HIA REF: [ ]

NAME: [**HSCB and PHA**]

DATE: [29th February 2016]

THE INQUIRY INTO HISTORICAL INSTITUTIONAL ABUSE 1922 TO 1995

Witness Statement of Health & Social Care Board / Public Health Agency

---

I **FIONNUALA MCANDREW**, Director of Social Care and Children, **MARY HINDS** , Director of Nursing PHA and **DR CAROLYN HARPER** Director of Public Health PHA will say as follows: -

1. Further to the request from the Inquiry for a statement addressing various questions in respect of Lissue, the Health and Social Care Board and Public Health Agency (collectively referred to as "the Board") would respond as follows;

Q1. When did Lissue open and during what period did it operate?

2. In responding to this question, the Board has been assisted by "Lissue Hospital, History 1981" which is exhibited hereto at **Exhibit 1**.

3. Lissue House was a private home to Colonel D C Lindsay. Its first link with the Royal Belfast Hospital for Sick Children ("RBHSC") occurred during the second World War when Colonel Lindsay offered accommodation at his home to give as many children as possible care and safety at the time of the first bombing blitz in Belfast. The links continued after the war, noting: "the location being an ideal settling for long term and convalescent care and treatment". On 1 May 1947 Lissue House was donated by the Lindsay family to the RBHSC.

4. As detailed in the history document, by 1959 Lissue was a busy branch hospital of RBHSC, treating surgical and medical patients.

5. A psychiatric inpatient service for children and young people was first provided on the Lissue site from May 1971. It is this service that the Board understands is the focus of the Inquiry and thus forms the focus of this statement.

6. Prior to the opening of this unit at Lissue Hospital, there was no provision for in-patient child and adolescent psychiatry in Northern Ireland. The first proposal to consider Lissue for such a service was on 21 June 1968, following which a medical staff sub-committee in RBHSC was appointed on 1 July 1968 to: "Consider the best way Lissue House could be converted into an In-Patient Child Psychiatry Unit and if this was not possible, whether or not a new Unit should be provided". This subcommittee subsequently produced a report which is at **Exhibit 2** and details the committee's deliberations in relation to the proposed use of the building and staffing needs.

7. In November 1968, the Belfast Hospital Management Committee confirmed to the Northern Ireland Hospital Authority that they had accepted in principle a recommendation from Dr Porter that part of Lissue Hospital should be converted into a 20-bed inpatient child psychiatry unit. See **Exhibit 3**

8. The in-patient unit subsequently opened in May 1971 with the first patients admitted on 17 May 1971 as detailed in the in-patient admission book.

9. The Child Psychiatry unit at Lissue also offered day patient admissions. It is noted that the day patient admission book records the first patients for this service in September 1971.

10. From May 1971, therefore, there were two inpatient services at Lissue Hospital:
    a. A Paediatric Unit (on the ground floor) comprising of 20 beds providing the full range of services for physically ill children;

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

11. The Child Psychiatry Unit continued at Lissue Hospital until 29 February 1989 when the services transferred to the Forster Green Hospital site, Saintfield Road, Belfast.

Q2. How many individuals spent time in Lissue?

12. The Board has provided the Inquiry with:
    a. The admission book for in-patient admissions to the Child Psychiatry Unit;
    b. The admission book for day patient admissions to the Child Psychiatry Unit.

13. At **Exhibit 4** the Board details an analysis of the admissions to the Child Psychiatry Unit at Lissue Hospital. From same it is noted:
    a. Between May 1971 and 29 February 1989 there were 1,124 children admitted as in-patients;
    b. Between the same dates there were 250 children admitted as day patients.

14. The Inquiry may note that out of this total number of inpatient admissions, there are 10 Applicants in this Module, 9 of which relate to the Child Psychiatry Unit. This represents less than 1% of children admitted to the inpatient unit over its 18 years of operation between 1971 and 1989.

Q3 On what basis were children admitted to Lissue?

15. Please see response to Question 1. Prior to 1971 the main function of Lissue Hospital related to surgical and medical patients. After 1971 there remained a Ward on the lower floor which was a Paediatric Unit.

16. In considering the Child Psychiatry Unit, the initial proposal prepared by the sub-committee in 1968 did not comment upon precise admission criteria. It did, however, consider what age of children should be provided for, envisaging that

the cut-off age for children to be admitted would be "*up to the age of puberty*", anticipating that the greatest demand would be for children in the age group 8 – 12 years (see pg 5 of **Exhibit 2**)

17. In 1981, the History exhibited at **Exhibit 1** described Lissue in 1971 as offering residential treatment, or "*24 hour intensive treatment*" of psychological disturbances manifest in children under the direction of the Consultant (Family Therapist), Dr Nelson. Following the appointment of Dr Roger McAuley as Consultant Psychiatrist (Behavioural Therapist) in 1976 it is described: "*the previously eclectic milieu changed to absorb a more behaviourist approach which incorporated intensive behaviour modification programmes*". This coincided in the same year with the beginning of family admissions, which focussed on the child management skills of the parent. Accommodation was developed from 1977 to allow two families to reside on the site. However, the Board believes that usually just one would be in occupation. Four years later, in January 1980 it is noted: "*following a global recognition of the significance of Family Psychopathology in the aetiology of psychological disturbances, the repertoire of treatments extended to include a study of Family Therapy and the development of this alternative approach to psychiatric illness, the main emphasis here being on seeing every member of the child or young person's family"*.

18. Children that were admitted to Lissue were admitted as patients whose treatment plan was led by a Consultant Psychiatrist with the aim of treating emotional or behavioural disturbance, or psychiatric illness. A Consultant Psychiatrist referred patients for admission and supervised their treatment in the Unit during admission. The Board understands this was through ward rounds on a weekly basis.

19. An undated contract is at **Exhibit 5** details the expectations upon family members and their involvement in the therapy offered at Lissue. It is important to note the emphasis that is placed on the involvement of the family in this contract, which required parents to agree: that they would spend at least one afternoon or evening per week on the unit; that the whole family would attend once a week for family meetings unless the therapist required otherwise; that while the unit was

open seven days per week, the child may spend weekends at home. It is significant that if the parents were unable to fulfil this involvement and co-operation that "*the staff at Lissue Hospital reserves the right to discharge*" the child.

20. It is also noted from the Belfast Hospital Management Committee Annual Report that there were 2,626 outpatients at the Child Guidance Clinic in the RBHSC, with 507 day patients at the Child Psychiatry Unit, Lissue Hospital. For the same year there were 53 inpatient admissions. It is likely therefore that the inpatient unit was dealing with the most complex of patients.

Q4. What legislation governed the operation of Lissue?

21. Lissue operated as a hospital. It was therefore governed by entirely different legislation from that which governed residential Homes for children.

22. The principal statues that governed the operation of Lissue were:
    a. The Health Services Act (NI) 1948 ("the 1948 Act");
    b. The Health Services Act (NI) 1971("the 1971 Act");
    c. The Health and Personal Social Services (Northern Ireland) Order 1972 ("the 1972 Order").

Q5. What Rules, Regulations or Orders (legislative or otherwise) applied to Lissue (please provide copies of any Rules, Regulations or Orders) ?

23. While provision existed within the 1948 and 1971 Acts for the making of Regulations, the Board has not identified any exercise of that power. The power to make Regulations under the 1972 Order was exercised, however the Board has not identified any that are relevant to the questions now posed (for example, inspection or monitoring of hospitals).

24. The Board also believes, as a result of information received from Dr McAuley, that written policies would have existed within the Unit in relation to: the

supervision of children; general health and safety; use of medication; child protection; time-out; first aid; recording of untoward incidents.

25. The Board has retrieved some written policies and information from PRONI which would have applied to Lissue. These include:
    a. a nursing policy on behaviour modification dated December 1986;
    b. a written policy on seclusion dated December 1986;
    c. a written policy on the use of restraint (Policy No ANT/4/88), an untoward incidents memorandum dated 13 January 1988;
    d. undated written guidance regarding 'Time Out'; and
    e. Procedures for Dealing with Cases of Abuse and Neglect dated March 1983.

    Further, written policies have been found regarding:
    f. the Management of Violent or Potentially Dangerous Patients dated August 1989;
    g. procedures to be followed in the case of abscondments involving children on the Child Psychiatry Unit (3rd revision – June 1990);
    h. a written policy to be followed if any child (in patient or day patient) goes on the roof of Ward 7, Forster Green Hospital; and
    i. a memorandum regarding action to be taken in relsyion to incidents occurring in the Child Psychiatry Unit dated 17 September 1990.

    These documents are all exhibited at **Exhibit 6**. Whilst some of these policies post-date the closure of Lissue on 29 February 1989, it is believed that they reflect accepted practices thst were is use at the time of Lissue's operation. It is also noted that the 1990 Procedures to be followed in the case of abscondments involving children on the Child Psychiatry Unit was a 3rd revision document.

Q6 Who regulated Lissue and what approach was taken to regulation?

26. The Board has not, to date, identified any regulations in law that would have governed the operation of Lissue Hospital. However, prior to 1973 Lissue operated under the authority of the Northern Ireland Hospitals Authority who reported to the Ministry of Home Affairs.

27. From October 1973, Lissue Hospital was the responsibility of the Eastern Health and Social Services Board. The nursing reporting and management structures within the Board were (as also developed in Module 5):
    a. District Administrative Nursing Officer, at District Level, who was a member of the District Executive Team, reporting to the Area Executive Team;
    b. Chief Administrative Nursing Officer, who was a member of the Area Executive Team who reported to the Health and Social Services Board.

28. The Health and Social Services Board reported to the Ministry, later the Department of Health.

29. In 1986, Part VI of The Mental Health (Northern Ireland) Order 1986 established the Mental Health Commission for Northern Ireland ("the Commission"). Functions conferred on the Commission by the 1986 Order included a duty "*to keep under review the care and treatment of patients..*" (Article 86). By virtue of Article 86(2) there were specific duties placed upon the Commission to exercise this function, with powers as to how the functions were to be exercised in Article 86(3). Broadly, this required the Commission to inquire into any case where it appeared there may be ill-treatment, deficiency in care or treatment, improper detention in hospital, or where a patient's property may be exposed to loss or damage. The Commission also had a duty to visit patients liable to be detained, and to bring matters to the attention of the Department of Health and Social Services, Secretary of State or a Board such matters as may be appropriate, including where the Commission considered that that body should exercise its functions to prevent the ill-treatment of a patient or to remedy the care provided. The legislation gave the Commission powers, among others, of visiting hospitals and requiring the production of any records in relation to the detention or treatment of a patient.

30. The Board has not addressed provisions relating to Mental Health Review Tribunals within this statement. The Board does not believe children were detained in Lissue, and as such those provisions did not apply.

31. Article 88 of the 1986 Order detailed funding arrangements for the Commission, which was to be funded by the Department of Health and Social Services. The Department also had power by Article 88(4) to direct the Commission as to the application of the sums paid to it.

32. The doctors and nurses who worked in Lissue were registered and regulated by their respective professional bodies.

33. Between 1921 and 1983, there were three General Nursing Councils (GNC) in existence in England, Wales, Scotland and Ireland. The councils had responsibility for the training, examination and registration of nurses. The register of nurses was first published in 1922, and was produced annually until the late 1940s. These listed the nurse by name, registration date and number, permanent address at that time, and where they qualified with dates. Later volumes were produced in the 1950s, which listed only new nurses for each year and did not give the address. Originally, there was a general part of the register, with supplementary parts for ‘mental’, ‘male’, ‘fever’ and ‘sick children’s’ nurses. After the 1943 Nurses Act, registration became compulsory. This is still a legal requirement for someone wishing to practice nursing in the UK. The publication of the registers ended in 1968. In the 1970s, the Briggs committee was established to consider issues around the quality and nature of nurse training and the place of nursing within the National Health Service. It recommended a number of changes to professional education and the regulatory structure. In 1983, the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC) became the profession’s new regulatory body and National Boards were set up in each country of the United Kingdom with responsibility for the education, training, examination and assessment of student and pupil nurses. The UKCC and the National Boards ceased to exist in 2002 and its functions were taken over by the Nursing and Midwifery Council (NMC).

34. The Medical Act 1858 created the body now known as the General Medical Council – then known as The General Council of Medical Education and Registration of the United Kingdom. The Act created the position of Registrar of the General Medical Council – an office still in existence today – whose duty is to

keep up-to-date records of those registered to practice medicine and to make them publicly available. The 1950 Medical Act introduced disciplinary boards and a right of appeal to the General Medical Council. The 1950 Act also introduced a compulsory year of training for doctors after their university qualification. The Medical Act 1983 provides the current statutory basis for the General Medical Council's functions which include responsibilities in relation to medical education, registration and revalidation of doctors, and for giving guidance to doctors on matters of professional conduct, performance and ethics. The General Medical Council also has responsibility for dealing with doctors whose fitness to practice may be impaired.

Q7 Who inspected Lissue on behalf of the regulator and when, please provide copies of any inspection reports?

35. For the period 1971 (when the Child Psychiatry Unit at Lissue opened) until 1 October 1973, the Ministry of Home Affairs had a power of inspection concerning any hospital pursuant to section 63 of the Health Services Act 1948. The Board believes that the power of inspection conferred on the of Ministry of Home Affairs by section 63 of the 1948 Act remained in effect under subsequent Acts (see section 31 of The Health Services Amendment Act (NI) 1969. The Board has not found any records of inspection for Lissue hospital for this period.

36. The Health Service was re-organised by virtue of the Health and Personal Social Services (Northern Ireland) Order 1972, which came into effect on 1 October 1973. Section 5 of the 1972 Order places a duty on the MOHA to provide hospital accommodation. However, Section 50 of the 1972 Order provided the Ministry of Home Affairs with a power of inspection in relation to '*any home for persons in need or other premises in which a person is or is proposed to be accommodated by arrangements made by the MOHA*'. This does not explicitly refer to hospital accommodation and the Board has not found any records of inspection for Lissue hospital, or details of any visits by the Ministry, for the period 1 October 1973 until its closure on 28 February 1989.

37. It is known that following the establishment of the Mental Health Commission, Miss Lyons, Secretary, wrote to the Lisburn Unit of Management on 24 November 1986 to advise of an intended visit to Lissue Hospital on 5 January 1987 by two members of the Commission, Dr B G Scally and Mrs J M Eve. The letter opens:
"*You will be aware that the Mental Health Commission will be undertaking a programme of visits to hospitals whereby it is intended that each will be visited by some members of the Commission at least once per year.*"

38. The letter also makes it clear that as part of their visit private interviews with patients will be undertaken, and their files are to be made available at the times of their interviews. In responding, Mr Heaney, Group Administrator of EHSSB, noted that all parents/guardians of all patients were notified of the visit and offered the opportunity to meet with the Commission members. He recorded that no parent had indicated a wish for such a facility. A copy of these letters is found at **Exhibit 7.**

39. A report is available from a visit of J Eve of the Mental Health Commission to Lissue Hospital at **Exhibit 8** . While the report appears to be undated, the Board believes that it is likely this followed the visit in January 1987. Issues raised by the Commissioners are recorded thus:
"*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…"

40. A statistical return provided by Lissue to the Mental Health Commission on 8 December 1986 is at **Exhibit 9.**

41. While it is noted that the Commission indicated an intention to visit at least once per year, to date the Board has not identified any later reports of visits by the Mental Health Commission to Lissue Hospital. However, it is also noted that the Child Psychiatry service moved off this site on 28 February 1989.

42. To offer the Inquiry an insight into the current arrangements in this respect, the functions of the Mental Health Commission were transferred to the Regulation and Quality Improvement Authority ("RQIA") in 2009.

Q8 What were the governance arrangements for Lissue?

43. Upon the establishment of the Health Service in 1948, Section 20 of the 1948 Act provided for the establishment of the Northern Ireland Hospital Authority (NIHA); Section 28 made provision for schemes for the general managements and control of hospitals. Section 28(1) placed a duty on the NIHA to submit to the Ministry of Home Affairs (MOHA) a scheme making provision for the general management and control of hospitals through which hospital and specialist services were to be provided**.** Section 28(2) provided that that the general scheme shall provide for the management and control of each hospital or group of hospitals through which hospital and specialist services are to be provided by a committee known as a hospital management committee. Section 29(1) placed a duty on the NIHA to submit to the MOHA a scheme or schemes making provision for the performance by each management committee of such functions as the NIHA, after consultation with the management committee concerned, considers necessary for the local control and management of each hospital or group of hospitals. Section 29(2) provided, *inter alia*, that the provision made by a management scheme shall include provision for (a) regulating the financial arrangements between the NIHA and the Management Committee, (b) the appointment of officers, (c) the maintenance of premises, (d) the acquisition and maintenance of equipment. Section 29(6) placed a duty on the Management Committee to control and manage the hospital on behalf of the NIHA.

44. Thus, on its inception in May 1971, the Child Psychiatry Unit at Lissue was governed by a committee within the RBHSC, who reported to the Belfast Hospital Management Committee, who in turn reported to the Northern Ireland Hospitals Authority. This arrangement was in place from the establishment of the Health Service in 1948.

45. The position changed following the re-organisation of local government that was implemented in 1973 with the establishment of the Health and Social Services Boards. From that time until closure, the Child Psychiatry Unit at Lissue fell within the provenance of the Eastern Health and Social Services Board.

46. On a day-to-day basis Lissue was a Consultant led unit.

Q9 Was there a Management or Visiting Board and how was it comprised?

47. Please see response to Question 8 above.

48. In the Belfast Hospital Management Committee Annual Report for 1971, Dr McSorley was named as allocated to Lissue Hospital within the visiting team. That report noted:
"*The system of Management Rounds established in 1965 continued until October 1971 when, because of continuing civic unrest, it was decided to defer further visits until March 1972.*"
See Exhibit X (Belfast Hospital Management Committee Annual Report 1971).

49. The Board therefore believes that it was likely Lissue was visited on behalf of the Belfast Hospital Management Committee, however no reports of such visits have been found. It is noted that the 1972 Annual Report of the Committee is silent in relation to the issue of Management Rounds. See **Exhibit 11.** From discussion with former members of staff of the Northern Ireland Hospital Authority and another Hospital Management Committee, the Board believes that these visits were predominantly for the purposes of familiarisation.

50. The composition and structure of the Belfast Hospital Management Committee is detailed within their Annual Reports exhibited as outlined above. Beneath the Management Committee sat a series of committees that specialised in particular areas. This included, in particular, committees comprised of Doctors, and Nurses, who would have been concerned with the day to day running of the hospitals.

51. The Royal Belfast Hospital for Sick Children also had a Matron, who would have visited Lissue Hospital. Following reorganisation it is believed that the Matron in charge would have been attached to Lisburn District. The Board is aware that Dr Nelson recalls such visits.

52. No records have been located by the Board in relation to any visits to Lissue undertaken by the Eastern Health and Social Services Board after it assumed responsibility in 1973. However the Board believes, having spoken to relevant staff, that the Area Executive Team visited on an annual basis.

53. Whilst not directly related to the running of the Lissue Unit, the Board believes that the Royal College of Psychiatrists visited the Royal Belfast Hospital for Sick Children, including the Child Psychiatry Unit at Lissue, every three years to examine the educational content of training and professional development of doctors. The Board believes that the visits from the Royal College of Psychiatrists lasted in or around two days during which members of the College would have met and talked with staff.

54. Similarly, it is known that following its establishment in 1983, the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC) became the nursing profession's regulatory body and National Boards were set up in each country of the United Kingdom, including Northern Ireland, to monitor the quality of nursing and midwifery education courses, and to maintain the training records of students on these courses. The Board is aware that from an EHSSB memo dated 10 June 1988 from Ms. A Grant, Director of Nursing Services to Mr. R Lyons, Assistant Group Administrator that " *The National Board Inspection of Jan/Feb 1987 withdrew approval as a nurse teaching unit as the philosophy of care was seen as restrictive and "custodial". The structure and layout of Lissue was not seen as well suited for its present use*." **Exhibit 12.**

Q10 How was Lissue funded?

55. From opening to 1973 Lissue Hospital was funded through the Belfast Hospital Management Committee who received an allocation from monies from the

Northern Ireland Hospital Authority. The NIHA budget ultimately was determined by the Ministry.

56. From 1973 Lissue was funded by the Eastern Health and Social Services Board out of monies allocated by the Ministry, later the Department of Health and Social Services.

Q11. What were the staffing arrangements?

57. When developing the proposal for an in-patient psychiatric unit the medical sub-committee of RBHSC made the following recommendations in relation to staffing:

"Medical: 9 consultant sessions
Registrar and Senior Registrar, with sessions amounting to two full-time persons

Nursing: Overall ratio of one nurse to one patient, increasing if necessary to 3:2
Sister and Charge Nurse
Staff nurses
Student and pupil nurses, enrolled nurses, nursery nurses and others
Male and female nursing staff

Other Professional Staff:
Occupational Therapist
Psychiatric Social Worker
Psychologist
Teachers

Other Staff: Clerical and others

See page 6 of **Exhibit 2**

58. It can, therefore, be seen that the proposed unit was to have a multi-disciplinary approach. **Exhibit 1** (same as paragraph 2) details that "*in the initial phases of the development of the in-patient unit, the medical, social work, psychological and nursing staff were provided by the parent hospital in Belfast*", that is the RBHSC.

59. From 1973, the nursing staff came under the control of Lisburn District (under EHSSB), who took on administrative responsibility for the hospital after reorganisation. Clinical links were maintained however with the parent hospital, RBHSC, which following reorganisation fell within the North West Belfast District (also EHSSB). Medical staff continued to be employed by that District. In 1984, there was a reorganization of hospitals and the North and West Belfast District was replaced by the Royal Group of Hospitals and a separate Community Management Unit for the North and West Belfast area (source: Richard Clarke's book entitled "*The Royal Victoria Hospital Belfast, a history 1797-1997*", page 141).

60. By 31 December 1983 it is known from **Exhibit 13** that the full staff complement in Lissue was described thus:
"*Consultant medical staff responsibility for both specialities 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 31 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*."

61. These 73 staff did not include the medical staff that were employed through RBHSC, as it will be noted that numbers of doctors are not detailed. It is known that the Child Psychiatry Unit at Lissue was a Consultant led unit. The Board is aware that Dr Nelson recalls visiting on an almost daily basis, even for short periods, at varying times. Dr McAuley, who was appointed in 1976, himself recalls that he would have attended Lissue Hospital once a week. They each recall a weekly ward round undertaken with the multi-disciplinary team. Daily cover would have been provided by doctors at Registrar level. In addition, the statistic of 73 staff does not include the social workers and psychologists who worked in Lissue, or the teaching staff who taught the pupils in the school on site.

62. It should also be noted that these 73 staff covered both units at the Lissue site, which in 1983 had 20 beds each, making a total of 40 beds. For that year it is

noted that the occupancy level of the paediatric unit was 66.4% while occupancy in the child psychiatry unit was 83.2%.

63. Also in 1983 the District Administrative Nursing Officer completed a report in relation to Lissue. The detail and context of this report is set out in response to Question 18. It notes the staffing structures and arrangements at that time. With regard to the issue of communication, the DANO concludes: "*The approach to treatment in this unit is very much a multi-disciplinary one and there are regular meetings between all the professionals regarding the programme for, and progress of, each child*".

Q12. Was there any vetting of staff?

64. The recruitment of staff would have been consistent with Health Service arrangements as they developed over the years.

65. For any appointment of a Doctor or Nurse at Lissue Hospital references would have been taken up during the recruitment process and checks would have been undertaken with their registering body.

Q13 What records were kept in Lissue?

66. The Board has been able to identify the following records as kept in the Child Psychiatry Unit at Lissue:
    a. Admission Books, with separate books maintained for in-patients and day patients. These have been provided to the Inquiry;
    b. Notes and Records for individual patients in Lissue. These would have comprised case records, medical notes, nursing notes, school teaching notes, psychology notes and social work notes. They included:
        i. Detailed accounts of the patient's referral to Lissue;
        ii. Clinical records in relation to the patient's treatment which can include:
            Nursing Notes
            Medical Notes
            Psychology Notes

Social Work Notes

Family Therapy Notes

iii. Summary upon discharge;

Examples of these are available through the records produced for Applicants to the Inquiry. The Board understands that these records were only held on site during the period of treatment. Upon discharge the records were forwarded to RBHSC- Psychiatric Outpatients, or the Ulster Hospital depending on the source of the referral. See **Exhibit 14**.

67. To date no other contemporaneous records made in the Child Psychiatry Unit at Lissue Hospital have been located. The Board has however been told that an Incident Book was kept on the unit.

Q14 Was any form of physical chastisement permitted in Lissue?

a) What form did physical chastisement take?

68. Lissue was a hospital. Physical chastisement of patients was not permitted in Lissue. However, given that many of the young patients were emotionally, psychologically disturbed, it is documented that physical restraint by staff was required at times.

69. The remainder of questions on this issue are answered with reference to physical restraint.

b) Under what circumstances was it administered?

70. The Board refers the Inquiry to the EHSSB's written policy on the Use of Restraint (previously exhibited at **Exhibit 6**.

71. Having noted that physical restraint was used, the Board refers the Inquiry to the analysis of same in the Historic Case Review at paragraph 6.1.1 on pages 14 – 15 and Appendix 5 commencing at internal page 35, which identified the use of

restraint in the files of 6 patients, 2 of which related to admissions to the Child Psychiatry Unit at Lissue Hospital. In respect of the patients analysed:

a. Child D – the correct admission date is 22 January 1992, this is, therefore, a Forster Green admission;
b. The dates of children M and S are also admissions to Forster Green;
c. Child CC – the correct admission date is 13 April 1989;
d. Children FF and EE were admissions to Lissue.

72. As regards the examples of restraint in Lissue, it is documented as having occurred in the following circumstances:
    a. “her behaviour was unreasonable yesterday”;
    b. “verbally abusive and non-compliant and restrained by staff as she was losing control”;
    c. “would not settle despite being given several chances to do so and eventually had to be physically restrained”;
    d. “had to be restrained by clothing due to aggressive self abuse and injury to others”;
    e. “restrained for his own safety and that of staff and peers”;
    f. “got aggressive to staff and became a danger to himself and others”;
    g. “became physically aggressive to [..] eventually had to be restrained and put to bed”.

73. The Board, therefore, believes that physical restraint was used in circumstances where it was necessary to do so to safeguard a child who was posing a danger to himself or others around him, whether peers or staff.

74. It is also noted that, when addressing the Northern Ireland Assembly on 7 November 2011, Minister Poots said that while physical restraint may be perceived as harsh, it is still a necessary part of a humane and patient-centred regime.

c) By whom?

75. The examples documented indicate involvement of nursing staff in physically restraining the children.

d) How was it recorded?

76. A record was made of any physical restraint in the child's individual case notes.

e) To whom was it reported?

77. The Board has not identified any evidence that the use of physical restraint was reported to any particular person. The patient's case notes would, however, have been reviewed by the staff involved, including the Consultant in charge.

Q15. Was any other form of discipline employed in Lissue, if so what form did this take?

78. A primary aim of the Child Psychiatry Unit at Lissue Hospital was to help children who had significant emotional and/or behavioural problems. This included children with conduct disorders. In this respect, what may be perceived as "discipline" within the unit formed part of a Consultant led treatment plan for a child by way of behaviour management or behaviour modification. These treatment plans were discussed at a weekly ward round attended by the Consultant Psychiatrist. The parents of the children were also closely involved in implementing the plan, through attending at the hospital for direct engagement with the therapists, and in some cases living on site, to learn the techniques. This was a clinical approach which should be seen in the context of practices of the time, the medical and nursing oversight available in the Unit and the available Nursing Policy on behaviour modification dated 1989 (see **Exhibit 6**)

79. The Board offers the following examples:
    a. Keeping a child diagnosed with anorexia confined to bed;
    b. Time out for children where it was felt that they need to be removed to reduce aggression or hostility;

c. The use of medication to respond to particular behaviours (for example HIA 251);
d. Being placed on special observation;
e. Being placed in pyjamas;
f. Confining a child to his room with loss of privileges and on constant observation by a member of nursing staff until he earned his way back out of his room by means of a star chart (an example of which is seen in the nursing notes of HIA 251);
g. A card system or points system to achieve privileges, or have privileges removed (an example of which was loss of outdoor clothes in respect of HIA 172).

80. The above list is not intended to be exhaustive. The Board would note that some of these techniques, particularly time out and removal of privileges by way of sanction, remain effective and valid tools for managing difficult behaviours of children, whether by professionals or parents.

81. Particular examples of how such sanctions were employed, and in what circumstances will be seen in relation to the individual Applicants.

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

82. The Board is aware that in March 1983, LS 71 alleged buggery by another patient in the Child Psychiatry Unit. The following chronology summarises the steps taken:
a. LS 71 was an inpatient in Lissue from 19 August 1982 to 24 September 1982;
b. LS 71 was subsequently placed in Marmion Children's Home. In February 1983 consideration was being given to a further admission to Lissue, which upset LS 71 Over the course of discussion with his Social Worker, LS 114 LS 114 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 LS 71 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 LS 71 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.

(see Composite **Exhibit 15**, Letters dated 29 March 1984 and 30 May 1984 entitled "Untoward Event – Lissue Hospital" and chronology which runs from March 1 1983 – 25 April 1983, DANO report, "Memo from W Celso to All Staff 29.03.83 re Lissue", Memos of R J Bunting dated 23 April 1985, 10 July 1985)

83. The Board is also aware of contemporaneous complaints made of abuse through the Historic Case Review, which has been provided to the Inquiry, and is discussed in further detail in response to Question 22 below. The Historic Case Review involved a review of file extracts of a sample of patients admitted to Lissue between 1975 and closure in 1989, with consideration to patients admitted to Forster Green Hospital thereafter to 1995. This review identified complaints recorded in notes as having been made by children and/or their parents during their admission to the Child Psychiatry Unit at Lissue Hospital as follows:

a. Complaints of sexual abuse by peers (see internal pages 22 to 24 of the report):

   i. Child A (LS 67), an 8 year old girl admitted between June and August 1986, complained that a male child had kissed her in the private parts. She later said that this was all lies;

   ii. Child [redacted], a 13 year old girl admitted between April 1979 and March 1980 (with a further period as a day patient from November 1980 to

October 1981), complained about a named peer feeling around her breasts[1];

b. There are no contemporaneous complaints of sexual abuse by staff, however Child A (LS 67) and BB (LS 66) made allegations after leaving Lissue. Those complaints are detailed in response to Question 17 below.

c. Complaints of physical abuse by staff:

   i. Children J and BB made allegations at a much later time which are detail with in response to Question 17 below;

   ii. Child FF, an 11 year old girl admitted between March 1988 and March 1989 (her final month would have been in Forster Green) (see pg 37), accused staff of twisting her arm[2] in May 1988;

d. Complaints about general treatment:

   i. Child Y, a 14 year old boy admitted between July 1981 and August 1982 (see pg 39), complained that he was the only child sent to bed early for bad behaviour;

   ii. The father of Child V, a 13 year old girl admitted from March to October 1983 (see pg 41), complained that his daughter had been strip searched;

84. In addition to the Historic Case Review, a Retrospective Child Protection and Safeguarding Audit within the Regional Child and Adolescent Inpatient Service was undertaken by Belfast Trust which is discussed further at Question 18 below. While it does not record any complaints specifically, it is noted that two contemporaneous records of abusive behaviour in Lissue are noted as follows:

a. L3 – it was noted: "*the child went over to his father who struck him in the face*";

b. L9 – this child's records noted a number of recorded incidents of alleged physical abuse, attributed to his parents;

[1] Child R is also attributed to Lissue in the report, however as this is dated to 1993 this should be described as a Forster Green admission and is not therefore included in this statement;
[2] Children D and E should also be described as Forster Green admissions and are thus not referred to here. The admission date is incorrectly stated in the Report for Child D.

85. The Board notes that these records of abusive behaviour relate to potential knowledge by staff of parental abuse of the child. The key criticism appeared to be a failure to follow up / report this to the appropriate authorities.

86. The Retrospective Sampling did identify two allegations against members of staff (internal page 15 of report). However, it is noted that these files were from the period 1990 – 2003 and thus do not relate to the Child Psychiatry Unit at Lissue Hospital.

87. The Board is also aware that on 19 November 1986 a female child reported her distrust of LS 79 to LS 21. A review undertaken by Belfast Trust of LS 79 staff file in or around 2008 noted that the matter was reported to LS 8, Assistant Director of Nursing, who interviewed LS 79. "*The report concluded that* LS 79 *was aware of this responsibilities towards vulnerable children.*" In 2008 it was noted: "*there was no evidence of the young person / parents being interviewed with regard to this matter or indeed what was meant by distrust*".

88. In responding to this question, the Board has drawn on files identified to be relevant and sampling exercises which included a targeted consideration of files. The Board has not been able to review the file of every inpatient in Lissue Child Psychiatry Unit between 1971 and its closure in 1989. However, the Board considers that the targeted sampling exercises carried out in respect of Lissue provide a good measure of the nature and range of complaints made and, as part of its own historic case review process, the Board did not consider further sampling exercises were required.

Q17. Is the Board now aware of any complaints of abuse at Lissue between its opening in 1946 and its closure in the early 1990s, and when were those allegations first known?

89. Further complaints of abuse at Lissue became known to the Board subsequent to the closure of the Child Psychiatry Unit on that site and the transfer of the service to Forster Green Hospital as detailed below.

90. A note dated 1 October 1990 from LS 118, Senior Social Worker, records an allegation by LS 67 "that while attending Lissue Hospital, Lisburn, she was touched up by a member of staff". See **Exhibit 16**. LS 67 was known to have been admitted to Lissue between 23 June 1986 and August 1986. Further detail is contained in a social services report prepared for a Case Conference on 11 October 1990. See **Exhibit 17**. This was referred to police at that time. It is documented that LS 67 family did not accept that an incident had occurred, and while the social worker continued to attempt to gather information, permission had not been granted by the family circle for LS 67 to discuss aspects of this alleged sexual abuse. See **Exhibit 18**. No further information had become available by November 1990, although the police were investigating a further disclosure by LS 67 that a friend of the family had assaulted her. See **Exhibit 19**. By February 1991 it is recorded in a social work report: "LS 67 *was reluctant to give Social Services any information about the incident in Lissue. She was unable to give a description or a name of the staff member alleged to have been involved.*" See **Exhibit 20**. It is reported that LS 67 refused to be interviewed by police reference the alleged incident which is described thus: "*She was approached by a male member of staff in her bedroom and inappropriately touched in the vaginal area*". See **Exhibit 21**.

91. In 1993, following the closure of Lissue, a disclosure was made to Dr Hilary Harrison by LS 66, who was then in her late 20's and who knew Dr Harrison as she was a former patient of Tara Lodge, Barnardo's. LS 66 LS 66 was an inpatient in the Child Psychiatry Unit from April 1979 to March 1980. She made an allegation of sexual abuse against LS 21, Charge Nurse. The following sequence is known in relation to same:
    a. The initial disclosure was made to Dr Harrison on 19 May 1993, with further details given on 26 May 1993. This was reported to Dr K F McCoy and Mr N Chambers by Memo dated 27 May 1993. See **Exhibit 22**;
    b. The police were contacted, and a statement of complaint was taken by police from LS 66 on 29 May 1993 – **Exhibit 23**;
    c. Police carried out a full investigation, including interviewing two members of staff from the relevant period (1979 – 1981);

d. A direction of "No Prosecution" was issued: "*due to the lack of evidence corroborating the allegations*".
e. Greenpark Healthcare Trust, who were then LS 21 employers, responsible for the Forster Green Hospital became aware of the allegation on 27 May 1993. A decision was made to place LS 21 on precautionary suspension on 28 May 1993. See **Exhibit 24**. The Trust continued to liaise with the police in respect of the allegation, see **Exhibit 25**.
f. Mr Bunting, Assistant Director, EHSSB was notified of the concerns by telephone on 3 June 1993. See **Exhibit 26**
g. On 4 June 1993 the Mental Health Commission was advised of the issue arising. See **Exhibit 27**
h. The fact of this complaint and investigation was reported in the media by the Irish News on 23 July 1993. See **Exhibit 28**
i. Following confirmation that LS 21 had been interviewed by the police on 4 August 1993, and that a recommendation would be made by police to the DPP for no further action, the precautionary suspension was lifted. See **Exhibit 29**. The Trust were subsequently aware of the decision of "No Prosecution" in October 1993. See **Exhibit 30**

92. On 18 December 1994, LS 67, who was then aged 17 and resident in Barnardo's Sharonmore Children's Home again alleged that she had been abused by a member of staff at Lissue. This disclosure was made to BAR 8 BAR 8, who reported same to Dr Harrison. It is recorded that LS 67 continued to be unable to remember the name of the staff concerned. This was referred to Ms Lyn Trainor, APSW, South and East Belfast Trust who initiated a "joint protocol investigation" with the police. Ms Trainor was also advised of the 1993 investigation following complaint by LS 66. See **Exhibit 31**

93 LS 67 again did not agree to be interviewed by Police. This situation and her views around the allegation were up-dated on 5 August 1996 when she was seen by LS 119, Social Worker. At that time, it is recorded that LS 67 indicated that "*her concerns related to the past and that she did not wish the matter to be pursued*". See **Exhibit 32**

94. On 9 January 1997 Dr Harrison wrote to Chief Inspector Cardew noting the two allegations, and detailing that the "*Social Services Inspectorate's concern is that there may be information in the 1990* LS 67 *' file if linked with the* LS 66 *investigation, may well have wider child protection implications*". See **Exhibit 31**

95. Dr Harrison was contacted by police on 4 May 2001, In a subsequent memo Dr Harrison detailed the previous allegations known to have been made by LS 66 LS 66, and another girl which is likely a reference to LS 67. It seems the impetus for this contact by police was "*another young woman unconnected with either of the above girls and a former resident of Sharonmore (now in her 30s) has come forward stating that she was sexually abused while in Lissue*". See **Exhibit 33.** At the date of writing this statement the Board is unable to identify the female involved.

96. In 2008 allegations were made by LS 69 of abuse by a number of staff at Lissue Hospital. LS 69 was an inpatient at Lissue during the following periods: 23 - 27 March 1987, 17 September 1987 – 23 October 1987 (when she became a day patient), 9 February 1988 – 31 March 1988. She also had admissions to Forster Green Hospital from 20 July 1989 – 12 August 1989, 11 September 1989 – 9 February 1990. The sequence of information becoming known and steps being taken is as follows:
    a. Whilst in inpatient at the Psychiatric Unit of the Mater Hospital, LS 69 had mentioned to a Staff Nurse that she had been abused by staff whilst an inpatient at Lissue Hospital and Forster Green. This was referred to the Child Protection Team in Belfast Trust on 19 February 2008;
    b. A complaint was made to Police and a clarification interview had been conducted on 28 March 2008 under joint protocol procedures.
    c. A strategy meeting between Belfast Trust and the PSNI was convened on 3 April 2008 – See **Exhibit 34**. This detailed the agreed actions, which included checks to be undertaken with the Human Resources Department regarding the staff named in the clarification interview, and the submission of a Serious Adverse Incident report to the Department of Health;

d. On 9 April 2008 a further Strategy Discussion was held, attended by Belfast Trust, South Eastern Trust and PSNI. This confirmed the outcome of initial checks undertaken regarding the employment status of staff named in the complaint and identified agreed actions. See **Exhibit 35;**

e. On 2 May 2008 a Serious Adverse Incident report was submitted to the Department, which notes that the Eastern Health and Social Services Board was notified on the same date. See **Exhibit 36**. This report was up-dated on 18 June 2008;

f. In the context of the investigation into the Serious Adverse Incident, on 12 May 2008 Ms Norma Downey, Child Care Policy Directorate, Department of Health, wrote to Ms Carol Diffin, Children's Services Manager Gateway, Belfast Health and Social Care Trust, to advise "*The Department has just become aware of previous allegations and investigations into abuse at Lissue and Forster Green Hospital and is now sharing that information with Belfast Trust*." See **Exhibit 37.**

g. On 19 May 2008 Ms Marion Reynolds, EHSSB, requested that Belfast Trust invite the Board to future meetings concerning the SAI "*as the Board had direct responsibility for both hospitals between 1985 and 1991*". See **Exhibit 38**

h. On 23 May 2008 LS 69 gave a full statement to the police by video recorded interview;

i. On 9 July 2008 a further Strategy Discussion was convened and agreed three processes that needed to be taken forward as described in Question 18 below. It was further agreed that the EHSSB would chair a working group to oversee the process, and that the Department would be advised that all future communication on the issue should be processed through the EHSSB rather than the Trust. See **Exhibit 39**.

j. Belfast Trust continued to keep under review LS 69 situation and any information she was able to give relevant to her complaint throughout 2011 and into 2012, at which time she was in a specialist placement in London.

97. In November 2011 the Board became aware that allegations had been made by HIA 172. In this respect by e-mail on 1 November 2011 HIA 172 notified the then Minister for Health, Mr Edwin Poots MLA, that he had attended Lissue Hospital. HIA 172 complained that "*abuse was a daily occurrence*". He advised that he had made a statement to the RUC from Bangor about his experiences on 26th October 1993. On the information available, it appears that this first came to the Board's attention when Minister Poots forwarded HIA 172's e-mail and his response to the Board under cover of letter dated 8th November 2011. The correspondence referenced is at **Exhibit 40**

98. The Board is also aware of complaints as a result of civil proceedings which have been initiated as follows:
    c. On 25 September 2011 a letter of claim was issued on behalf of LS 115 LS 115. He complained of physical and sexual abuse at Lissue Hospital between 1984 to 1986 approximately. A copy of the relevant papers, to include the Statement of Claim are being made available to the Inquiry;
    d. On 24 November 2011 a letter of claim was issued on behalf of HIA 220 HIA 220whom complaints of "negligence, assault, battery and trespass to the person". The Statement of Claim subsequently issued on 30 March 2015 indicates this complaint refers to a period between 1975 to 1976. A copy of the relevant papers from the civil claim are being made available to the Inquiry;
    e. On 27 January 2012 a letter of claim was issued on behalf of LS 116. It details that he complaints that "he was abused by members of staff at Lissue House". To date no other pleadings or details have been received in relation to this proposed claim;
    f. On 4 July 2013 a letter of claim was issued on behalf of LS 17 in relation to complaint of abuse *inter alia* at Lissue in or around 1975, when he was aged 6. The letter alleges in respect of of Lissue Hospital: "*Whilst there he was put in a restraining jacket and helmet. He was physically restrained by chair for a period of hours. There was no toilet and no food. He was frequently slapped and thrown against walls."* A copy of the relevant pleadings and reports from the civil claim are being made available to the Inquiry.

99. During work by a Strategic Management Group, as described at paragraph 112 et seq below, it was identified that there had been 11 individual approaches to the Police Service of Northern Ireland in relation to complaints relating to Lissue Hospital. The Board is seeking to identify the identity of these complainants.

100. Finally, the Board has just become aware of complaints made by Applicants to the Inquiry through receipt of their statements. Individual response statements will be filed.

Q18. What steps were taken in the Board in relation to complaints between 1946 and the closure of Lissue in the early 1990s?

101. Please refer to the responses to Questions 16 and 17, which detail particular steps taken in relation to information received.

102. By July 2008 a three strand process was agreed to explore the issues arising in detail:

a. Strategy meetings were to continue in relation to the individual complainant;
b. Belfast Trust took forward an investigation in relation to LS 69 allegations against two named staff that remained within the employment of the Trust: LS 79 and LS 117. This was to ensure that no current employee posed a safeguarding risk for children or vulnerable adults. South Eastern Trust was to consider the issues arising in respect of staff remaining in their employment, particularly LS 78;
c. The Eastern Health and Social Services Board took the lead on the investigation of historic complaints.

103. The Board intends to file a separate statement detailing the specific information know about, and steps taken in relation to, the staffing issues that arose as result of the complaints. That will provide full details in relation to the steps that were taken to confirm the status of staff that were identified in the complaint made, and the investigations that were undertaken in respect of those confirmed to be current employees.

104. In relation to the Historic Case Review lead by the Eastern Health and Social Services Board, who was directly accountable for service provision at Lissue Hospital during the operation of the Child Psychiatry Unit:

a. A project group was set up involving the Senior Members of the EHSSB;

b. A project steering group for the Review was established which comprised: relevant staff from EHSSB, Belfast Trust, South Eastern Trust and PSNI. Two of the project steering group's meetings were also attended by Mr R S Stinson, the appointed Independent Consultant;

c. A sample of files was chosen for review. This comprised: files specifically identified (to include known complaints, LS 69, LS 66 LS 66 and LS 67 and files of other children named in their complaints) and files chosen by random. These were chosen by a computer randomly selecting 25 dates between 1 April 1981 and 31 March 1994. The file of the child admitted on that date was then reviewed. If more than one child was admitted then the first admission was chosen. It was intended that this would identify 20 files, with 5 available alternates. The final sample reviewed totalled 33 files. For the purposes of the Inquiry, it is important to note that the Child Psychiatry Unit at Lissue closed on 28 February 1989;

d. The first phase involved a sift of the files by Gaynor Creighton, a librarian, to produce file summaries of relevant information contained in the files. All summaries prepared will be provided to the Inquiry;

e. The second phase then involved a review of those summaries (which were all tracked to the original file) by an Independent Consultant, Mr R S Stinson;

f. Mr Stinson's observations were then presented to and discussed with the steering group to provide the final report. An initial preliminary report was presented at a meeting attended by Mr Stinson on 19 November 2008, with a further report considered by the group on 3 February 2009;

g. On 9 February 2009 the process of finalising the report was underway and the Directors of Social Work in both Belfast Trust and Southern Eastern Trust were both advised of an intention to make the report available and the need to be alert to staffing issues;

h. On 5 March 2009 the draft report was considered at a meeting of Board Officers which noted that Marion Reynolds confirmed that the report was in

the process of being finalised on the basis of comments received. It is believed that this work was undertaken within the Eastern Health and Social Services Board.

105. The resulting Historic Case Review report has become known as "the Stinson Report". However, as will be seen from the above process, this was a review led by the Eastern Board informed by the consideration of the file summaries by an independent consultant to identify the issues arising.

106. Upon consideration of the final Historic Case Review which had been social work led, the Board determined that a nursing and medical perspective should be obtained in relation to same. Thus the Review of the Standard of Nursing Care Provided to Children and Adolescents as Part of the Lissue Hospital Historic Case Review, "the Devlin Report", authored by Maura Devlin, Director of Nursing and Midwifery Education, as a nursing perspective following review of 4 files, and a Commentary Report on: Independent Report Lissue & Forster Green Hospitals Historic Case Review "the Jacobs Report", authored by Brian Jacobs, Consultant Child and Adolescent Psychiatrist, as a review of the Historic Case Review. In taking these actions, Ms Marion Reynolds noted in an e-mail of 15 July 2009 to Pat Cullen, Assistant Director of Nursing in the EHSSB:
"*I should also perhaps confirm that the EHSSB has endorsed and agreed the Lissue Report as one of its last actions; albeit that the reports from medical and nursing perspectives were not available at that time*". See **Exhibit 41.**

107. Also in July 2009 an interim report was written by Marion Reynolds, See **Exhibit 42**. This was submitted to the Department, with the Historic Case Review ("Consultant's Report") on 15 July 2009, see **Exhibit 43**.

108. This process was taking place within the Board with a specific focus on the Child Psychiatry Units at Lissue Hospital and thereafter Forster Green Hospital. Almost contemporaneously, regional Audits were being conducted on hospitals / units that cared for mentally unwell or learning disabled patients (which was not restricted to children and young people). This followed a complaint (by an adult) relating to Muckamore Abbey Hospital. Regionally all five Trusts were asked by

the DHSSPS to audit their units, and this information was being collated alongside the PSNI who were conducting Operation Danzin. As part of this regional exercise, Belfast Trust undertook a Retrospective Child Protection and Safeguarding Audit within the Regional Child and Adolescent Inpatient Service which was authored by Margaret Burke, Principal Practitioner (Social Work) and Geraldine Sweeney, Child Protection Nurse Adviser. They excluded a period believed by them to be the subject of audit through the EHSSB Historic Case Review sample, and included an earlier period relevant to Lissue Hospital: 1 January 1970 – 31 December 1979. Ten files from that period (denoted L1 – L10) were reviewed.

109. These reports were all considered by the Department in May 2010 with comment thereon. See **Exhibit 44**.

110. On 22 August 2011 a meeting was convened between the Department, HSCB and the PSNI. See **Exhibit 45.**

111. After a series of discussions between the DHSSPS, the Board and the PSNI a Strategic Management Group (SMG) was established in accordance with The Protocol for Joint investigation of Alleged and Suspected Cases of Child Abuse in Northern Ireland. The SMG had its first meeting on 25 April 2012 and its remit extended to a consideration of how to proceed with concerns in relation to historic care of children and vulnerable adults which emerged from the retrospective sampling work previously undertaken on a regional basis with overnight from the DHSSPS between 2008 and 2009.

112. The purpose of the SMG review was to provide assurance to the DHSSPS that where incidents of abuse were noted in the retrospective sampling exercises, these had been appropriately identified and dealt with. Having conducted its review, the SMG was "*able to provide assurance to the DHSSPS that, with one exception, where incidents of alleged abuse were noted in the retrospective sampling reports, that any issues or concerns in relation to individuals have been actioned appropriately; any criminal concerns or issues have been referred to the PSNI and any Human Resources and regulatory issues have been taken forward*

by the appropriate Trust or employer." It is important to note that the SMG's review concerned the entire region of Northern Ireland and was not specific to Lissue. In fact, the SMG report stated that *"whilst the review of cases within Lissue did not present with any concerns, it is noted that of those who have made contact with the PSNI 14 had been former patients in Lissue hospital*. *This is a matter that sits outside the SMG but may be an area of interest to the Historical Institutional Abuse Inquiry process*." Chapter 10 of the SMG report which sets out the PSNI analysis of the regional audit returns also states that "*There are a further 20 cases which have been reported directly to police. All 20 of these cases involve injured parties who were children at the time of the alleged offence. Of these twenty complaints there are 11 relating to Lissue; 1 to Forster Green; 1 to both Forster Green and Lissue; 1 to Crawfordsburn Hospital and 4 to Shamrock House, Rachael and 1 to Bannvale Special Care Hospital*." At this time the Board is seeking to identify the names of the 11 children that are attributed to Lissue Hospital.

See Exhibit 46

113. In addition to this, it is important to note that by the date of these actions the services at both Lissue Hospital and Forster Green Hospital had closed. A new regional inpatient service for Child and Adolescent Psychiatry had been opened at Beechcroft, Saintfield Road, Belfast. A QNIC Report (Quality Network for Inpatient CAMHS) was commissioned on this unit, and was planned for 30 September 2008. That report was subsequently received and raised no safeguarding issues around the current provision for inpatient CAMHS services.

Q19. The Inquiry has received a number of complaints about specific matters and wishes to know the following in relation to the years between 1946 and the closure of Lissue in the early 1990s:

a) How did Lissue deal with those children who wet the bed?

114. This appears to have been a regular issue for staff to deal with. The Board would expect that this was responded to by nursing staff in keeping with practice

at the time. Medical advice would also have been directly available to guide such responses within the Child Psychiatry Unit.

b) What chores were children expected to engage in, were chores ever given as punishment?

115. The Board does not believe that patients at Lissue were expected to routinely engage in chores. The staffing within the unit included staff who had specific responsibilities for cleaning and other domestic tasks. The children would, however, have been expected to keep their own bedroom tidy.

c) Were children provided with cigarettes? In what circumstances?

116. Patients at Lissue Hospital were not encouraged to smoke. Some inpatients were admitted to the hospital having already commenced smoking in the community. In such circumstances smoking may have been tolerated, but would have been controlled by nursing staff so that the child was not permitted to retain his or her own packet of cigarettes. In such circumstances any cigarette permitted would have been provided to the patient at intervals.

117. The Board does not believe that any non-smoking child would have been provided with cigarettes for any purpose.

d) Was bullying condoned, if not, how was it dealt with?

118. The Board believes bullying would never have been condoned in Lissue and that staff would have taken steps to try to prevent bullying occurring. However, the patients in Lissue had severe emotional, behavioural, psychological or psychiatric difficulties and while staff would have tried to prevent all forms of bullying, it is likely that some children may well have tried to upset others.

e) How were children supervised at night?

119. The Board believes that there was nursing supervision at night in Lissue as was the case in any other hospital.

f) Were children physically restrained at night, if so, in what circumstances?

120. The Board believes that the use of physical restraint would have been in the circumstances previously detailed in response to Question 14.

121. In relation to the use of this at night, the Board is aware that in the Historic Case Review an example of this was seen in relation to Child M who was an admission to Forster Green Hospital in 1990. It is outlined that she, a 13 year-old girl, was held in bed for 30 minutes for disobeying instructions to stay in bed. While it is expected that this was at night, the detail recorded in the Historic Case Review is insufficient to be sure.

g) Were children isolated, if so, in what circumstances?

122. There is a EHSSB written nursing policy on seclusion dated December 1986 as exhibited as page 2 of **Exhibit 6**. This appears to apply to patients generally rather than specifically to minor patients in Lissue Hospital. It is noted however, that 'seclusion' is defined in the policy as "*the social isolation of a patient in a locked room, on his/her own which he/she is unable to leave of their own volition*" and the policy states that "secl*usion must only be used in instances of prolonged uncontrollable aggressive or violent behaviour where the patient is a danger to himself or others*" .This nursing policy also states that a patient may not be secluded unless this has been agreed by the relevant doctor and this recorded in the patient notes. The Board is aware that Dr Nelson and Dr McAulay do not recall patients being locked in rooms in Lissue and the nursing records read by the Board thus far do not evidence the use of seclusion in Lissue. In addition, the written policy dated August 1989 entitled 'Management of Violent or Potentially Violent Patients Ward 7, Forster Green Hospital' states at (B) (3) that '*if it is necessary to remove a child for the purpose of getting rid of an 'audience' or to ensure that he/she remains in his/her room for a short while to settle or as a punishment (if appropriate), then the door must not be locked…*".

123. There was also a written policy to be followed if any child in went onto the roof of Ward 7 Forster Green, as exhibited at page 9 of **Exhibit 6**. Paragraph B (1) of the said policy provided for the isolation of the child in his/her room immediately for a 24 hour period with the removal of personal effects and belongings from the room. No interaction was to be allowed with other children and members of nursing staff were to stay with the child/children during this 24 hour period. Whilst this policy post-dates the closure of Lissue, the Board believes that similar steps were followed in Lissue, as this is reflected in the nursing notes of HIA 251.

124. As previously referenced some patients in Lissue were subjected to 'time out' as part of a behaviour modification programme. However, the Board believes that this was implemented for a limited time period. The undated written guidelines on "Time Out" as exhibited at page 4 of **Exhibit 6** state that *'in most young children short durations of approximately five minutes are quite appropriate. However, in general the duration should not begin until the child is reasonably quiet*.".

Q20. The Inquiry is aware that there was a school on site – by whom was it regulated and inspected?

125. The school on site at Lissue came under the auspices of the South Eastern Education and Library Board and was referred to as the Lissue Hospital School. The files provided on the Applicants also show that reports were provided to the Board for the area in which the child was ordinarily resident. For example, in relation to HIA 251 a report was sent to the North Eastern Education and Library Board because in this case the child went to Ballyclare High School. This will be seen in his files provided to the Inquiry.

126. The Board believes that both the Regulation and Inspection of the Lissue Hospital School would have been undertaken by the South Eastern Education and Library Board.

Q21. The Inquiry is aware that a television documentary was made in relation to Lissue, please provide a copy of same.

127. The Board is not in possession of the television documentary. The Board is aware that a third party has published the documentary on UTube at the following links:

Part 1: https://www.youtube.com/watch?v=ByFPwmK4BVE

Part 2: https://www.youtube.com/watch?v=8VgCIw51lGs

Part 3: https://www.youtube.com/watch?v=CumhcdsAGb8

Part 4: https://www.youtube.com/watch?v=ovbxs3Y3Lko

128. This Horizon documentary was produced by the the BBC and was broadcast nationally. It focused on the work of Dr McAuley in relation to behaviour modification. One of the two families featured is HIA 172 and his mother.

129. The documentary closes with the following narration:

"So what do you think about the therapy, does it deserve its unpopularity in the psychiatric profession? The therapy's success rate in general is that one family in three improve. None of the other therapies on offer are any more successful, except for tranquilisers, and with them it is difficult to know what success means. Behaviour therapy is criticised for treating the symptoms so that nothing really changes. Is that true [for the two mothers involved] or was their determination going to develop anyway? The other therapies have a relatively slow process of giving insight into unconscious motivation, would these have suited [the two mothers involved] better than the dramatic intervention they experienced?"

One of the mothers involved says that it worked quickly and she saw results within 10 days, but had she not seen it working she would have *"definitely scrubbed it, I would have thought it was too brutal, I think for want of a better way of describing it, it was like training a dog or an animal and for those reasons you sort of thought what am I doing, what am I doing to my son, you know and.. it worked, it has worked and it has changed the child and it has changed me – it has given us both what we needed, freedom from each other and confidence in each other"*.

130. Dr Roger McAuley, Consultant Psychiatrist, who was appointed to Lissue in 1976 and led the behaviour modification programme has also co-authored a

book, published in December 1977 with Patricia McAuley: Child Behaviour Problems: An Empirical Approach to Management. The Board is obtaining a copy of this text and same can be made available to the Inquiry if that would be of assistance. A book review published in the Journal Child Psychology [19: 1978] in respect of this text is at **Exhibit 47.**

Q22. The Inquiry is aware that a Historical review was carried out into child safeguarding issues, (the Stinson review). How was that review received and were any steps taken by the Board on receipt of same?

131. Please refer to the response to Question 18 wherein the Board has detailed the process in relation to the Historic Case Review, and subsequent actions taken.

Q23. What systems failures, if any, relating to HIA Inquiry's Terms of Reference can identify from the material?

132. The HIA Inquiry is examining whether there were systemic failings by institutions or the state in their duties towards those children in their care between the years of 1922-1995.

133. Lissue was the regional inpatient NHS Hospital for Children and Young People in Northern Ireland with the governance arrangments as described in parapraph 59 above.

134. Lissue Hopsital was led by Consultants in Child and Adolescent Psychiatry. These Consultants were and are highly regarded expert practitioners in their field and referrals to Lissue were made by General Practitioners, out patient Hospital Departments and Social Services in respect of children with serious behavioural, emotional, psychological and/or psychiatric problems.

135. As set out in the body of this statement, the Board is aware of both contemporaneous and more recent complaints of historic abuse made by previous patients in Lissue Hospital. The contemporaneous complaints known to

the Board at the time of drafting this statement relate to sexual abuse by peers, physical abuse by staff and complaints about general treatment. No contemporaneous complaints of sexual abuse by staff have yet come to the attention of the Board. However, it is known that allegations of sexual abuse by staff have been made by former patients after leaving Lissue, including by some Applicants to the Inquiry.

136. It is also known that police investigations have taken place into complaints made against former staff members in 1993 and 2008 and there were no resulting prosecutions.

137. In addition, the PSNI was a member of the project steering group set up as part of the EHSSB's historic cases review into Lissue in 2008. It is known that the police considered the allegations arising against both staff and peers and no police action ensued, see **Exhibit 48.** Also, at the time of the SMG review in 2012, it is recorded that 11 former patients of Lissue had made complaints directly to the police about their experiences in Lissue. The Board does not believe there has been any prosecutions to date arising from any of these complaints.

138. Belfast Trust investigated the allegations made by LS 69 against nurse LS 79 LS 79 and although there was no evidence that corroborated or substantiated the allegations made, the number and overall pattern of reported incidents that were similar in nature and that were recorded on LS 79 staff file and the files of LS 69 and [redacted], gave rise to concerns over a significant period of time. In light of this, it was recommended by the safeguarding practitioners who undertook the investigation that Trust management should review with nurse LS 79 any training and staff development issues arising from the investigation. Thus, no disciplinary actioned ensued and, with the consent of Belfast Trust, LS 79 took early retirement in January 2009.

139. Belfast Trust also carried out a review of the allegations made against staff arising from the EHSSB historic case review into Lissue and the retrospective sampling exercise to ensure that no current employee posed a safeguarding risk

to children and no disciplinary action ensued as a result of the review. Similarly, the South Eastern Trust considered the issues arising in respect of staff remaining in their employment and there was no ensuing disciplinary action.

140. The actions of the Board and its predecessors in some cases demonstrates, however, that some of the allegations made by former patients of Lissue were considered to be credible. This is seen in the following cases:
   a. LS 71 allegation of peer sexual abuse in Lissue in 1983;
   b. An interim report written by Marion Reynolds, see **Exhibit 42** states that 'in respect of LS 66 [LS 66] 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".
   c. Allegations/complaints made about nurse LS 79 because, after his retirement in 2009, such was the level of concern about his nursing practice that Belfast Trust asked the Chief Nursing Officer (CNO) in the DHSSPS to issue an alert in July 2009. However, in a letter dated 1 September 2009 the CNO explained that he as unable to issue an "Alert Letter" as no disciplinary action had been taken, no referral had been made to the Nursing and Midwifery Council and LS 79 erosional listing on the POCVA Disqualification from Working with Children List was rescinded in January 2009, see **Exhibit 49**. LS 79 NMC registration lapsed in October 2009 and Belfast Trust asked the NMC to make a note on his file should he attempt to re-register, see **Exhibit 50**

141. It is also known that the National Board Inspection of Jan/Feb 1987 withdrew approval as a Nurse teaching unit as the philosophy of care in Lissue was seen as restrictive and 'custodial' and the structure and layout of Lissue was not seen as 'well suited for it's present use'. This seems to be in keeping with conclusions of the Board and its predecessor following the Historic case review process that there was a harsh regime in Lissue. However, in the course of preparing for Module 13, the Board has made contact with former retired medical staff who worked at Lissue and who have been asked to prepare statements for submission to the Inquiry. The Board wishes to consider these statements and all

the relevant evidence as it emerges in Module 13 before forming a view about whether there were systemic failings at Lissue.

142. The Board intends to continually reflect upon the issue of systemic failings as the evidence unfolds and, in so doing, the Board is mindful that some of the allegations and complaints relating to Lissue date back to the 1970s.

143. Since then, there have been significant changes in legislation, policy and procedures on how to respond to and investigate allegations of child abuse. Some of these changes reflect recommendations from Inquiries, Case Management Reviews, societal change and increased knowledge and awareness over time about the nature of abuse and its consequences on children. The Board intends to exercise caution when trying to interpret historic events so that they are considered, so far as is possible, by reference not only to practice, policies and procedures extant at the relevant time but also in the context of children receiving medical and nursing care as part of a Consultant-led multi-disciplinary team.

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. See **Exhibit 51**
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.

145. Following media attention in relation to events at Lissue Hospital, statements were made by Minister Poots in the Northern Ireland Assembly and during appearances before the Committee for Health, Social Services and Public Safety ("the Health Committee") as follows:
a. 26 October 2011 – Appearance before the Health Committee
b. 7 November 2011 – Statement to the Northern Ireland Assembly;
c. 18 January 2012 – Appearance before the Health Committee.

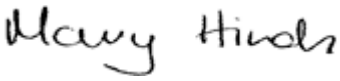
146. From 2008, the Board and Health and Social Services Trusts in Northern Ireland have been undertaking a period of self-examination through the EHSSB Historic Case Review (including the Devlin Report, Jacobs report), retrospective sampling exercises and the SMG review process. The Board is clear that abuse of children can never be excused, that there can be no room for complacency and that no organisation can ever be completely confident that it does not harbour a person who is a risk to children. In light of this, the Board has and continues to take allegations and criticisms made by former patients of Lissue

very seriously and during the SMG review process the Board has recognised that individuals affected by abuse, whether as victims or those named by others, should be offered support and advice as appropriate.

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

Signed 

Dated 29 February 2016

Signed 

Dated 29 February 2016

Signed 

Dated 29 February 2016

Mary Hinds

I have held a variety of posts at practice and managerial levels including:

- Staff nurse Accident And Emergency Department Mater Hospital (1981-89)
- Sister Accident and Emergency Department, Lagan Valley Hospital (1989-93)
- Manager Lindsay House Respite Centre – for children with learning disabilities (1991-92)
- Senior Manager, planning and Contracts Down Lisburn Trust (1993-97)
- Nursing Officer, DHSSPS (1997-2000)
- Director Nursing Mater Hospital (2000-2006)
- Director Royal College of Nursing (2006 – 2009)
- Director Nursing Public Health agency / HSCB (2009 to date)
- Senior Director Turnaround Team NHSCT (2013-14)

Qualifications

Register General Nurse, Mater Hospital 1981

BSc Professional Development in Nursing 1992

Master's in Business Administration 1995

Awarded the Honorary Degree of Doctor of The Open University, for work in areas of special educational concern to the University. 2011

EASTERN HEALTH AND SOCIAL SERVICES BOARD

MEMORANDUM

From: Miss A Grant
Director of Nursing Services
Ref. Belvoir Park/Forster Green Hospitals

To: Mr R Lyons
Assistant Group Administrator
Ref. Belvoir Park/Forster Green Hospitals

10 June 1988

RE CHILD PSYCHIATRY LETTER 27.5.88 SENT BY THE THREE CONSULTANTS TO DR A GREER ACTING C.A.M.O.

I will only comment on those paragraphs which include a nursing item in the above letter.

Para 3 The transfer of nursing staff from Lissue to Forster Green "will be taken care of" (I quote) by the Nurse Managers concerned and the first stage of this was completed some weeks ago. Formal and informal contact with staff at Lissue has been maintained. I am sure they would resent the implied criticism of the clinical work in the unit.

Para 4 "Plans" were not prepared by medical staff. They were given the courtesy of looking at the feasibility of the number of rooms being adequate. Medical staff do not recognise the need for domestic, changing or other storage, so these "plans" did not continue to be used. In fact, most of the room usage has been agreed, changing various rooms at the suggestion of the medical staff - such as their offices, second floor, from back to front wing. Parents' accommodation has been increased and moved from back to front wing.

Meetings On one occasion an "emergency" meeting was called by the Department Architects at short notice, the medical staff were given the option of attending.

One area is the subject of strong disagreement between medical and nursing staff, this is the former school rooms and rooms opposite at end of ground floor, back corridor, Rooms 44, 46, 47.

Medical staff wish the corridor walls removed to create one large play (or dining) area. Nursing staff, irrespective of cost or feasibility and the fact that it is a throughway to fire door, are strongly opposed to this idea for the following reasons.

A large number (up to 20) of children of varying ages, temperaments and backgrounds, plus perhaps some parents, do not integrate well as a "herd", and become difficult to control. The plan as presently shown will give two larger rooms (for snooker, table tennis, etc.) and three small rooms, for privacy and sanctuary.

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

We would also refer to the E.H.S.S.B. document "Coping with violence (agression) in a work situation", Chapter 4 "Caring for patients in small groups, facilities for privacy and the development of individual programmes of rehabilitation and therapy for each patient should be important aspects of hospital policy. Overcrowding.... in wards and waiting rooms should be avoided".

Continued/.....

4. The Board believes that patients would have been admitted to the paediatric ward for care/ respite, given their very difficult medical conditions.

5. The Board has been unable to identify the precise date of closure of the paediatric service on the Lissue Hospital Site, although it is known that it transferred to a new site at Belvoir Park Hospital and then eventually to a purpose built unit at Musgrave Park Hospital which is still in operation today. It had, however, certainly moved off site by the early 1990's, and an offer for the purchase of the property had been accepted by 14 September 1994, see Exhibit 1.

6. The Board does not currently have available any admission logs to confirm the total number of patients that were admitted to the paediatric ward. Statistics were held prior to re-organisation from 1 October 1973 by the Belfast Hospital Management Committee, however annual reports do not specify admissions specifically to Lissue until 1970. In the reports prepared for 1970 and 1971 it is noted that paediatric beds in Lissue were unavailable due to rennovations taking place to provide the psychiatric inpatient faciltity. The Mangement Committee's final report, in 1972, which is appended to the Board's first statement at **LIS 201** does confirm that during that one year there were 291 admissions to the paediatric unit.

7. As another Ward within the hospital, the paediatric ward was governed by the same principal legislation as already outlined in the Board's first statement at paragraph 22. The same arrangements for regulation and governance would also have applied (responses to Questions 7, 8 and 9 of the Board's first statement), save that the aspects relevant to the Mental Health legislation would not be applicable to the paediatric ward.

8. The Board is aware through Minutes of the National Board for Nursing, Midwifery and Health Visiting for Northern Ireland that an Inspection of Lissue Hospital was undertaken by that Board in January 1987. A copy of the inspection report is not available to the Board, but the minute of meetings note that concerns were raised as a result of same. This inspection is also referenced at paragraph 54 of the

Board's first statement. The minutes now available indicate that in 1987 the National Board accepted recommendations of their Education Committee and Mental Health Nursing Committee that neither the psychiatric ward nor the paediatric ward in Lissue Hospital be approved for nurse training purposes. On 8 April 1987 the Education Committee also considered that their grave concerns should be drawn to the attention of the Area Board (the Eastern Health and Social Serivces Board). Their meeting on 9 December 1987 records receipt of a letter from the Chief Administrator, EHSSB. Members noted that many of the items raised had been dealt with. Extracts of the National Board's minutes that reference Lissue throughout 1987 are at Exhibit 2.

9. The funding of the paediatric ward would have been as outlined in response to Question 10 of the Board's first statement.

10. The Board believes that the staffing structure for medical staff, doctors and nurses, would have been broadly similar to those in the psychiatric unit with each unit having its own separate staff. The Board is not aware of any sharing of staff between the two Wards.

11. The patients admitted to the paediatric ward would have had a Consultant in charge of their treatment. The Board believes that the Consltant would have had additional duties at the main RBHSC site. The Board expects that there would have been, at a minimum, a weekly ward round led by a Consultant with a Senior Registrar based full time at the Lissue site. The Board also expects that on call arrangements would have applied so that if medical assistance was required at any time it could be requested. The clinical links for medical staff were with the RBHSC.

12. Nursing staff would have consisted of: Nursing Auxilliaries and Staff Nurses who would have reported to a Ward Sister or Charge Nurse. The Sister was responsible to the Nursing Officer. Nursing staff, post-reorganisation in 1973, were the responsibility of Lisburn District.

6.1.8 Working Group - Guidelines on Nurse Training - Report of the Working Group - Optimum Number of Examiners who should be involved in the completion of Progress Rating Forms

Copies of the above Report had been circulated whilst a paper detailing amendments for Sections 10.0, 10.1 and 11.6 of the Report were tabled. LS 107 reported on the background to this issue.

Members noted that the main principle which arose from the deliberations of the Working Group related to instruments which could be seen in an examination context as having a direct and identifiable relationship with set learning objectives and/or competencies established by or on behalf of the educational authority. It was noted that the Progress Rating Forms have been controversial in the past where the decision of one examiner could lead to discontinuation of training. In the light of this it was agreed to endorse the proposal that more than one examiner would be involved in determining the result of the first or subsequent entry to the examination.

Accordingly it was agreed to recommend to the National Board that the Report of the Working Group be approved.

Agreed.

6.2 Local Training Committee Minutes

Receipt was noted of the following:-

(i) College of Mental Health Nursing.....4 February 1987

(ii) Southern Area College of Nursing.....16 February 1987

(iii) Western Area College of Nursing.....24 February 1987

6.3 Colleges of Nursing

6.3.1 College of Mental Health Nursing

6.3.1.1 Inspection of Clinical Facilities - Child Psychiatry Unit, Lissue Hospital, Lisburn

Copies of the report of the above inspection had been circulated.

Members were asked to consider Section A together with that part of Section B which dealt with the Child Psychiatry Unit.

LS 108 stated that this report had been previously considered by the Education Committee in respect of Section A and the Paediatric Unit in Section B.

Having examined the report it was agreed to recommend to the National Board that the Child Psychiatry Unit at Lissue Hospital be not approved for nurse training purposes.

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

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

1.1 the need for a philosophy on which to base nursing care

1.2 the need for the current pattern of excessive door locking

1.3 the supervision of children who abscond from the Unit

(Ref. Page 25, Items 12.3 and 12.5).

2.0 The practice of storing non-medicinal material in the medicine storage cupboard should be discontinued, and the security light should be functioning (Ref. Page 25, Item 12.4).

3.0 The policy for secure storage of video tapes should be clarified (Ref. Page 26, Item 12.6).

4.0 Copies of appropriate nurse training programmes should be available in the Unit (Ref. Page 26, Item 13.1).

5.0 Learning objectives and teaching/learning processes designed to facilitate their achievement should be developed as a joint exercise by staff from the Unit and staff from the College of Nursing (Ref. Pages 26 and 27, Item 13.3).

6.0 An adequate clinical teaching service should be provided by the College of Mental Health Nursing (Ref. Page 28, Item 13.4).

It was further agreed that consideration be given to the points arising from the inspection of the Child Psychiatry Unit, listed at page 29, para. 14.3.1.

Agreed.

6.3.1.2 Inspection of Clinical Facilities, Ward 11, Holywell Hospital - Training Committee Response

Receipt was noted of a satisfactory response from the Training Committee to the report of the above inspection.

Noted.

4.8 Review of Circular No. NBNI 86/5 - Requirements and Guidelines for the Format and Conduct of Examinations for Admission to Parts 1, 3, 5, 7 and 8 of the Register (Minute 6.1.4)

Members noted that the National Board had approved the recommendations of the Committee.

Noted.

4.9 Belfast Northern College of Nursing - Integrated Training Programme for Parts 1 and 8 of the Register (Minute 6.3.1.1)

It was reported that the National Board had approved the recommendations of the Committee.

Noted.

4.10 Belfast Northern College of Nursing - Post-Basic Clinical Course - Short Course in the Care and Management of Persons with Human Immune Deficiency Viral Infection for Registered Nurses, Midwives and Health Visitors (Minute 6.3.1.2)

It was reported that the National Board had approved the recommendations of the Committee.

Noted.

4.11 College of Mental Health Nursing - Report of the Inspection of Lissue Hospital (Minute 6.3.3.1)

(i) It was reported that the comments of the Education Committee, in respect of the response of the Training Committee of the College of Mental Health Nursing to the above Report had been referred to the Mental Health Nursing Committee. Members noted that the latter Committee had agreed to include the comments of the Education Committee in their response to the College.

Noted.

(ii) Receipt was noted of a letter dated 7 October 1987 from the Chief Administrator presenting the response of the Eastern Health and Social Services Board to the above Report.

Members noted that many of the items raised had been dealt with.

Noted.

(iii) Receipt was noted of a letter dated 12 October 1987 from the Director of the Belfast Northern College of Nursing, presenting a satisfactory response from the Training Committee to the above Report.

Noted.

LIS-1416

C O N F I D E N T I A L

INVESTIGATORY NURSING REPORT - CHILD PSYCHIATRY UNIT, LISSUE HOSPITAL

On Thursday morning, 3rd March, 1983 the Chief Administrative Nursing Officer informed me that an allegation of sexual assault had been made by a former patient of the Child Psychiatry Unit.

The allegation, made by LS 71 who had been an in-patient in the Unit from 19.8.82 until 24.9.82, stated that he had been sexually assaulted by another patient on three occasions during this time. The assault was alleged to have taken place in his room at night.

NURSING INVESTIGATION

On receiving the allegation from the C.A.N.O. I started an immediate investigation

1. to establish the facts surrounding the allegation in as far as this could be done within the Unit and on the basis of the information available at the time,

2. to protect the children currently in the Unit by seeking to establish elements of risk to which they could be subject with a view to taking action on any risks found.

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

GEOGRAPHY OF THE UNIT

This is a 20 bedded unit, with 5 day places.

The physical layout of the building is such that the day rooms, dining room, day toilets and main outside play areas are all on one level within the same area making daytime supervision of the children relatively easy. A separate pool room, tennis court and playing field are some distance from the main building, the children use these under staff supervision mainly in the evenings, at weekends and during school holidays.

Night accommodation (known as "The Bothy") is on two levels, the first, consisting of three 4 bedded rooms, is on the first level opening off the dining room, the second on the upper level consisting of 8 single rooms reached by stairs from the first level at the opposite end from the dining room.

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

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

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

There is an internal telephone link between the two duty stations and between each of these and the rest of the hospital.

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

DAY TO DAY MANAGEMENT OF THE UNIT

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

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

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

A large proportion of the children go home for the weekend leaving on Friday evening and returning Sunday afternoon. (See In-Patient figures Appendix 1)

Bedtime in the Unit starts around 7 p.m. for the younger children and unless there is a special treat allowed - such as an outing or T.V. programme - all the children would be in their bedrooms by 10.30 p.m. Once the bedtime routine begins the sleeping area is staffed and is not left unattended throughout the night.

The sleep patterns of the children are monitored and recorded on a nightly basis, each sleep pattern record becomes part of the child's in-patient records and is considered with other aspects in assessing the child's progress and response to treatment. (See Appendix 2)

AGE GROUP OF CHILDREN

Children are admitted to the Unit up to the age of 14 years. There is evidence however in more recent times that a considerable number of children have been over 14 years and one at least 15.

NURSE STAFFING

The total staffing in whole time equivalents is 22.73, this reflects the need to provide for

1. 24 hour cover
2. the admission at any time of a seriously disturbed child,
3. the possibility of a child having to be returned from school due to its disturbed behaviour,
4. the treatment programmes followed which on occasion may require a 1 to 1 relationship with a child,
5. the family therapy carried out in the Unit.

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

RECRUITMENT POLICY

Staff are recruited to either day or night duty on a full time or part time basis but all staff understand the need for flexibility and may be rostered to other duty times if this is necessary.

The need for continuity in care is recognised particularly in caring for the disturbed child and staff are not recruited below 15 hours per week.

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

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

All staff on taking up post follow a planned orientation programme. (See Appendix 3)

Nursing Assistants (who do not require prior training or experience) complete an in-service training programme following appointment. (See Appendix 4)

STAFF QUALIFICATIONS AND EXPERIENCE

The Nursing Officer in charge and the Nursing Sister and Charge Nurses are all Registered Mental Nurses and all except one also hold the S.R.N. qualification.

Of the other 15 trained nurses on the staff

3 hold	R.M.N.	registrations
3 hold	S.R.N. and S.C.M.	"
1 holds	S.R.N. and R.M.N.	"
1 holds	R.S.C.N. & S.R.N.	"
1 holds	R.S.C.N.	registration
1 holds	R.N.M.S.	"
1 holds	S.R.N.	"

4 are State Enrolled Nurses (of whom 3 undertook their S.E.N. training in a psychiatric hospital)

The Nursing Officer, Nursing Sister and Charge Nurses all have appropriate training in First Line and Middle Management.

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

There are weekly multidisciplinary clinical meetings run by the Child Psychiatry division at the Royal Belfast Hospital for Sick Children which the nursing staff attend regularly.

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

STAFF WASTAGE AND SICKNESS/ABSENTEEISM RATES

The turnover of staff in the Unit overall is small with 3 leaving in the past 12 months - in each case there was a straightforward reason.

Sickness/Absenteeism rates are within the upper 1/3rd of the District as a whole at 6.46%, there were 2 instances of long term illness which increased the percentage considerably bearing in mind the relatively small staff numbers in total.

STAFF RELATIONSHIPS AND MORALE

There is a close working relationship between disciplines which includes the school staff on site, these are mature and stable working relationships.

There is no evidence of friction among nursing staff, there is considerable pride in the Unit and the improvements they have helped to bring about in the physical condition of the building and the development of play areas.

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

DUTY ROTAS

The staffing pattern is based on the needs of the children and reflects the overall programme of care.

There are 2 full time Charge Nurses on Day Duty and one Nursing Sister full time on Night Duty (the latter has responsibility for the whole hospital at night).

Maximum staff are rostered for maximum periods of activity, with fewer on duty at weekends when a number of children are allowed weekend passes. However staffing levels always reflect that it may be necessary to bring a child back early.

There is an 'overlap' of staff between day and night duty with 1 day staff member rostered until 10 p.m. Sunday to Thursday. This ensures that there are sufficient staff available to supervise bedtime activities.

Daytime staffing varies throughout the day from 4 to 9, with fewer at weekends. At night there are 2-3 staff on duty Sunday - Thursday (after 10 p.m.) with 2 at weekends (this night time staffing does not include the Night Sister).

Nursing students undergoing psychiatric training are not included in the rosters specified. (See Appendix 5)

OTHER NURSING POLICIES

In addition to the policies already referred to there are clear written policies on

1. The grades of staff to be rostered at all times.
2. Rules to be observed if a change of duty becomes necessary for any member of staff.
3. Overtime.
4. The ratio of male staff which may be rostered.

(See Appendices 6, 7, 8 and 9)

SECURITY STAFF

There are 2 night security officers appointed to Lissue Hospital with a minimum of one on duty each night.

These staff can be called on to assist if a child becomes violent.

COMMUNICATIONS

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

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

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

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

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

SUMMARY

I have examined all these matters in detail and had discussions with the Nursing Officers and Nursing Sister/Charge Nurses.

I believe the policies are sound and there is adequate provision for the nursing care of all children brought into the Unit. I have one reservation - the more recent tendency to admit children over 14 years is of some concern to the nursing staff in the Unit. These children have increasingly different needs from the younger children and in some instances have patterns of behaviour which, because of their physical size as much as anything else, cause fear in the younger age groups.

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

While fully appreciating the needs of this group and the absence of a Unit for adolescent psychiatry in the Province, this pattern of admission could produce strain and stress if pursued.

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

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

1. The philosophy of the Unit permits a degree of freedom and encourages independence and the development of a good "self image" in the child - this means an element of risk which must be accepted.
2. The policies and practices in the Unit were adequate but there was a failure in performance by the staff at post at the time of the incident.
3. An element of each could exist.
4. The more recent tendency to admit over 14 year old children is stretching the Unit beyond that with which it can be expected to cope.

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

(B) Since the police enquiries are not yet complete I have not taken any action to counsel staff on this particular incident.

M. Matheson

DISTRICT ADMINISTRATIVE NURSING OFFICER

16th March, 1983

Use of Regional Restraint Guidelines

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

Care Plans

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

All other recommendations have been either:

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

In making their recommendations, all three reports highlight the need to consider the findings in the context of practice at the time and it is clear that some practices that were common place would not be tolerated today. It is also important to recognise that current inpatient and residential accommodation for children and young people is open to more external scrutiny than in the past. However, it is also clear that children accommodated within these hospitals were subjected to a harsh and punitive regime, and that staff were challenged by the complex needs of the children, a poor physical layout and at times inadequate staffing levels. Specific concerns were identified in relation to some individual staff members and I am satisfied that these have been appropriately addressed.

Incident Report

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

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

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

Methodology of the Review

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

Independent Review Reports

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

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

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

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

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

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

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

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

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

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

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