HIA REF: [ ]

NAME: LS81 [redacted]

DATE: [4/04/2016]

THE INQUIRY INTO HISTORICAL INSTITUTIONAL ABUSE 1922 TO 1995

Witness Statement of LS81 [redacted]

I LS81 [redacted] will say as follows: -

1. My career history is as follows: I started nursing in [redacted]. I did a State Enrolled Nurse [S.E.N] qualification and it was with the School of Nursing at that time in the [redacted]. I then worked for a short while in [redacted], medical unit as a state enrolled nurse. I was inspired to commence a Registered Mental Health Nursing course in [redacted], this also was within a School of Nursing programme. On completion of that programme, [redacted] I took up a staff nurse post in [redacted] in a ward for acutely mentally ill patients. During that period I worked with woman survivors of abuse and other mental health conditions. That work inspired me to work with children. I subsequently successfully applied and took up post as a staff nurse in Lissue during [redacted]. I continued there until [redacted], at which time I moved to work with adult mental health services [redacted]. I then returned to work with child psychiatry with Dr McCune [redacted] for 10 years. From [redacted] I was working in the Royal College of Nursing. During this time, I spent 1 year's secondment in the Department of Health and Social Service as Nursing Officer for Mental Health and Learning Disability. I am presently Co-Director of Nursing Workforce Education and Regulation in the [redacted] Trust since [redacted].

2. While I was working with Dr McCune, he, I and other colleagues that had worked in Lissue influenced the development of the child and adolescent mental health nurse training course at [redacted] School of Nursing. This programme commenced in 1990, which later transferred into Queen's University and has been registered by the Nursing and Midwifery Council (Nursing and Midwifery regulation body) as a recognised course. Upon completion of that course you are considered a specialist nurse. I hold that qualification since [redacted] and it is registered on my statement of entry with the NMC. I was commissioned to lead the review of Child and Adolescent Mental Health with [redacted], and [redacted] within NI. I also had involvement in strategic planning in the scoping and preparation for the design of the current regional provision within NI.

3. My line manager upon commencing employment in Lissue [redacted] was LS21 LS21 . I recall that LS78 [redacted] had just left the ward when I was arriving. We were divided into teams so there was one senior staff member that you would have been managed by. LS21 [redacted] was my team manager.

4. I recall my period as a nurse in Lissue with fondness. It was a proactive experience working with Dr McAuley and Dr Nelson. They were implementing new models of practice. Dr McAuley used a behavioural model and Dr Nelson a family therapeutic model. These required different approaches with different children, and they were both of their time. Many of the techniques were new and innovative at that time in relation to the video undertaking with families, with their consent etc. From an academic model perspective I recall using the work of Michael Rutter and Dr Minuchin, and these models would also have been implemented nationally across the United Kingdom. I also recall student doctors and nurses in the Unit, as well as other disciplines working together with families in a multidisciplinary way.

5. There were some of the Multi Disciplinary Team (MDT) in Lissue and some came from the Royal Hospital in Belfast. There was a movement of professional staff between the two hospitals to support the children who were admitted or attending as day patients to the ward. There were weekly significant meetings of the MDT.

As a junior staff nurse you would be expected to attend to report your observations and understanding, about what was happening for the children that you may have been, key nurse for, then listen to the Team deciding what the particular care plan might be for that particular child, with senior nurse influencing the plan. As I gained experience I had an opportunity to influence the plans professionally. These meetings were attended by the Consultant Psychiatrist, Doctors in training, Nurses, Social Worker, Psychologist, and there would have been a secretary keeping a record of the meetings in the form of minutes. There were occasions that some members of the family would have joined that to take part. I recall the head of the school, LS3 [redacted] attending. On occasion a particular teacher working with a particular child would also have attended. This MDT meeting reviewed the care plan for each patient, on two different days each week, one being Dr McAuley's patients, and one Dr Nelson. This allowed all relevant staff working with a particular child to come together to inform patients case/care plan to be reviewed and altered if need be.

6. On a monthly basis there was also a journal club of professionals, where the Doctors, Nurses and Social Worker came together to consider training and development of practice issues through presentation of cases, research or other information.

7. As between the day shift and night shift nursing teams, there would be a handover. This would have been a detailed discussion of each individual patient. Occasionally if the staffing need required it, some day staff would support the night staff on the ward while others met to ensure a handover of information. On those occasions the senior Night Nurse provided a handover to the available day staff, who would then share that among all day staff.

8. In terms of the nursing plan, Nurses were expected to write a report on a daily basis as to the implementation of the plan, which was drawn up and reviewed through the MDT process. From a nursing perspective this report was informed by the Logan and Tierney model of daily activities of living and the nursing process assessment, plan, implement and evaluate. Each time you concluded

your shift nurses were expected to write a report of that period and what the children experienced while you were caring for them.

9. My memory is that I was expected to record the implementation of a model of care that had been prescribed by the consultant in charge. At the MDT that is where the plan would have been modified. That was the expected practice. Any changes to the plan should have been recorded in the notes. If I was working with someone with encopresis the plan should have been evident, so that as key nurse if I was not on the Ward other Nurses could be aware of the plan and what was expected, intended, in the management of that child. For a child with encopresis, this would have psychological, nutritional, fluid intake and toileting elements or factors.

10. I recall that I would have been specifically assigned to four children as key Nurse at a time. A second Nurse would also have been assigned, with a health care support person making up a core team of three for each four patients. I do not recall difficulties with staffing while I was there; in fact this was a considered a good staff, patient ratio. We of course had occasions when staff members were sick when alternative plans had to be made to cover care for their patients care needs, but short staffing is not a prevailing memory I have during my time in Lissue between [redacted] to [redacted].

11. As regards records in Lissue, I recall that each section of the MDT kept their notes separately, in different cabinets in the one room, during the admission. There were other diary type books that information was recorded in. I cannot recall exactly what types, but I do remember other logs. I also recall people were advised not to write into the book. If it was relevant to a specific child it needed to be recorded in their notes.

12. There was a manual on the ward, with printed out copies of guidance that you would be expected to read and be up to date on. I recall that when I started, I spent the first few days having the time to read that folder; this was part of an induction period. If you later had any doubt you would be directed back to the office to refresh your knowledge and practice. Other training involved a planned

period of observation of senior staff, for example the Consultant or Social Worker. After the observation a discussion would then be held with a senior nurse to discuss what had been observed and learnt. This could have included going to the Royal Hospital or on home visits. It would have been akin to shadowing and considered work place learning. Continued professional development and mandatory training were also in place during this time.

13. Communication between the different disciplines of the MDT was very good in my experience. I recall raising queries about the implementation of plans, for example time out, with Dr McAuley, who was always receptive and helpful, as was Dr Nelson. Each would have taken the time to talk through the matter raised.

14. There were some occasions where I observed what I perceived was a misapplication of a behavioural technique, this was in relation to time out. This had two aspects: first, a move to implement time out first before using a diversionary technique and secondly, to extend the time the child was in time out waiting until the child was quiet prior to counting that time within the 1 min per year application of time out. Although the extension of time was for minutes longer I still shared this information with senior staff, the aim of which was to clarify seek consistency of approach and not expect the patient/child to remain any longer in time out than was prescribed by their age and the medical team. When I had such concerns I brought this to the attention of senior staff. This would then have been discussed with the Nurse in question and I would have been aware of their practice modifying, thus resolving the issue. I did not consider what I witnessed as abusive practice or this I would have reported, and never saw time out being extended to significant periods.

15. Another issue that would arise with time out related to the specific child and whether the timing of the time out should commence when the child was not yet quiet. For some children this had the potential to extend the time unduly in my view. This issue was raised with Dr McAuley, who was very receptive and engagement would then ensure the modification of the technique to suit the needs and presentation of that particular child.

16. I have read undated written guidelines on time out that are available. I do not recall it being as punitive as it appears to have been written. I think it is also important to explain that time out (or time away as I called it) was not seen in the context of punishment but rather a means of de-escalation and reflection time to reconsider personal choices regarding self-regulation and support to achieve this important attribute.

17. My Nursing code from the regulatory body expected me to report if I saw something/poor practice as a nurse, and I did report concern to the senior nurse. I think it is also important to explain that time out (or time away as I called it) was not seen in the context of punishment but rather a means of de-escalation with an ultimate aim of habit reversal or modification of the behaviour.

18. One of the issues I recall arising on the Ward was the combination of children demonstrating and presenting behaviours that were described as difficult, high risk and unacceptable. It was a challenging environment to work with, children who were clashing with one another from a cultural and behavioural perspective. The ward promoted a neutral cultural environment but on occasions the history of Northern Ireland, the children and their cultural, social and family backgrounds, had to be given very careful consideration. Depending on the balance this did present the nursing team caring for the children/patients with significant challenge. Other factors that also needed to be thought about were the age ranges and the differing needs of children to ensure their needs were met.

19. A child's first three or four weeks on the Ward would have involved assessment and observation to learn about the presenting behaviours. Thereafter on the outcome of the assessment, the MDT would begin to design a care plan and implement to achieve positive outcomes for the patient/child.

20. For example for a patient admitted for anorexia, which was relatively common, a behavioural model would lead the treatment plan. This was known to me as a model being used across the United Kingdom and involved a feeding programme, which was essentially one whereby if you ate, you gained health and

privileges. Some of these children needed medical treatment in hospital before they could even come to Lissue they would have been so under nourished. Their health would have been seriously at risk, with potential for collapse, fainting or dehydration. Their physical health in this respect informed plans, including the need for rest periods and bed rest. The behavioural model may also have included a child not having weekend leave, but such a step would have been agreed with the parents, and would not have prevented family contact which would have taken place on the Ward or by telephone. For a patient who did have home leave, sometimes their parents brought them back to the Ward early – because at home they were reverting to not eating and the parents were therefore concerned for their welfare. Some of these children were extremely underweight. As I was leaving Lissue, practice was developing towards inclusion of a family therapy model.

21. I do not have a memory of refusal of home leave being set out in plans for children presenting with other conditions. It would not have been a general practice in my view. One concept was from Social Learning theory perspective "when you do this, we can do that". This was and still is a recognised behavioural approach which involved the co-operation from the child. This is neither punishment nor sanction. Punishment was not the ethos of the care environment. So many times the children came from environments, having been exposed to challenges at home and or in care. We worked with the children compassionately. We aimed to develop their resilience and their relationship abilities and improved behaviours to maintain their socialisation at school, leisure environments and the home place, be that at home or a care placement with foster carers and or care homes. Often what a child did was to present with behave in a way to initiate, predictable experience that was more familiar to them, behaviours that may have occurred at home, which often may have been a negative response that they were used to. The receipt of a compassionate response to presenting behaviours would have been quite a challenge for some patients.

22. The concept of 'holding' was another part of the behavioural regime – where you were aiming to contain the aberrant behaviour being presented. This was not

considered restraint. The theory was that the child was being held to contain self (self-regulation) and the situation, and helping them learn to self-regulate. All of the approaches were modified for the individual needs of the particular patient, how they presented and what their particular challenges were. Holding would have been to contain for example severe temper tantrums. In physical terms this would have been a firm but gentle response encouraging calmness and de-escalation of the situation. This approach would have had particular application for children that were younger, perhaps up to the age of around 10 years. This would often translate into the child wanting comfort when calm and or to cuddle in to the member of staff, and this is where professionalism was extremely important not to facilitate this behaviour, although support the patient/child to self-comfort in an appropriate way. As a professional you needed to be mindful to be providing care within the context of maintaining a professional environment for the patient/child, preventing confusion or blurring of roles for the patient/parent/professional. One little boy I had worked with asked me if he could home with me and I could be his Mummy. This required great professional sensitivity while providing professional care for this young person.

23. I do not recall ever witnessing restraint been used. I do recollect holding. If there was a child that was particularly aggressive you might have persuaded them to remain in another part of the unit that was less dangerous to them. If the child absconded, for example, they might have been returned by policeman with quite an outburst by the patient/child on their return. In those occasions you would often try to use a part of the unit which gave them space in a safe way to de-escalate their behaviour, while not placing either themselves or others at risk. The aim was to achieve the point where the child could regulate their own behaviour.

24. I have also been asked about my memory of sedation being used on patients in Lissue. Medication was prescribed for patients/children in line with their presenting condition and was only used as prescribed by the consultant responsible for the patient/child's care plan. I am aware that on occasion, medication that may have had a response of sedation on a patient would have been prescribed as part of the patient/child care plan.

25. I also recall patients being on the roof of the building of Lissue, and having slates thrown at staff. I have been shown a policy which related to Forster Green Hospital. That dates to after my experience, but in terms of my experience in Lissue, I do not recall many aspects of it. I do recall the escalation process, namely to alert senior staff to the events, would have applied, but I have no recollection of implementing any period of 24 hours in isolation after the event. My recollection is that one staff would have remained to speak calmly to the child, far enough away to speak, but not close enough to place yourself in any danger from potential missiles. Other children would have been encouraged away from the scene into the unit for their safety. When the child came down from the roof, the child was brought to a quiet area to discuss and explore what it was that might have initiated their behaviour. You would try to work out what started it, what kept it going and whether there was any reason for it. This would then assist with trying to help the child resolve the situation and or precipitating factors with alternative behaviours that are low risk behaviours for self and others, this was to invite and hopefully develop empathy for others. The aim was to achieve ability for the child to identify and modify self and develop alternative choices.

26. In terms of locking of doors within Lissue, I do not recall this as practice. I do however recall a door into the unit being locked upon the return of a patient that had absconded under the supervision of the Police, until the situation de-escalated. The door was then unlocked.

27. In terms of bedrooms there were rooms with four beds down stairs, and then upstairs there were individual bedrooms. I do not remember bedroom doors being locked. If there were locks, I do not recall ever using them. There may however have been a door closed with a member of staff sitting at it to supervise time out. This was also the subject of debate in terms of implementing the technique with the door open, as the use of a closed door may give the child the feeling that they were closed in. This resulted in the technique being changed in consultation with Dr McAuley, so that the door would be left open.

28. I have also been asked about Tourette's syndrome. There was also a behavioural model for treatment at that time, which by today's standards would be considered harsh, but it was a model of the time. Habit reversal was a technique that would be used. The theory was that if, in relation to vocalisations, could the patient gained the ability to manage the vocalisations, this would in turn be less disruptive and open up opportunity's for greater socialisation in school and other leisure/public environments as we as at home or care placement. These techniques would have been used in a one-to-one setting, not within a group, and timetabled at particular times of the day.

29. I have been asked about searches. If children returned from home leave and the family shared their concerns that they may have been able to access medication and/or sharp implements, the child themselves would not physically be searched but their property would have been, for their safety and the safety of other children that were vulnerable on the Ward.

30. I understand that further questions have been posed. My recollection in respect of the various issues are:

    a. I do not recall children being provided with cigarettes or being allowed to smoke. Some children would have been smokers on admission and we would have asked them to give up their cigarettes. I do not recall nursing staff ever holding cigarettes for a patient.

    b. I have no recollection of physical chastisement in Lissue.

    c. In terms of wetting the bed, there was the bell and buzzer system. If the child wet the bed, he or she would be encouraged to help the nurse take bed sheets off and then the nurse would remake the bed for the child to get back into. I understand the policy of children helping to take the sheets off the bed is still a practice recommended today. Charts were used to see whether there were any patterns, as some children had enuresis in relation to a psychological issue, some for a physical issue. Charts were also used to build a picture of the sleep pattern of the child.

d. Patients were not expected to engage in chores, and chores would not have been given as a punishment. The child/patient would have been expected to keep their bedroom reasonably tidy, as an example clothes not on the floor as a bedroom cupboard was provided.

e. Bullying was not condoned. Among peers I recall arguments on the Ward; this would have been managed by the staff with the patients/children. The nurse would have engaged with the children involved in the argument, to resolve the issue and re-engage them in co-operative play. If there were serious concerns they were discussed through the MDT meetings.

f. I had no awareness of peer sexual abuse being a difficulty on the Ward. However, I was aware of the need to be vigilant given some of the experiences of the children.

I believe that the facts stated in this witness statement are true.

Signed LS81 [redacted]

Dated 4th April 2016