Her behaviour was highly sexualised. It appears that staff were aware of this and tried to maintain a level of supervision. However, it would seem that she required 1:1 observation when she was awake and it is unclear to me a) whether this was considered b) whether the staffing levels of the unit would have been sufficient to maintain this c) was this an appropriate admission and d) if not where else the child could have gone.

3.3. Child X: It is unclear who (nurse, doctor what seniority?) recorded their assessment that staffing levels were inadequate to manage this young man of fourteen. It is also unclear to me why a child who had been previously behaviourally out of control was readmitted to the ward unless there were compelling psychiatric reasons which are not specified in the information made available to me. For me, it is an example of the unclear remit of the two wards in the system at that time in Northern Ireland.

3.4. Child Y: Why was this child admitted? Why, as a teenager, was he on the same ward as a five year old boy? Having wards that mix younger children with teenagers carries a variety of risks. However, in the early 1980's this was not uncommon. The first ward that I was responsible for (1985) had children and young people up to age sixteen.

The issue of appropriate levels of staffing again appear here. I also think it likely, as suggested by Mr Stinson that an alternative placement should have been considered. In London, I would have been pushing for this boy to be placed in a secure setting, psychiatric if he was mentally ill but if his difficulties were psychosocial I would have wanted a secure social services setting. I do not know what the alternatives that the consultant might have accessed in Northern Ireland at that time.

If he had to be in a psychiatric unit, I would have wanted him nursed away from other children on 2:1 or 3:1 constant supervision. I have no idea whether that would have been possible in your context. Without it, you have the consequences documented.

3.5. Child P: I have some difficulty understanding exactly what happened here. When the girl is said to be covering up for another alleged perpetrator, I am unsure what that means, somebody else who had SI with her or who had SI with the 9 year old or both? She is 4 years older than the 9 year old but this section is written as if he is the perpetrator rather than him being her victim. Because a child is male that does not necessarily make him the perpetrator.

I agree that it is a bit surprising that his notes apparently have little reference to the effect of all of this on him and his subsequent behaviour and as to whether he had already been sexualised by an adult or adults before meeting the 13 year old girl. I am not convinced that a police interview would have been the best way to find out the truth in this situation.

The implications of this incident go far wider than Lissue. I am concerned that this commentary is drafted inappropriately. It does seem that the staff at Lissue were concerned about his sexualised language and knowledge but I am not sure they were in a position to do more.

Mr Stinson refers to allegation in paragraph 1.2. I assume that he means para. 1.3. I am not in a position to know how they relate to child P.

3.6. Child FF: I agree with Mr Stinson here. I think that this was an allegation about a serious incident of alleged sexual activity between two eleven year old children in the care of Lissue at the time. I think that the unit should have investigated it much more thoroughly and / or documented carefully that investigation.

This suggests to me that there was a lack of policy about such matters at that time at Lissue. This was at a time that issues of family sexual abuse were coming much more to the foreground in the public perception. Whether the issues of sexual activity between pre-teenage children was in professionals' focus in Northern Ireland, I am not in a position to comment.

3.7. Child EE: Before criticising this, I would want to see what the nature of the discussions was about these incidents in the records. We would have reported such matters to social services rather than the police and a multi-agency strategy meeting would be convened.

I agree with Mr Stinson's comments indicating concern. I note that Dr McAuley was informed about this incident. There is no comment in the report about his response or the senior staff group's management approach to this situation.

As a consultant, I would have been concerned at several allegations of pre-teenage children apparently having sexual intercourse with each other and would have wanted the senior staff to meet with management to consider how safely to manage these children. They were in a position of "loco parentis". However, it is not at all clear to me that if such discussions had taken place, that they would have found their way into the children's individual case files, the basis for this investigation. On the units I have run, they would be in policy meeting minutes etc. This means that you should be wary of jumping to criticism. However, there are lessons to be learned for the future.

4. <u>Section 5.1.3 and Appendix 3 – Allegations of sexual abuse by staff</u>

4.1. Child A: Like Mr Stinson, I was concerned at the apparent handling of this allegation from 1990 onwards. Whilst this information may exist, there is no evidence presented that the Lissue local management was informed at the time of the initial allegation, nor that there was active, assertive collaboration across agencies, including health at a senior level to try to ascertain whether other children might currently be being exposed to risk when the allegations came to light. There is no indication that the consultant, Dr McAuley was involved in any such discussions. However, as with other aspects of this investigation, such actions may have occurred but be documented other than in the children's notes. Would it have been possible to show each of the sisters photographs of the staff? Does this have any implications for keeping a photographic record of staff working on such units? We do not do this methodically even now.

4.2. Child E: Sometimes it is just impossible to ascertain the truth or otherwise of such allegations but they must, and should at that time have been taken seriously by the staff. In that era, we would have had a discussion with social services and almost certainly referred such an incident to them, even though it might mean suspending a member of staff whilst the allegation were investigated.

4.3. Child BB: Is this what the report writer really means? Does he mean "receiving" rather than "accepting"? These are very serious allegations of criminal behaviour which may or may not be true.

I would support further investigation of them. It would be relevant to know the diagnosis for this patient. Why was she requiring sedation by injection regularly? What was her previous history? Was her reported violence being appropriately managed? Was she correctly placed in a psychiatric unit? Did she need other accommodation etc?

Having questioned all of that, I would want to know if by LS25 she meant her grandmother and if that lady were still available for interview. Her grandmother might well ask lots of questions. I was also quite concerned by the detail of her indicating that she was unable to masturbate LS21 because of loss of control of her hands; this rings true as the sort of small detail that can help corroborate such an allegation.

I also note that another patient, child A refers to a member of staff lying on top of her. Is this coincidence? I would have thought that it is quite unusual behaviour and is suggestive of paedophilia. Can any of the other children she mentions be traced as adults? Would they be willing to be interviewed about their time at Lissue and staff behaviour and any possible abuse or boundary violations?

The allegations of physical abuse are also worrying. Sometimes staff do have to manhandle children when they are being violent. They should avoid doing so alone.

It is never pleasant but it should never be used as retribution or as revenge. The main issue here is one of corroboration.

We do have allegations against staff of rough handling or violence on occasion. They are all immediately investigated. Sometimes they are fabricated because the child does not like a particular staff member, sometimes they are misconstrued and fortunately, only very occasionally, they are true. I think that we would have investigated such incidents in that era.

A senior nurse who is not directly involved leads such an investigation. It may be the ward manager, the modern matron or a service manager depending on the circumstances. Social services will also be informed and if they or the police want to investigate, the internal enquiry may have to be suspended until their investigation is resolved. This requires close inter-agency collaboration to maintain appropriate confidentiality, to avoid the ward becoming paralysed and morale dropping.

5. Section 5.1.4 & 5.1.5

I would only comment here that in my experience, violence by young people is minimised by a combination of factors including:

- A clear purpose of being on the unit or of continuing he admission that is agreed by parents or carers
- the child's previous behaviour, so that case mix of patients is important
- staff numbers and training leading to high morale
- staff who evoke the trust of the children
- a tight timetable for the children so that their time is occupied
- therapeutic opportunities for the child and for the family

If any of these factors slips, violence tends to rise. Sometimes one patient can absorb enormous amounts of staff time and two or three such patients can overwhelm a unit.

If children see staff being unfair or becoming violent, they will mimic this.

6. Section 5.1.6 and appendix 4 - Allegations of physical abuse by staff

6.1. Child D: No comment possible

6.2. Child E: Such investigation might be recorded elsewhere such as incident forms. Was there a separate system for recording any investigation? Would such an

allegation be investigated by the hospital or by social services given that it is against a social worker?

6.3. Child J: see section where greater detail

6.4. Child BB: I have discussed this under 4.3

7. Section 5.1.7 – Grooming (category 7)

7.1. Mr Stinson raises important issues here that flow from a wide age range of children and young people on the same unit. We had similar issues that arose for young people trying to be older siblings to younger patients when I first started as an inpatient consultant on a ward admitting up to age sixteen. Separating teenagers in adolescent units largely obviates this issue. Occasionally a thirteen year old will be better managed on a children's unit because of their diagnosis or because they have learning difficultles or major immaturity for some other reason. An adolescent unit may be too robust an environment for such young people, at least initially.

The potential risks that he raises arising from past physical or sexual abuse are real and will be greater in an inadequately staffed unit, a situation that Mr Stinson repeatedly questions about both units.

8. Section 6.1.1 Restraint and Appendix 5

8.1. Child D: This appears to be an inadequate reason for restraint but what is not documented is what the child was doing that initiated the restraint. Equally, we would not encourage a parent to be involved in a restraint but it can happen if there are insufficient staff or if the parent were the subject of a child's attack etc.

8.2. Child M: I do not recall hearing of a child being held in their bed as a method of restraint because they would not stay in bed. Firstly restraint should only be used in dangerous situations and a child getting out of bed does not fit that category, secondly, if you have to restrain a child, doing so in their bed will be potentially hazardous as well as giving the child particularly unpleasant associations to their bed.

With regard to child M being wrapped in a blanket for 45 minutes, I do remember this being used as a method of restraint in the early to mid 1980's. However, it had disappeared in London units by 1990. 45 minutes seems a long time for this method at any time and it would not be used today.

Overall Conclusions

1. There are a number of worrying aspects to the allegations and recorded behavior of children and young people at The Lissue and Forster Green psychiatric units.

2. The paper trail is rather disjointed so that it becomes really impossible to tease out what protective systems were in place to minimize risk and to prevent abuse whether by children or the adults looking after them.

3. From the limited information I have had, it is not really possible to tease out the frequency each week for the consultant psychiatrist's presence at either unit, the ways in which the consultant was kept informed by junior staff and the frequency of this when he was off site. There is evidence in some of the notes about communication with him when he was off site. I understand that responsibility for the inpatient unit was only a limited part of his clinical responsibilities. Such a job plan can work well and is important in avoiding professional isolation for the consultant running an inpatient service (see report by Lord Carlisle, 2002[1]).

4. There was no information provided to me on the policies of the units or the clinical governance arrangements that were in place. Whilst that was not systematized in the same way as today, there would have been documents addressing these issues at least to some extent.

5. Inpatient child or adolescent psychiatric units are stressful places. There is often some aggressive behavior by some of the children or young people and that can easily reduce morale for the other patients and for staff. A very few children can occupy much of the available staff resources.

6. The central person for a well-run inpatient service is the senior nurse on the unit. The person holding that role is pivotal in terms of communication and in terms of building a skilled and safe nursing team. If the person holding that role is ineffective it causes severe malfunction of the unit that other members of the multi-disciplinary team can do little about. Worse, if that person were a paedophile then they would be in a very good position to keep this secret for significant periods.

7. The relationship between the senior nurse and the psychiatric consultant to the unit is also crucial for the morale and smooth running of such units.

8. Having an externally employed competent social worker on the unit can help reduce risk and in my view, is essential both as a critical friend and also as a person to whom children can go if they have concerns. The social worker has both to be a part of the unit

[1] *Too Serious a Thing – The Review of Safeguards for Children and Young People Treated and Cared for by the NHS in Wales – Lord Carlisile (2002) obtainable at http://wales.gov.uk/?lang=en*

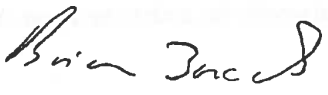
but also have a very clear understanding that they are slightly separate from it in this regard.

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

10. Reading the case histories that were supplied and the other documents available to me, I was struck that the two inpatient psychiatric services were being used at times for children and young people who were proving too difficult to manage in a social services setting. This is not the job of an inpatient psychiatric unit in my view and that of most inpatient consultants. It is very easy to be pushed into the position of accepting such children by senior management but it is a mistake. They are usually not unwell; often they quickly resent being in a psychiatric setting. They show this through aggression and other delinquent acts. Sometimes, even though they are unwell e.g. depression, they are so conduct disordered that they require a secure setting that cannot be provided safely in the context of an open child or adolescent psychiatric ward. It was my impression that other children who would normally be manageable were becoming less so because of the behavior of others and insufficient resource to manage the situation.

11. I have run a child psychiatry unit that took children and young people up to the age of sixteen in the past. I think that it is not a good idea to have young children mixing with teenagers. The latter try to parent the younger children in an inappropriate way and they are often quite frightening for the young children.

12. I have been asked specifically to address whether the services provided by the child psychiatrists at the time to the two hospitals, Lissue and Forster Green, were adequate in the light of subsequent complaints detailed in the above report. After carefully sifting the partial information available to me, I think that the service they provided was clinically good. I think that they were part of a failing system that was not of their making and that they probably had limited opportunity to effect change. I have seen no documents that suggest that the units were adequately resourced for the tasks they were being asked to undertake.



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Appendix 1 – Documents made available:

1. Independent Report Lissue and Forster Green Hospitals Historic Case Review (R.S. Stinson, January 2009)
2. Appendix to the above with details of the allegations
3. "SIFT" document of 150 pages
4. Case notes on the following children:

    4.1. Child A

    4.2. Child B

    4.3. Child E

    4.4. Child H

    4.5. Child P

    4.6. Child X

    4.7. Child BB

    4.8. Child GG

    4.9. Child HH

(These notes consisted of the medical notes and often did not include the nursing notes)

[redacted]

- **Record Management Systems and Recording**

A number of issues in relation to record management systems and recording were identified.

- In some instances there was a lack of written evidence of what action was taken following the identification of child protection concerns. It is unclear from the files if this was due to a lack of awareness in relation to risk assessment processes, relevant child protection procedures, and thresholds for referral to Family and Child Care Social Services or if it was due to poor record keeping. In the period 1970 – 1979, while there might have been a lack of understanding in relation to some forms of abuse, there would have been an expectation that alleged physical abuse would have been referred to Family and Child Care Social Services. However in six files reviewed relating to this period there were incidents of alleged physical abuse recorded in the inpatient files and no evidence of these being reported to Family and Child Care Social Services. In the period of 1990 – 2003 there would have been an expectation that where child protection concerns were identified that these concerns would have been brought to the attention of Family and Child Care Social Services. Thirteen of the files relating to this period lacked written evidence of action taken following the identification of child protection concerns.
- There were difficulties in identifying a list of children/young people who had been admitted to the Inpatient Units for the relevant periods.
- In a number of the files there were recordings which were not signed therefore it was not possible to identify the professional responsible for the record. There were also issues relating to the legibility of some of the records.