HIA REF: [ ]

NAME: [Dr Roger McAuley]

DATE: [8 March 2016]

THE INQUIRY INTO HISTORICAL INSTITUTIONAL ABUSE 1922 TO 1995

Witness Statement of Dr Roger McAuley

I, Dr. Roger McAuley, will say as follows: -

1. My career history is as follows;

1.1 Bachelor of Medicine (M.B.) July 1969.

1.2 Commenced psychiatric training August 1970.Diploma of Psychological Medicine (D.P.M.) July 1972

1.3 Commenced training in child and adolescent psychiatry 1973.

1.4 Membership of Royal College of Psychiatrists (M.R.C.Psych) Jan 1974.

1.5 Research Fellow Royal Belfast Hospital for Sick Children (R.B.H.S.C.) 1973 – 1974.

1.6 Appointed Consultant in Child and Adolescent Psychiatry April 1976. Job based at both R.B.H.S.C. (outpatient Unit) and at the Child Psychiatry Inpatient Unit at Lissue Hospital.

1.7 Doctor of Medicine (M.D.) by thesis, July 1980.

1.8 Chairman of British Association of Behavioural and Cognitive Psychotherapy (B.A.B.C.P.) 1985.

1.9 Appointed Fellow of the Royal Collage of Psychiatrists (F.R.C.Psch), May 1996.

1.10 Retired September 2000. However continued locum work for a further 6 years (between 2 and 3 session per week) at several different Community Trusts.

2. I am preparing this statement to assist the Inquiry with their understanding of how psychiatric services were provided to children and their families in Lissue where I was a Consultant Psychiatrist from 1976 until it moved to Forster Green in March 1989. I continued to work until September 2000. I was not aware of the allegations made later and so I have been provided with the Stinson, Devlin and Jacobs Reports to update me in these subsequent developments.

3. Overview of the Child Psychiatry Inpatient Unit at Lissue Hospital.

3.1 There were 2 Units in Lissue Hospital;

First the Paediatric Rehabilitation Unit opened in 1946 and secondly the Child Psychiatric In-Patient and Day Unit was opened in 1971. Dr W Nelson was largely responsible for the inception and planning of this Unit. The latter Unit is described below.

3.2 The Unit was located in an old country mansion. The rooms were spread over an area accessed by corridors and this was never completely satisfactory in facilitating children's whereabouts – it on occasions stretched nursing resources.

3.3 The Unit was established to provide for a maximum of 20 inpatients and 5 day patients, and accepted children up to 14 years of age.

3.4 A school was provided for the Unit by South Eastern Education and Library Board (S.E.E.L.B.)

3.5 Staffing:

3.5.1 Staffing provision for the Unit roughly followed the Royal College of Psychiatrists recommended levels set out in around 1971.

3.5.2 Consultants in Child and Adolescent Psychiatry. Between 1976 and 1978 there were 3 consultants visiting the Unit. Dr Nelson attended many times each week – 1 of his visits being for a complete morning multidisciplinary meeting (M.D.M). Dr Barcroft and I attended for one mornings M.D.M. and usually on at least 1 other occasion each week, in order to discuss cases or work directly with cases. After 1978 Dr Barcroft left to take up a job in England. His input to Lissue was not replaced.

3.5.3 A medically qualified psychiatric Trainee attended the Unit on a full time basis and normally each trainee remained for a 6 month period.

3.5.4 Nursing Staff. The Unit was staffed with S.R.N. and S.E.N. nurses. This always included a nurse at Charge Nurse/Sister grade.

3.5.5 A Social Worker was based full time at the Unit and as well as working with children and families would have liased with Social Services when required.

3.5.6 A Psychologist was based full time at Lissue and worked with children and families.

3.5.7 For several years (until 1978) there was also an Occupational Therapist whose work was largely child focused. The post was not replaced when this person moved to another job.

3.5.8 Overall a Multi Disciplinary ethos was in place – see below.

3.6 Patients up to the age of 14 years (this followed R.B.H.S.C. policy) were in the main referred from the Out – Patient service at R.B.H.S.C. Other significant referrals came from Social Services. The referrals reflected a wide range of problems including; conduct/behaviour problems, emotional disorders (such as phobias, school refusal, anxiety, depression, self – harming, anorexia nervosa, psychoses, Obsessional Compulsive Disorders, encopresis, and enuresis.

3.7 In 1976 provision was made to facilitate the admission of the parents of selected young children with difficult behaviour problems in order to provide them with intensive coaching in behavioural management techniques – including differential attention, positive reinforcement, time – out, use of point incentive systems etc. . Normally these admissions were time limited to approximately 2 – 3 weeks. This program was developed and supervised by the author of this report – see Appendix 1 for 2 examples of this work – also a BBC Horizon documentary made in 1981 (mentioned in requests for reports on Lissue) illustrate other examples of this work – unfortunately the author does not have a copy of the documentary.

3.8 In 1978, Family Therapy was introduced and developed by Dr. Nelson and became an important part of the therapies in place. Largely this involved meetings with the family system (including the child) in an effort to seek out strategic solutions for the problems.

4. Day to day functioning of the Unit

4.0 The inpatient unit mainly functioned on a Monday to Friday basis. Children remained at the weekends only under exceptional circumstances – and reasons for this may have included cases such as anorectic patients, who had not reached agreed target weights, patients who were regarded as being at a high risk of self harm, and also other who remained for reasons relating to family circumstances.

4.1 The average day began with the nursing handover – events of the previous shift were related and discussed.

4.2 After breakfast children in middle age group attended a morning meeting which was in the main run by nursing staff , though often members of the M.D.T. would attend. The meeting was used to review the previous 24 hours and to attempt to resolve any untoward issues. On other occasions the meetings were used to explore the use of problem - solving and social skills.

4.3 During the school day most children attended school during normal school hours. Breaks times were normally supervised by nursing staff.

4.4 Following school hours children were separated into roughly 3 age groups, and were then supervised in a range of activities such as walks, swimming, table tennis, football, various arts and crafts activities, occasional trips out in the minibus to special places – obviously this was more frequent during school holidays, when it was possible to go to museums, beaches, parks etc.

4.5 Parents were encouraged to visit in the afternoons after school. The unit minibus was always available to transport parents from R.B.H.S.C. to Lissue (the latter really being well off any regular bus routes).

4.6 Of course during each day many of the children were seen for counselling on their own, or with parents (and the latter may have been either for family therapy or family management sessions). From time to time, depending on the case mix small groups may have been run in the afternoons, which focused on areas of social skills or problem solving All of these areas of work were managed by various members of the Multi Disciplinary Team (M.D.T.). Also each day specific treatments for certain disorders were managed. Such included dietary programs for anorexic patients, toileting regimes for children with faecal soiling problems, and various programs for bed wetting (including regular toileting, fluid restriction in the evening, night lifting, use of eneuretic alarm and on occasions medication.

4.7 During each week each Consultant meet roughly for a whole morning when they meet with the M.D.T. in order to review the individual patients progress and subsequently plan the relevant continuation of treatment. Regularly representatives of outside agencies involved in the case (eg therapists from the out - patient child psychiatry department, social workers, teachers, other medics etc) would be invited to the meeting in order to discuss progress and eventually to plan for continued support following discharge.

4.8 Overall in spite of the frictions that occur in M.D.Ts (largely caused by the different line management responsibilities of different disciplines), my lasting impression was of a Unit that largely worked well and reasonably cohesively. Of course at times when the case mix was problematic patience could at times be frayed – such tended to be of a short duration. At worst it occasionally resulted in us having to discharge patients prematurely.

5 My role within The Child Psychiatric Inpatient Unit.

This included:

5.0 Evaluating requests for admission and discussing these with the multidisciplinary team.

5.1 Supervising progress and treatment as already discussed at the weekly M.D.T. meeting.

5.2 Frequently working directly alongside other staff in parent child management programs.

5.3 Visiting at other times to deal with issues of importance. For example if there were problems with working of treatment regimes. Take for example one which might be regarded as inappropriate or even abusive – this involved a very serious case in which a 2 year old child with congenital oesophageal problems which had been

treated surgically, continued long after the surgery to resist ordinary feeding - many attempts by different professionals using different strategies were tried unsuccessfully - after 9 months we took this case over, and after careful consideration we engaged in a force feeding regime with parents agreement, and which began to work well after about 10 days – thereafter progress being slow but always forward. Other occasions of importance may arise as a result of special problems, for example when children started to climb onto the roof of the main building. A response to this situation involved sitting down with the M.D.T. and drafting a management policy for the problem.

6. Lissue Hospital Inpatient Records.

6.0 All previous records accompanied any child admitted to the inpatient unit. Such would have included referral letters, other relevant correspondence, and all assessment and treatment records of all involved child psychiatry personnel. If the child was referred directly for an in patient admission, then a new case file was opened and this would have contained referral letters, and notes of an original case admission case discussion.

6.1 During the inpatient stay nursing and school records were normally held in separate files whilst medical, social work, and psychology and multidisciplinary records were maintained in the main case file.

6.2 At the time of discharge, all notes mentioned above were all incorporated into the main case file. Thus at this time the main case file should have contained all records of the patients admission – including referral letters, daily progress notes, treatment records, and finally discharge summaries and discharge letters.

7. General issues / concerns about the Child Psychiatry Unit.

There were a number of issues concerning day to day running of the Unit which caused concern.

7.0 The interests of different line managements resulted sometimes in a lack of empathy with the overall purposes of the Unit. As already mentioned – issues regarding the building were dealt directly by E.H.S.S.B, medics were the responsibility of E.H.S.S.B., social workers were managed by N. and W. Belfast District, Nurses were managed by the Lisburn and Down District, and psychologists by the Royal Group of Hospitals. The different Trusts were always looking to cut staff – in other words there was little cohesive caring for our service, as might have occurred if we had operated under one trust.

7.1 The case mix in general became more difficult to manage as the years went on – there were more serious child care problems referred by social services, and this from time to time as already mentioned caused difficulties.

7.2 The Lissue Building was not exactly "consumer friendly". As mentioned it was spread out, and this made supervision of a full Unit difficult especiallly when children were in different locations, at a time when a particularly difficult child management problem occurred. The move to Forster Green made this a little easier – though initially this "new" building was horrendous in terms of its unchild friendly space. It took years to gradually make improvements.

8. The broad context within which the Child Psychiatry Inpatient Unit functioned in the 1970s through to the 1990s.

8.0 There are a number of important interlinked issues which influenced our working environment in the Child Psychiatry Inpatient Unit. During the years of Lissue's existence major enquiries and research projects in the area of child care, child development, family cohesion, and also into the effects of interventions in children's lives in both the home and in those (in care and) managed away from the natural home, produced a range of important findings. Some of these important findings are briefly described below, and are then discussed with regard to their ramifications for day to day practice.

8.1 The increased awareness of a range of different forms of child abuse.

8.1.1 The recognition and extent of non-accidental injuries (N.A.I.) was first recognized in the 1960s.

8.1.2 In the 1970s the extent and effects of emotional abuse and neglect on children's emotional and social development began receiving much attention.

8.1.3 In the late 1970s the frequency, significance and serious effects of child sexual abuse, within the family and local social environment came increasingly into focus.

8.2 The findings from high quality research (mostly in the 1960s and 1970s) began to indicate that;

8.2.1 Very poor parent and carer child care (i.e. those often falling into some of the categories as in 7.1.1 – 7.1.3 mentioned above particularly in the first 6 months of life) can cause very serious social damage to children – which even the highest quality adoptive parents cannot completely reverse.

8.2.2 Children abused and then removed from parents within the first year of life and then;

- returned to the natural parents continue to do badly in terms of social adjustment even with agency support.

- reared in childrens' homes tend to also do badly socially.

- those reared in foster homes tend to do much better socially in the long term.

- and finally those adopted develop best of all (though in a portion some long term mild social difficulties in relationships are still detectable at age 17years of age.

8.3 Findings such as those reported above had some major influences on ongoing child care practice and policy and contributed to;

8.3.1 Gradual closure of many voluntary and statutory Children's Homes (and I suspect this was also driven by financial pressures).

8.3.2 Increased attempts to return children to their natural parents with the help of professionals from social services.

8.3.3 In more difficult cases moves to make more use of fostering and adoption.

8.4 The overall political and practice changes precipitated by very important research mentioned in 7.2 have not been implemented altogether successfully. Why?

8.4.1 The closure of many childrens homes often resulted in the most socially damaged children being accommodated together in the remaining homes – resulting in very difficult circumstances for both children and staff!!

8.4.2 Attempts to return children to their own homes has no doubt in some cases been aided by the development of family centres (provided both by social and voluntary agencies). However the day to day support for families is still carried out by the youngest and least experienced social work professionals – our experience in child psychiatry is that, even the most experienced professionals often find great difficulty in working with many of these families

8.4.3 The point mentioned immediately above also applies to many foster parents and also occasionally to adoptive parents.

8.5 Naturally, all of the above aspects and results of research and practice did over time have ramifications for the work carried out in the Inpatient Unit in Lissue, in the form of increased requests from social services for help with difficult (and often very abused) children in their care. In other words a sizable proportion of the children referred and admitted by us already have a history of the sorts of abuse being investigated in the I.H.A.I.

8.6 Dr Brian Jacobs has been critical of our decisions to attempt to help with children whose problems, and needs suggest that a long term secure and safe environment might often be preferable. It may well be, that secure and safe environments outside the juvenile justice system can be found in London – in the years that Lissue existed that was not the case in N. Ireland.

Secondly many of the children who fall into the groups above do have recognizable psychiatric diagnoses – such as conduct disorder, depression, attention deficit

disorder – where does this ideally suggest where such children should be managed – obviously a secure and safe environment with good psychiatric input!

8.7 Overall in the light of what has been mentioned here, in all of section 7 (and especially in 7.3 – 7.6), it is my personal view that government policy makers, by omission, need to share some of the responsibility for Institutional abuse!!

9. My knowledge of the allegations.

9.0 Initially I was surprized by the number and breadth of allegations of alleged abuse in the Child Psychiatry Inpatient Unit at Lissue Hospital. I had to ask myself was this the place I worked in – I just had no memory of the problems that are being investigated in this major Inquiry. After reading and considering the reports regarding the allegations I submit the following views.

9.1 Firstly with the kinds of populations of young children (many with serious social problems) that we had over time there are bound to be some allegations of abuse – there is no way out of this position. Over a 15 year period what would be statistically acceptable? I do not know.

9.2 Clearly a number of the allegations seem more serious than others. I refer to the Stinson report;

9.2.1 The allegations made some 15 years after the alleged event by [redacted], appear serious, and were reported by a patient had quite serious problems at the time of admission. These were investigated by the police (and during this time the supposed perpetrator was suspended from work for quite a number of months). No action was taken, and the alleged perpetrator returned to work in the child psychiatry inpatient unit.

9.2.2 The observation by a member of staff that child [redacted] permitted a boy to stroke her thigh and on observing this the staff member then asked [redacted] whether she fancied the boy is inappropriate on the part of the staff member. Clearly this situation should have been dealt with. This finding and additional concerns about this staff member's style of questioning children about intimate matters at inappropriate times and in inappropriate places eventually led to his retirement.

9.2.3 The sexual allegations made by Cases [redacted] and [redacted] against staff members are really very inconclusive and to some degree what I say below may be relevant to their interpretation.

9.2.4 I had the impression that many of the sexual episodes reported between children were handled by staff without any great anxiety or worry – and in part the oft mentioned poor records, in some cases may just reflect that point. Why would the records be "poor"? I suspect that many of the inappropriate sexual activities reported, may well have been already known (to social services) as having occurred before admission to us. In other words these sorts of behaviours may have been

observed before. The examination of referral letters to ourselves, social services and social carer records, may throw light on my point. I did not notice that this sort of detail was considered in the Stinson report. The point here is that the shortage of records, whilst not condoned, may just point to lack of worry about episodes, which may well otherwise have been reasonably managed.

9.2.5 With regard to alleged physical abuse by staff members - child [redacted] made allegations about the violence of 2 specific persons and in particular referred to them pulling children by the hair and also kicking children. I just cannot imagine these particular staff members engaging in this type of abuse. These two staff members were in my opinion, excellent in general, and particularly, in their way of interacting with children.

9.2.6 Allegations have been made about breaches of human rights e.g. restricting weekend passes, and restraining children. These allegations completely ignore the contexts in which the allegations are said to have occurred. Sometimes powerful consequences are required in order to handle difficult situations. For example restricting weekend home leave in a child who has anorexia nervosa and has failed to gain what has been set as a reasonable weight gain in that week is often in their long term best interest – anorexia nervosa can result in serious health problems and sometimes (rarely) lead to death. A discussion with the parents of such children on this point will in most instances put you right

Restraint is often viewed very negatively by health professionals and planners. A 10 year old child who has after all reasonable attempts to calm him, continued to wreck all around and possibly damage himself, may be best managed through the use of restraint which aims at holding him until he/she takes control of him/herself.

9.2.7 I acknowledge in retrospect that records were not detailed enough. I suspect that if one compares them with today's standards one would notice a considerable improvement

9.2.8 The lack of written policies was mentioned in the review papers. This is just not true. There were written policies for supervision of children, general health and safety, use of medication, child protection, time – out, first aid, recording of untoward incidents, and these were all held in a file held by nursing staff. I understand that the HSCB may be able to provide some of these policies.

9.2.9 As a final point here there was an incident book in use in Lissue Hospital in which significant incidents regarding day to day child issues were recorded. Some of the "abuse" episodes not properly recorded in child psychiatry records mentioned in the Stinson report may be included in the incident book records.

10. <u>Some final points.</u>

10.0 On first reading the Stinson Report I was initially taken aback by the range of and number of alleged episodes of abuse, and I thought did I really work in

Lissue Hospital and did all of these incidents occur (albeit over an 18 year period), and secondly, this report castes a dark shadow over an environment that I valued, because of its commitment to children with psychiatric problems.

After reading and carefully considering the report what do I now feel? I make a number of points:

10.2 We do have evidence of some poor records dating back 25 – 40 years ago (and which I think would be less likely to occur today). Also some may question the management of some of the alleged incidents – however this is in no way straight forward.

10.3. We have 2 worrying alleged episodes (and episodes) supposedly perpetrated by 2 different staff members against two different children. In one case the staff member was suspended for months, but was able to return to his work) at the Child and Family Centre at Foster Green Hospital), after the police investigation. The other staff member went into retirement following the Stinson Report.

10.4. Then finally we have a whole series of incidents which are much more difficult to interpret – the main problem here (and to a degree this also applies to the above in 9.2), is that the contexts of the incidents have not been given the "light of day". How does one know how to begin to deal with abuse, if one does not have a good understanding of the context of the abuse, in terms of not only its immediate detail, but also its immediate and distant antecedents, as well as its immediate and later consequences?

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

Signed _____
(Dr R.R. McAuley MD, FRCPsych)

Dated 8th March 2016.

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/.....

[redacted]
Marmion Children's Home,
Church Road,
Holywood

March 1st 1983

Accompanied LS 109 to Police Station after we collected LS 71 from Marmion. We were at the station for a number of hours. Inspector LS 98 and Sgt. Skelly talked to LS 109 and myself. Sgt. Skelly 'phoned the information through to Lisburn Station, and said written confirmation and copy of statement would follow in due course. Sgt. Skelly took LS 109, LS 71 and I to Bangor Station where LS 71 was examined by police doctor. The doctor stated that in his opinion (despite the time elapsed since alleged incident) that sexual interference may have taken place. We returned LS 71 to Marmion late that night.

March 2nd

I accompanied LS 71 to police station at 10 a.m. Sgt. Skelly took LS 71 statement. It was a long ordeal for LS 71 Sgt. Skelly was very thorough but sympathetic. LS 71 and I signed his statement. The whole process lasted until 2.45 p.m.

March 2nd 1983

I accompanied LS 109 to see LS 111 She was upset when we broke the news to her and very concerned for LS 71 We discussed her difficulties in relating to LS 71 and how she could resolve these.

We called at LS 112 house in [redacted] and then to [redacted]. We left a note for LS 112 with [redacted], asking LS 112 to call at James Street the next day if convenient.

March 3rd

LS 112 called at James Street. I explained what had happened to LS 71 at Lissue. LS 112 did not seem in the least perturbed and dismissed the whole thing as not worth getting excited about - he said "I've travelled quite a bit, this doesn't shock or surprise me". He asked that we do not inform his mother and father - he felt they would be too shocked and upset.

4th March

Meeting at Marmion. The decision was made to inform the staff of the incident at Lissue.

Leave - March 4-21st.

24th March 1983

Called with LS 111 and left note re Easter plans.

25th March

'Phoned Dr. McAuley about allegation and to enquire if any progress made re identity of other boy.

'Phoned Inspector LS 98 re enquiries C.I.D. Lisburn. He rang me back. Apparently Lisburn C.I.D. had called at Lissue but Dr. McAuley was not there. Lisburn do not seem to have any sense of urgency.

Off ill 5th-25th April, 1983.

EASTERN HEALTH AND SOCIAL SERVICES BOARD

LISBURN DISTRICT

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.

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.

IN-PATIENT NURSING NOTES

Name HIA 251 Date 30.5.86.

Doctor

c/N LS 21 relieved my special observations at 4.30 pm.

LS 109 S/N.

30.5.86 Dr. Mc Auley consultant, requested that A/N after child was returned to unit that child was being given tranquillisor to relieve distressing Pressure not given as a punishment for being on the roof, he asked that Nursing Staff were not to be negative towards the child, but having said that, said child was to earn all her privileges back as she earned them (by positive behaviour) I informed Dr Mc Auley that ~~not~~ Nursing Staff were not negative but other disciplines had done nothing re arranging visits from Mum & Dad as had been promised previously and child had little positives to look forward to also child was very immature socially.

at 6.15 pm this pm I was c HIA 251 until relieved, child sleeping c thumb in her mouth.

LS 7 c/N.

Please ensure Hall Smoke room top floor Both AP 940 to be kept locked. Smoking can proceed in lounge Bathroom. LS 21

when re directed · Blushes easily when teased and tells peers to shut up, appears to have a short fuse but holds back. appears to be afraid to show "feelings".

LS 7 S/V.

3·12·84·

HIA 3 unable to share a joke with his peers & staff, he likes to sit & have a laugh at other peers but doesn't like the joke to be on him. Tonight staff teasing him and he was unable to take it, Ran out of the room and began to cry, when spoken to kindly he settled quickly. Parents & rest of family attended for F.T.

LS 87 S/V.

F/T Report 3/11/87 P.M.

All family attended. Therapist enquired re previous week - discussed how they dealt with HIA 3 panic attacks. Parents & children were asked in turn what changes needed to take place in the family in order for HIA 3 to be well again. Mum - don't know. [redacted] (Big sister) agreed with Dad [redacted] & [redacted] who said HIA 3 must change - not be so selfish & wanting everything for himself. Also Aiden said the family must change - must talk more rather than argue & fight. Dad said he must try to control his temper HIA 3 & have HIA 3 Mum Dad. [redacted] stated that had always had his own way at home.

LS 34