Belfast Health and Social Care Trust

1.6 spitting up blood for which we have not yet been able to find any medical explanation.

1.7 She recently raised allegations of mental and physical abuse when she was an inpatient at Liseux and Foster Green between the ages of 11 and 16. This is currently being investigated by the PSNI.

2. Current Mental State

2.1 LS 69 s a young woman who looked her age. She was well kempt and appropriately dressed.
2.2 Eye contact was reasonable and rapport was established quickly. She showed a good range of facial expression.
2.3 She described her mood as "good". Objectively, she appeared relaxed.
2.4 She described a normal appetite and sleep pattern.
2.5 She denied any thoughts of harm to herself or to others.
2.6 She denied having any abnormal perceptual experience.
2.7 There was no evidence of delusions.
2.8 She was fully orientated. Her conversation was normal when tested.
2.9 LS 69 viewed herself as being 'Okay' but feels she needs support from social and psychiatric services.

3. Drug and Alcohol Use

3.1 LS 69 does not use illicit drugs and does not drink alcohol.

1 Medications

3.1 LS 69 current medications are:
Sulpiride – an anti-psychotic, which is being used to control symptoms of Tourette Syndrome.
Duloxetine – an anti-depressant
Diazepam – for anxiety
Warfarin – to prevent blood clot
Procyclidine – to treat the side effects of Sulpiride
Cyclizine- anti-histamine prescribed for nausea and vomiting
Nuvelle – a contraceptive pill
Pizotifen – anti-migraine
Codamol – Painkiller

3.2 LS 69 told me she feels sedated and tired in the mornings. She feels these symptoms are side effects of her medications, but usually resolve before noon.

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4. Current Situation

4.1 LS 69 is currently residing at 603 Antrim Road, Belfast, on a temporary basis, until her accommodation at Clearwater House is ready.
4.2 She is unemployed.
4.3 She has no regular contact with her family

5. Follow-up Plan

5 LS 69 will be reviewed regularly by Dr Reah McGookin in the out-patient clinic at Old See House, 603 Antrim Road Belfast.
5.2 She has been referred to the Department of Psychotherapy at Knockbracken Health Care Park for Psychotherapy.
5.3 Her Community Psychiatric Nurse, Deirdre Taylor will support and monitor her mental state in the community.
5.4 She has also been referred to the Alexandra Gardens Day Hospital. They will be involved in providing her with structured daily activities and occupational therapy.
5.5 LS 69 has been given contact details of NEXUS and CRUSE Bereavement Care. These are charity organizations that help people address ng from sexual abuse and bereavement respectively.
5. LS 69 physical health will be cared for by her GP.

6. Opinion

6. LS 69 fit for interview by the Police.
6.2 LS 69 current psychiatric diagnoses are Tourette Syndrome, Mild Depression, Borderline Personality Disorder and Somatization. (Somatization is the experience of bodily symptoms with no, or no sufficient, physical cause for them, with presumed psychological cause)
6.3 The above are well controlled and should cause little or no difficulties during interview sessions.
6.4 She is on medications that cause her side effects of tiredness and sedation in the mornings. These normally subside by noon. She is alert by mid-afternoon and as such I would suggest that the interviews are held between 14.00 and 16.00HRS
6.5 Ms Halliday is comfortable with interviews lasting up to two hours per session.

Yours sincerely

Dr O J Anyokwu MB ChB MRCPsych
LOCUM CONSULTANT PSYCHIATRIST

PM SC4

OCD-19-(75pg LS 69

TRANSCRIPTION OF: LS 69

Good afternoon my name is Detective Constable Paul McConnell. I'm presently attached to Child Abuse Investigation Team in Antrim police station. Today is Friday the 23rd of May 2008 and the time on my watch is 1524 hours and we're here today in Garnerville CARE Suite in Belfast. If you just like to tell me who you are?

LS 69 My name is LS 69

Okay LS 69 great and we've someone else in the room today, if you'd like to introduce yourself?

My name is Mary O'Brien Assistant Service Manager for Mental Health Team employed with Belfast Health and Social Care Trust.

Great Okay. No in the CARE Suite today just above me there you'll see there's two cameras. One's pointing more or less at you and Mary and the other one is a wide angled lens showing that there is nobody else in the room okay. Now this is all being recorded today and so that's recoding us visually and there's wee mikes there, which are probably okay, we don't need to put them on. That's just obviously going to pick up anything that we say. All right. Are you okay to talk with Mary and myself today?

LS 69 Yeah.

Yeah. Now as a result of what you are going to tell us this may eventually go to Court. Are you happy that this could be shown in Court eventually?

LS 69 Yeah.

That's great. Now throughout the afternoon whenever we're talking with you if you need a break just let us know okay if you need a drink of water, if you need to go to the toilet, if you need a break for whatever reason, let us know and we'll facilitate you in that way, all right. If I ask you a question that you don't really understand will you tell me and I'll try and put it in another way that you to help you understand?

LS 69 Yeah.

Okay and if I ask you a question and you actually you don't know the answer it's okay to say I don't know so basically don't be making don't be making things up to just please me okay and it's important today to tell the truth and not to leave anything out. Is that okay?

LS 69 Yeah.

OCD-19-(75pg LS 69

TRANSCRIPTION OF: LS 69

Great. Have you any questions at the minute you'd like to ask?

LS 69 No.

No, okay. Before I go on any further normally we would have somebody next door just making sure the equipment is working so I'm just going to nip next door to see if everything is okay. Now whenever I go there next door, volume wise could you just say something so I can hear if it's picked up?

Yeah.

To see if we need to use the wee clip on mikes?

Yeah no bother at all.

Thank you.

Okay Paul hopefully you can hear us and the volume is okay. You can let us know in a minute.
You okay LS 69

LS 69 Yeah.

You can let us know if you need a break or anything. All right. LS 69 an you say something just so we can make sure that we can pick up your voice as well, so just ask me something so he can make sure that we can pick up your voice?

LS 69 I don't know what to say.

That's okay you've just said something so that's fine just to see that we pick up your voice. That's great did you pick that up okay?

That's great yes everything's loud and clear so thank you very much for that. Okay. Just before we start I met you for the first time today, nice meeting you. Where is it you are living at the minute?

LS 69 I'm livin LS 69

Okay is that?

LS 69 It's a residential hostel for the mental health.

Right. And what's that like do you like it okay?

LS 69 Yeah it's nice.

Where is that up in Belfast?

LS 69

It's off the Antrim Road.

Right and what sort of accommodation do you have there?

LS 69

You have your own bedroom and wardrobe and stuff, you have your own room.

Okay.

LS 69

And there's two television rooms, one upstairs and one downstairs.

That sounds good.

LS 69

Kitchen and bathrooms down stairs and upstairs too. There's not a kitchen upstairs there's you know like a place in one of the television rooms upstairs that you can have maybe a cup of tea or coffee or stuff just like you know basic.

How long have you been there?

LS 69

I think about 5 weeks now.

Right is it going to be a long term thing or is it?

LS 69

No hopefully I'm going to get my own place soon.

Right. And how many would it accommodate, how many people would be there at the minute?

LS 69

I think about 9; I'm not sure 8 or 9 yeah.

Is it male and female?

LS 69

Yeah.

Okay of all ages or?

LS 69

Yeah mixed.

Adult?

LS 69

Yeah.

Okay and how do you feel then about moving on to get your own place, is that ultimately what you want to do?

TRANSCRIPTION OF: LS 69

LS 69 Yeah.

And again in the Belfast area?

LS 69 Yeah.

Do Social Services organise that for you or?

LS 69 Through the Housing Association and the Mental Health Team.

Okay so do you look forward to the possibility of that happening in the near future?

LS 69 Yeah.

Grand. Then excuse me, what about the other people that are there at the minute are they okay do you get on all right with them?

LS 69 Yeah. Everybody's very nice that's there at the moment.

The staff okay?

LS 69 Yeah.

Good, good. All right. Have you been enjoying the nice weather because it's been glorious this month hasn't it?

LS 69 Yeah it's good.

Do you get out and about much?

LS 69 Go into town shopping and do different things, go out with some of the girls to Abbey Centre and.

Right.

LS 69 Wee shopping trips and stuff or sit outside or you know they maybe have tea outside at night or something you know because they've got like with the no smoking everybody has to go outside now at night so they have a table and chairs outside.

Right, right.

LS 69 So people go out and sit and have a chat and bring a cup of tea or coffee out and sit outside.

Are your meals provided or do you make your own then?

[redacted] No the meals are based with residents who live there take turns everyday with a member of staff to see what you know and to make cook a meal for the rest of the house.

Okay.

[redacted] And everybody takes their turn. And then there's other ones who would help out and do the shopping and stuff and go with staff and stuff out to the shops.

Yeah.

[redacted] To get the weekly shop in and stuff like that.

Right.

[redacted] So there's different activities like that goes on.

So are you a good cook yourself?

[redacted] Not really no.

No. What would your, you know speciality be?

[redacted] I don't know pasta maybe.

Very good I love pasta yeah garlic bread, very good yeah. Okay the idea of that wee chat really was, you're probably quite apprehensive about you know what we're going to talk about today so it's really to settle you down, to settle me down, before we go onto the main body of why we're here and obviously you're here to tell us something. I know you've probably quite a bit to tell us so what Mary and I were maybe suggesting, have you discussed this with her?

Mary Yeah.

Yeah?

Mary No sorry no not this particular bit no.

No just if we could maybe concentrate on this specific area of where you were staying at a particular time and we'll see how we get on anyway so just in your own way, words and in your own time if you're going to tell us, you're here to tell us something and about a time whenever you were staying in somewhere in Lisburn?

[redacted] A place called Lissue.

OCD-19-(75pg [LS 69]

TRANSCRIPTION OF: [LS 69]

Lissue okay. Do you want to tell us a wee bit about your time there how, I know it's hard to know maybe where to start maybe you could tell me you know when you first went to Lissue?

[LS 69]

When I was 11 years old I developed Turrets, Turrets Syndrome. It was around Christmas time I was in first year in Secondary School. I remember distinctively clearing my throat a lot in one of the classrooms and it was about November time, because it was coming to the Christmas exams and then it got worse and worse so I was taken out of school then. So my mum and dad took me to a lot of different doctors and stuff, the GP and then we were referred to Child Psychiatry in the Royal under the head of Dr Nelson and when we went in to see him we spoke to him in a room a two way mirrored room and there was cameras behind you know it was being filmed.

Yeah.

[LS 69]

A bit like this and there was like other Doctors and Psychiatrists behind the screens and stuff and they didn't really know what was wrong with me at the time, you know they put it down to attention seeking, manipulating and hypochondria and that's what we were told at the time. My parents were told at the time to just to ignore her and send her back to school. So em em, so things actually got worse with my turrets it began to develop into like a noise eh like a bark like a dog and all it developed it got a lot worse I started jerking, I started (inaudible) you know, jerks, flicks, and my arms moving my legs moving and stuff em and that went on constantly. I can't really remember the first admission, it might have been around, I'm not really sure I know it was the winter time anyway the first admission to hospital which was to Lissue which was recommended by Dr Nelson from the Royal the Child Psychiatry em he recommended it for myself. He told my parents about it to admit me there at the age of 11 to see if they could sort stuff out or just you know to monitor me and see like that. I remember it was winter time it could have been a few months after I developed the turrets it could have been I know it was the winter time so it might have been about February, March after that I'm not exactly sure of the dates. It was away out by Lisburn but by the Ballinderry Road, it was miles out from everywhere, it was all open countryside and there was just the hospital and then there was the whole ground it was like a big wooden forest and they had slides and swings and stuff like that you know for younger children and in the downstairs there was the downstairs part to it where they had mentally and physically handicapped disabled children. Em I really don't know what that was about downstairs but it was mentally and handicapped and physically disabled who you know em I don't know if it was an orphanage type, type of thing downstairs because most of the children stayed there and their parents didn't you know didn't see them but upstairs was the psychiatric part which was where I was

brought to. I remember my mum took me that day and we went up to it the very first time we went up to it and we must have sat about two and a half hours in a room just me and my mum waiting to be seen to actually be admitted. We must have sat about two and half hours and we could hear all the noise and all in the back rooms, background and em then eventually em a girl I think it was someone who (inaudible) was called Marie Kenny I found out later on she was a Social Worker em and I was admitted from that. Em I wasn't shown bedrooms or anything like that until after my mummy left and em so they did, I can't really remember much about you know the admission but em told basically about how there was visiting days and stuff like that and what you could do like you know I think visiting was Tuesday and Thursdays and stuff like that and I can't really remember much about the admission really I can't remember much about it and em from there I was brought to em I can't think, I was brought into a TV room em and eh there was a lot of, a lot of noise because there was a lot of boys in it em they would have aged from say from about 8 to about 13, 14 maybe em and at that stage I was the only girl there at that stage em there would have been about 17 other boys at the time there and it was very, very scary and there was members of staff, the boys would have been running around the room and throwing cushions and somebody would have been sitting watching TV or it was just one big room and in in the room, just off off the room there was a bathroom and toilet so em and em I just em was very frightened because I'd never left home before and I just stayed there and I think the whole time from after my mum left until tea time and then excuse me we went down to the dining room and stuff and seen where the meals were given out and then after meal time about 6 o'clock there was, what they called tuck time, where you would, you would get like em two pieces, either crisps or a drink or chocolate and drink you know whatever your parents had brought you up or there was a shop downstairs if you had money to put in the office you would put it in the office and get it out when they called tuck time which was 6 o'clock. Em and basically after that after tea and after tuck time then you'd go back down to the television room again or sometimes em on different, you know, they did different activities some days you know there's out from em out from the back of the dining room there was like em built on to part of Lissue was like an interview suite and eh we'd I think somebody said there were stables like what they were years and years ago they were built on to this you know under Lissue and one of them you had to go across a big playground type it was all grass and stuff and em they had like a pool room but it was away you had to walk out through the door across a big field and it was attached onto the interview suite and there was a pool room and some of them would go and play pool with the staff and it was it was a good bit away from the from the house you know attached on and eh there was the interview suite where they would have had like family therapy and stuff like that. I'm trying to think what else there was there as well.

Just and then there was loads of fields and you would have went for walks and stuff like that too at night maybe after tuck we would have went you know for walks round the grounds or walks away out round say maybe a 2 mile walk or so round the grounds and come back in and then go back into the television room and then it would be supper time say about 8 o'clock the staff were changing over and eh then there would be a tea where you would get toast and milk and eh then it would be back to the television room again and it would be bed time, I think it was 9 or half 9 I'm not really sure, half 9 it was, and then it was time for bed and as you eh when I was getting from the, see I wasn't shown around or anything when I went in and they told me right my room was upstairs so everybody was walking to get to go to bed and up the stairs to get their medication as well. There was a big massive long hallway and em there was 3 big massive dormitories down stairs. It was like a big massive, massive room and em there was no windows or anything in the dormitories it was just 4 beds, 4 beds like steel beds like the old beds with waterproof mattresses with no sheets and no blankets or anything like that on the beds. There was 3 of those, some of them was I think some of them were for the boys there was 2 boys dormitories and there was a girls dormitory which would have had 4 girls or you know and then would have held 4 girls and depending on how many residents were in at the time or patients were in at the time and then you would go up then and downstairs in the long hall were the dormitories you walked to the very bottom of the hall and there was a shower room a bath and toilets and then you would go from there and there would be like a wooden staircase which went up into the attic and em my bedroom was the first one and I'm like up in the loft, mine was the first one and again you could walk along away to the very bottom it was a very long walk to the very top one and all the other bedrooms would have been up there. All along this whole, it was like a whole upstairs but it was like an attic type. There would have been about, maybe about 12 rooms upstairs and the staff room was upstairs as well for the staff for the nurses. And there was just as you come out of my room on the left there was a toilet and bathroom and when I went in to see my room I went in and em there was a bed and a wardrobe and that was it and em my suitcase and stuff was there and they said to me put your stuff away and em there was no hangers or anything it was just a wee tiny wardrobe with 3 wee drawers and that was it so I just put them in the bottom of the wardrobe and em I used to look, I used to drink a lot of juice and fluids because of my Turrets my throat was always very sore and I had a bottle of juice say for instance a bottle of Fanta orange, 2 litre bottle was sitting beside my bed and they took it off me and said it wasn't allowed up so I can remember that night then, then there was tablet time when they give their tablets out upstairs and then it was time for bed and I remember that, that, that very first admission I was very, very upset. I cried the whole day from my mummy left and I was still crying that night and I was crying in bed that night because I

hadn't stopped crying since (inaudible).

My phone I should have turned it off I do apologise sorry. And nobody ever phones me. Sorry about that. So you were saying there that I don't want to put you off your train of thought you were crying, you were very upset.

LS 69 Yeah I was and after about 20 minutes one of the staff came in and was quite abrupt and said to me, "What's wrong with you" and I just said I wanted to go home and she said, "Lie down there and be quiet you're not going, you'll not be going home lie down and go to sleep" and I noticed on the outside of the door that there was a curtain, there was a small window in the door and the curtain was on the outside of the door where the staff could pull the curtain back and forward and to look in on you and I heard you know when I was lying in bed crying I heard a lot of shouting and stuff going on up in other rooms and stuff like that and doors being banged and it was quite frightening and I kept crying and em they em, came in again, one of the other staff came in again and said, stop that nonsense now and go to sleep that's enough of that carry on you know quite abrupt and I was still very upset and I asked him for a drink and they said no you're not getting a drink and eh I kept on crying it was quite for a long time. And then on the last time that someone came in they closed my door over tight, closed the door over tight because one of them said to me that if you don't be quiet and lie down and go to sleep we'll lock you in your room. So that was my first experience of my first admission so after 3 days after my mum come up and seen the room and seen where it was and she asked me why didn't I hang my clothes up and I said because there was no hangers and my mum asked one of the nurses why had LS 69 no hangers in her room and the nurse turned round and said she didn't ask us for any, so that was the first admission to Lissue, that was my first, that was my first admission.

How long were you in for on that first occasion then?

LS 69 About 4 days.

Oh just for 4 days?

LS 69 Just 4 days.

Right.

LS 69 My mum discharged me then.

Right.

LS 69 And took me home.

And did you share a room with anyone or were you buy yourself in that?

LS 69 No they were all single rooms.

All single rooms.

LS 69 Yeah.

Okay. And then did you go back to Lissue on another occasion?

LS 69 Yeah I was in Lissue on a few occasions em the occasions I suppose would be the best ones to tell you about would be probably em another occasions I went in to Lissue I was in for a few admissions, em there em I met different people em on a few of other occasions I went in em a few I would call friends. Em and then em I began to meet more of the staff that were there while I was had admissions in, in Lissue. Em and I began to see a lot of things em that eh weren't right. Em I'm trying to remember different things I'm trying to remember.

Okay.

LS 69 To tell you all of them it's just I'm trying to start off with the first one. Em I think the first, the first em the first thing I can remember is em there was a lot of boys in and em about the age between you know teenagers em between roughly about my age, 11, 12, 13 and a lot of them were out of children homes and training schools and stuff like that and they were in with bad behaviour as they called it and em they would be given like time out and stuff like that as they call it for bad behaviour where they would have to lock them in a room and it would be like plastic chairs with cushions on them, that what we sat on, and they'd be throwing them around the room and getting their temper you know flying off the handle so the staff would sit outside and lock the door and they'd be in the room and that was one of the, that was frightening when the you know because the staff had to restrain them and put them into these rooms which were called time out or either if their temper didn't stop it they would go into one of the dormitories. The dormitory would be completely bare there would be nothing in the dormitories only the 4 beds and if em if their tempers didn't calm down then em they'd be kept in the dormitories and the door would be locked and the staff would sit outside em their shoes would be taken off them em so as they wouldn't hurt the staff if because they were fighting against the staff em sometimes if their temper got didn't calm down at all em their clothes would be taken off them too. So basically they were in this room and they had nothing in the room.

That's for the boys you are talking about?

TRANSCRIPTION OF: [redacted]

[redacted] Yeah.

Okay.

[redacted] And em that was my first sort of basic things seeing about the bad behaviour you know the tempers and stuff that the boys had.

Yeah.

[redacted] And em that's where I met a few of my friends at the time who had been in and out over the, over the years had seen a few times. Then there was another occasion when, sorry I'm getting all this mixed up, it's just not coming out right the way I want it to come out.

You're okay.

[redacted] Basically when one or two of the other admissions I was in there was a particular member of staff who em told all of us that em, he told us a bit of a horror story about, about Lissue and about you know how old it was and the building how old it was and the people who owned it before it became a hospital and that there was a murder had taken place in Lissue and there was a girl drowned in the bath up in the bathrooms where the dormitories were.

Eh eh.

[redacted] And because they were the closest toilets to the dormitories and the dining area and we were told that em at night time or in the dark, because you had to put lights on to do down the big massive hallway and sometimes the lights weren't on that you would hear them, you would hear the girl, he told us it was a girl who was murdered in the bathroom, she was drowned.

Eh eh.

[redacted] And that you would hear her crying and you would hear her wailing at night time sometimes. We were told horrific horror stories about the bathrooms and the majority of us were terrified. Em I think everybody was terrified and there was lights to go down the hallway but they weren't always on and if you needed to go to the toilet you were absolutely terrified to go to the toilet and some of us would try and go two at a time but the staff wouldn't let you go two at a time they would only let you go one at a time and the hall lights sometimes they would be on and sometimes they wouldn't. So basically you would get to the door, I rememebr doing it myself, you would get to just off the dining room just off the hall you would you would actually be running there and the light would go out in the hall and you would be down in the bathrooms and I can remember squealing and in the

bathroom and just be running back up the corridor again, you know it was terrifying, it was hard it I was only 12 you know and maybe the lights go out but I'm running back up squealing and then when you got out you'd be told off for squealing, you'd get told off for squealing, for making so much noise, and you'd be shouted at for squealing but it was just we were so terrified you know just doing that.

You were saying you were shouted at is that by staff members?

[redacted] Yeah.

Yeah. Okay.

[redacted] But it's just everybody the whole time you were there you were terrified. And at night time too you know in the dormitories if you were downstairs if you were in the dormitory sleeping you know you'd it would just be terrible. You'd just imagine you know because he said you could hear things at night and you could hear footsteps and all this sort of stuff and sometime they could appear at night the ghost can appear at night her spirit would wanders the place and wanders the dormitories. We were told all that. There was different things that happened in it as well like with, not just the staff, but with the other boys that were there at the time. Em I can distinctively remember two of the boys who were out of the training school, St Patrick's Training School and they were both there with bad behaviour and I remember one day going down. I remember one day going down to the bathroom and em there was, there was two of them, the two of them come down to the bathroom I could hear, I could hear the voices, I could hear them talking and the next thing I knew the toilet door, because you could open it from the outside the toilet door was opened and they came into the toilet into the bathroom and em.

Can you remember the boys names?

[redacted] Yeah.

Do you want to tell me?

[redacted]

[redacted]

[redacted] Yeah.

Okay. And these were people who were staying?

[redacted] Yeah.

And what happened.

LS 69 And em [redacted] turned round and said to me as I was in the bathroom and I still hadn't got my underwear pulled up, he turned round and said to me, they were both in the bathroom, they were both in the toilet and I was in the toilet and em he said, he said em, he, he wants to buck you, and he em pulled down his underwear and his trousers and he he said to me hurry up before the staff come and the two of them were still standing there and [redacted] then turned round and said let me, hurry up and let me stick my dick in you before the staff come and I said no and he kept saying hurry up, hurry up, the staff are going to come, the staff are going to come, and I kept saying no to him. And he started pulling at my clothes and then em and then someone heard someone coming and he pulled up his trousers and em the two of them ran out of the bathroom down the corridor so I was left there so I didn't say anything.

Mary Just need to check that they are recording because otherwise you have to go back over things so.

LS 69 Okay.

It's important they are recording. They okay.

It didn't transfer onto the other tapes.

You don't know what time at.

No but I put another tape in it seems to be recording now so we've 45 minutes on tape and I think maybe about 10 minutes of that isn't recorded but we've still got the video. The visual side should be okay.

I've everything written as well so.

All right. Sorry about that I just needed to check. So what you're telling me it was in the TV room I think.

LS 69 Yeah.

You talked about [redacted] ouching you between your legs and your breasts.

LS 69 Yeah.

Okay. And it was between the age of 11 to 13?

LS 69 Yeah.

TRANSCRIPTION OF: LS 69

Yeah. In Lissue and then we talked as well about the time that and ...

LS 69

Thomas well were in the bathroom and what had happened there. Okay. You said that that you were in Lissue on a number of occasions?

LS 69

Yeah.

Do you want to tell me of another incident maybe that has occurred?

LS 69

Em

We'll maybe just try and place what period this would have happened?

LS 69

Em on another occasion I just remember there was a member of staff that em a male member of staff would always get em because my hair was long and curly a picture of it there he always used to get me to sit on his knee and he be sitting, I'd be sitting on his knee and he's be sitting stroking my hair because my hair was very long and curly. My friend would be behind him and she would be coming his hair and this was a nightly routine when he was on duty. She's always, he's always get her to comb his hair, sometimes I would do it, sometimes she would do it and sometimes I'd be sitting on his knee and he'd be sitting touching my hair, putting his fingers through my hair and em one night em just as we were getting ready to go to bed, I was in the downstairs dormitory, and em it was very quiet and there was nobody there was nobody em in the dormitory some of the girls were in the bathrooms and some were upstairs and I went into the dormitory and put the light on and em and eh I started getting undressed and the next thing was that a member of staff walked in and em he said to me where's and I was half undressed and em then jumped out from under the bed and eh he told to go to his room because room was upstairs in the attic and em I was still standing there half undressed and he turned round and he said, "I know about you and em this is a regular thing you let him see you getting undressed and em and you let him do stuff to you. He turned round and he said you know there's a name for people like that. And I turned round and I tired to explain to him that I didn't know that was under the bed he had jumped out just as the staff had walked in and scared the life out of me and I was very shaken up about it and em that's all I can remember about that one.

What did you calla the male member of staff?

LS 69 Em

Do you remember his other name?

LS 69 It's either

Was he a care worker there or what sort of?

LS 69 Staff Nurse.

Staff Nurse?

LS 69 Yes.

Okay. Am I right in saying sometimes that you stayed at Lissue you had your own room and sometimes you stayed there you were in dorms?

LS 69 Yeah.

Yeah, okay. Was there a reason for you said the first time you were there you had your own room but on this occasion you've told me that you were in a dorm is there a reason why sometimes you were by yourself and other times you were with other people?

LS 69 Not it was just wherever they put you.

Okay right. And that was then again?

LS 69 Yeah.

And then he just went off to his own room whenever that incident happened?

LS 69 Yeah he went upstairs.

Okay.

LS 69 Because said to me at the time this isn't the first this has happened because I've heard a lot about this he says between you and

Eh eh.

LS 69 I know all about it that what the words he said that night when that happened and I was trying I didn't know what he was talking about.

Did you ask him?

[redacted] LS 69 No he just turned round and said there's a name for people like this, for people like me.

Eh eh. Anything else happen in Lissue then?

[redacted] LS 69 Em There was em em other things that happened. There was if you ran away, which was one of the biggest punishments, if you ran away from Lissue the police were called and naturally they had to search search the place for you. If they found you and brought you back you were stripped naked and put into a dormitory you stayed in that dormitory for at least a week to 2 weeks, the dormitories didn't have any pillows or blankets or anything like that and the staff would sit outside the outside the door and the door would be locked and you weren't allowed to mix with any, you know you were there you were in that room, day and night and if you were a girl and you ran away with one of the boys em you had to have to had to be internally examined and that was at the ages of 12.

Who was that by?

[redacted] LS 69 The doctor that was there at the time.

Right. Can I just ask you, you said that if you ran away and you were caught you were brought back and you were stripped naked and you were put in a dorm?

[redacted] LS 69 Yeah.

You said for up to a week?

[redacted] LS 69 Yeah.

What about if you need to use the bathroom or something like that?

[redacted] LS 69 You were allowed to go to the bathroom, they gave you em the boys usually got just em not their own pyjamas, it was like something you would have had in prison like em there were green stripes on them the pyjamas being green stripes, they only got bottoms and the girls if you were going to the bathroom only got tops.

A pyjama top just?

[redacted] LS 69 Yeah.

And you had to wear that to go to the bathroom and then?

[redacted] LS 69 Back into the room.

And did you keep wearing the top?

[redacted] Yeah.

You did, okay. Was there a reason for them taking your clothes then?

[redacted] No they didn't say, you didn't ask you were just told.

What about meal times then did you have to eat in the room by yourself?

[redacted] Yeah.

But you were fed okay?

[redacted] Yeah.

And did you have a blanket and stuff?

[redacted] No.

No bed linen at all?

[redacted] No the beds were waterproof just with plastic mattress.

You had nothing to put over yourself then?

[redacted] No.

Okay. What dorm was this was this downstairs?

[redacted] Down the stairs dormitories.

Did it have a name on the door the dormitory?

[redacted] No.

No.

[redacted] It was just the 3 dormitories downstairs depending if there was, if there was any of the boys were sharing maybe the second one then the girls one was the third one it was used either the first or second one it just depending if there was no one sleeping in it then they would put you into one of the dormitories.

And you said that if you ran away with a boy you came back and you were medically examined by a doctor?

LS 69 Yeah.

Did that happen to you did you run away with a boy?

LS 69 No.

So then you were never examined?

LS 69 No.

But did you run away yourself?

LS 69 No.

Can you think of anything else at Lissue?

LS 69 Em.

That happened to yourself?

LS 69 Em I can remember, I can remember the male member of staff I always wet the bed from a very young age and I did when I was there and em when you were there em you always got a shower and stuff and baths and things at night or in the morning and em this particular member of staff would always, you could always he would always come down into the shower or the baths or if you were going to the toilet em he would come in. If you were getting dressed or undressed with the curtain round the door he would stand and watch you getting dressed and undressed. I can actually remember a time I actually got dressed, I actually got undressed in the wardrobe I actually got into the wardrobe to get undressed because he was standing watching. Em you were always terrified to go to the toilet and stuff because he would always walk in, he'd always come in. He would come into the showers and he would come into the baths everything and I said at the start that there was pool rooms away out by where the interview suites were and he would take some of us up to the pool rooms and stuff, just the girls usually.

And did anything happen in the pool rooms?

LS 69 I can remember my friend coming back, I had left the pool room early to walk back over to the door and the door was always kept locked and she came back and she was in a bit of a state, she was hammering on the door, open the door, open the door, and I opened the door and let her back into the main building.

If you go back to the pool room time?

TRANSCRIPTION OF: [redacted]

[redacted] Yeah.

Mary Can you tell you the staff member's name?

[redacted] [redacted] was his name.

Mary And the girl's name?

[redacted] She's my friend but I don't allow her to give her name because I don't know whether she'll want to be involved in all this?

It would be helpful you know and we can speak to her and at least she'll want to talk to us. Are you still friendly with her?

[redacted] I haven't spoken to her in a while she lives in London.

Okay. It's your opportunity you know to tell us the details but it's up to yourself what you want to tell us.

[redacted] It's just that I don't know if she's want to be involved in all this?

Well if you tell us like we can approach her and certainly it's up to her if she wants to herself are you happy enough to tell us her name?

[redacted] [redacted]

Mary [redacted]

[redacted] Yes.

What age would she be?

[redacted] She would be the same age as me.

Same age as you okay. Were you friendly with her whenever you were?

[redacted] Yeah we were in a few admissions together.

Okay.

[redacted] And then when Lissue was pulled down we were both in Forster Green. That's where it transferred to.

Okay. Well do you want to go over that just again. That bit about the pool room so I've got that right in my own head. What age would you have been?

TRANSCRIPTION OF: [redacted]

[redacted] Em Probably about 12 or 13.

Could you remember the time of year it would have been would it have been dark outside time of day it would have been?

[redacted] It was dark outside.

Okay so it's was it the evening time?

[redacted] Yeah.

How did you end up over in the pool room?

[redacted] Some of them you know a mixture of the kids would go over to play pool and then some of them would go back to the house and there would be one or 2 left maybe.

Okay so you were over in the pool room with Vivienne?

[redacted] Yeah.

And [redacted]

[redacted] Yeah.

What did Harry say to you, and if you can't remember what he said it's okay?

[redacted] I can't remember.

[redacted] Did [redacted] y why she was upset?

[redacted] No.

Do you remember a conversation you would have had with Harry on that occasion?

[redacted] No.

So there was just the 3 of you there?

[redacted] Yeah.

Yeah. Can you describe what the pool room was like?

[redacted] Em

How many table would there have been?

LS 69 There was one table and there was a darts board on the on the wall with a cover for it a wooden doors there was a big black board you know you would get a big massive black board on the wall and you keep the score of darts or of pool or whatever and there was a door at the back of the pool room with a window in it where you could see horses and stuff that were about on the you know in the fields and stuff and then there was an entrance on the front door a big red door at the front where we all went in and you could basically, you could see you know it was quite bright in it, it was quite bright in the pool room there was just em there was just the darts board and a big pool table and the chalk board and that was it.

Was there any toilet facilities there or anything like that?

LS 69 No.

Or any kitchen?

LS 69 No.

Was there a seating area where you could relax?

LS 69 There was just plastic chairs.

Plastic chairs okay. So your memory is that the 2 of you were there and she was upset on this occasion?

LS 69 Yeah.

But you can't remember if you had a conversation with Harry or not you don't know what he said but she was upset for some reason?

LS 69 Yeah.

Did you ever talk to her about that?

LS 69 No.

Is this the same girl who used to comb his hair, remember you were saying?

LS 69 Yeah.

Would you have said that you got on well with Harry then, were you close to him?

LS 69 Em he always used to talk about my lovely long curly hair. He was very close to and myself.

He treated you well did he?

LS 69 Looking back on it now as an adult and, and em, spending hours in bedrooms and coming into bedrooms and em in Forster Green and stuff when it was moved, wasn't right.

Okay.

LS 69 The behaviour wasn't appropriate.

Okay we'll talk about Forster Green at a later time if you're okay and we'll try and keep sort of Lissue separate if that's all right?

LS 69 Okay.

So this time in the pool room that we're just concentrating on nothing, your memory of what things that would have happened to yourself or to [redacted] did something happen that shouldn't have happened looking back on it?

LS 69 Looking back on it now.

I'm thinking about the pool room incident here?

LS 69 [redacted] was in a terrible state.

But you don't know why?

LS 69 No.

And did anything happen to you down in the pool room?

LS 69 No.

Okay. But you think something may have happened to [redacted]

LS 69 Yeah.

Okay.

LS 69 [redacted] room in Lissue used to be away at the very, very back of the attic and em [redacted] would spend hours in her bedroom at night.

Did she have a room by herself?

LS 69 Yeah upstairs in the attic.

So from your time in Lissue was there anything else that has happened

to yourself that shouldn't maybe have happened that you want to tell us about?

LS 69

Em. There was the time that I was in em I met a boy he was, he would have been 13 or 14, and I would have been 12 maybe and his name was [redacted] and he also [redacted] same eventually when it was diagnosed with [redacted] and eh (inaudible) gave him a very bad time em [redacted] would have been [redacted] was a lot worse than mine was at the time and staff used to give him a lot of punishments, they would get him, all of us to sit with our chairs round in a circle and they would get [redacted] o, this particular member of staff would get [redacted] to stand up on the chair and he would say to [redacted] are you sure you are getting enough attention now and he would push him about on the chair as [redacted] was standing up on the chair and [redacted] would try to get off the chair to stand down and [redacted] was getting worse and he would shove him about on the chair as he was standing and we were all sitting round in a circle and he would say what do you want to get down for you know keep, keep going you know come on make all your noises and all this carry on and [redacted] would say stop it and you know let me get down off the chair and then he says that would be the main thing have you got enough attention now do you want to make any more noises you know all this carry on and that went on that went on a lot with this particular member of staff and then one day mark and I were both in the television room and [redacted] was quite bad at the time and [redacted] was quite bad and the member of staff, the male member of staff physically grabbed both of us by the back of our necks and by the jumpers and collars and ran us down the corridor at the back of the necks holding onto us and through [redacted] into one of the dining room tables and threw me into the other one and shouted now shut up and sit there and I don't want to hear another peep out of either of yous or yous are going to bed.

Eh eh.

LS 69

Physically thrown into the tables.

Do you know [redacted] other name?

LS 69

[redacted]

[redacted] And who was the male member of staff that did that?

LS 69

His name was either LS 44

Do you know what he did there?

LS 69

He was a Staff Nurse, senior Staff Nurse.

TRANSCRIPTION OF: LS 69

Okay.

LS 69 He em used to give a very hard time with and they also they had this group called did it with this is another member of staff called the action group and it was always on a Monday where it was like the group were all of the patients, the majority of the older crowed went in and there was cameras and stuff on and they would do different things in the group they would do like punching pillows to take out your temper and stuff like that and then the wee groups would all sit on the floor and there was different things I can't remember exactly what it was but any time tha was on he always tried to bring myself and down a lot. He always picked on us an awful lot, a terrible lot and I can remember him you know shouting at t one of the action groups and making him sit in the corner with his back in the corner or with his face in the corner and then em when he, then he was made to apologise to the group and apologise to and then he was allowed to go back into the group and he did the same with me as well. For no reason we were made to sit outside the circle and turn our back to the circle and then turn around and say you were sorry to the group and you were sorry to and we didn't know what for and em in the school, there was a school attached on to Lissue, it was just like mobile hut, mobile huts and the teacher there called LS 1 and em he used to not be able to cope with and he would get and he would if wasn't concentrating on his work he would get him to stand in the corner and if his nose wasn't right in the corner he would bang his head off the wall. He would push his head right into the corner of the wall, bang his face right in the wall and hold it there with his hand and we'd be sitting at the desks watching all this and he'd make him stand right in with his nose right in the corner and the could make him he would make him stand make him stand there wouldn't let him go to the bathroom or anything and he could be standing there for an hour or so.

Did he ever do the same to you, treat you in the same manner?

LS 69 Em not as bad as that but he used to shout at me a lot and he would have given me if my had of been bad he would have given me a bad report. You got a report 3 times a day to go over break, lunch and then when school finished at 3 to the ward again and if you were, if you didn't get a good if you didn't get a good report then you didn't get to go out swimming or things like that and I always got a bad report because m was bad.

Eh eh.

LS 69 So he punished me because of and he did the same with well.

His name again sorry, not [redacted] the?

[redacted]: [redacted]

[redacted]: Pardon?

[redacted]

[redacted]: Em [redacted] and do you know what position he held?

[redacted]: He was the he was just a [redacted]

[redacted]: I think he might be principal of Forster Green now.

Okay. Now you said that he would have made your friend stand with his nose in the corner, did he do that to you too?

[redacted]: No.

No. So there's obviously loads of stuff going on whenever you were in Lissue?

[redacted]: Yes.

Did you go in for like periods of at a time 2 or 3 weeks at a time, what way did that work?

[redacted]: Em it was to try it was to try for different medications maybe?

Okay.

[redacted]: And sometimes you'd go back and there would still be people you met the first time there or you would be back in again and they were just leaving or stuff like that.

Right. So what was the longest period of time you would have spent in?

[redacted]: Em you could also be a day patient as well.

Did you do that too?

OCD-19-(75pg [redacted]

TRANSCRIPTION OF: [redacted]

[redacted] Yeah I was a day patient as well. I can't really think probably about 2 months maybe 3 months quite sometimes you got home at the weekends and stuff like that.

Right. Then can you remember when sort of Lissue finished?

[redacted] I think around the time I was 13.

Thirteen okay.

[redacted] It moved to Forster Green then.

Okay so we what we can say then we talked about [redacted] first of all yeah. We talked about [redacted]

[redacted] [redacted]

[redacted] sorry. Yeah and we talked about whenever you were changing?

[redacted] [redacted]

[redacted] yeah. We talked about the pool room and your friend being there as well and we talked about [redacted] and the way you were treated and the way your friend was treated whenever you had bad periods of Turrets okay.

[redacted] Hmm.

And as I say they've been mainly at Lissue. Can you think of anything else? I'm conscious of the time.

[redacted] Yeah.

Mary I just want to check how you are doing [redacted] it's ten past five and I just want to check in about how you are?

[redacted] I'm okay for now.

Mary Okay.

I'm just conscious that tape I put in was a 45 minute tape can you remember what time I put it in at whenever I left.

Mary Yeah hold on ... at 25 past 4.

That would be 40 minutes by (inaudible).

Mary We're coming up to quarter past, twenty past will be 45 minutes, isn't

that right a quarter past, quarter twenty past so we're coming up to the end of that tape. I'm also conscious that you're psychiatrist recommended no more than 2 hour[redacted], what do you think.

[redacted] I'm okay if I just have a break maybe for 5 minutes I'll be okay again.

Mary Okay will we stop now at the moment?

[redacted] Yeah.

Mary Okay.

The time is 11 minutes past 5, 1711 hours. I'll just nip next door and stop the tape.

OCD-19-(75pg [LS 69]

PM:C5

TRANSCRIPTION OF: [LS 69]

Alright [LS 69] you want to get, you sit yourself down.

[LS 69] Here.

Yeah. Okay yeah.

[LS 69] I'll not need these sure I'll not?

It's okay you can hold onto them any way that's grand. Now sure whether you need us to say anything to check the sound. Okay?

I think we should be alright. Good afternoon my name is Detective Constable Paul McConnell, I'm currently attached to the Child Abuse Investigation Unit in Antrim Police Station. Today is Tuesday the 3rd of June 2008 and the time on my watch says 1435 hours.

My name is Mary O'Brien, Assistant Service Manger for Community Mental Health Teams, Belfast Health and Social Care Trust em and it's the 3rd of June 2008 and it is 2.30, 1435 on my watch.

Okay and you like to introduce yourself to me please?

[LS 69] Hi my name is [LS 69]

Okay [LS 69] well you're very welcome here to Garnerville CARE Suite in Belfast and I know that we have met you before and we've had a discussion with yourself here in Garnerville in this same room a couple of weeks ago and really this is a continuation of that but again I just want to remind you of the equipment that we have. Above me there's two cameras, one's got a wide angled lens showing there's nobody else in the room except the three of us and the other camera's sort of focusing in on yourself okay. There's little clip on mics there which will help pick up anything that you're going to say and everything is being recorded next door onto audio tape and DVD. Em are you okay to talk to me and Mary today on eh DVD, are you happy if this is all recorded?

[LS 69] Yeah.

And you're happy to talk to both of us?

[LS 69] Yeah.

Okay that's great eh if at any stage you want a break as we've said before you know not a problem just let us know and we can facilitate you in that way alright?

[LS 69] Okay.

Em what you have to tell us today you might find distressing and it's certainly understandable if you need a wee time out just to gather your thoughts or for whatever reason it's okay to do that okay and whenever we're talking to you today and we ask you maybe

something and you don't understand what I'm asking please tell me and I'll try and rephrase it in a way that you do understand and whatever you're telling me what you have to tell me it's important to just as much as you can remember tell me, as much detail as you can remember and don't really making things up?

LS 69 Okay.

Okay em and as I was saying the last interview that there is a possibility that this may em end up in court would you be happy that this is viewed in a court environment?

LS 69 Yeah.

Okay that's great. Is there anything you want to ask me at this stage?

LS 69 No.

No okay. Now em on the last occasion we talked primarily about your time in the Lissue house in Lisburn. Now sort of the purpose of today is maybe continue on from that but is there anything em that you would like to say further in relation to the Lissue maybe you haven't mentioned before.

LS 69 Em.

What I'm just going to do sorry LS 69 I'm going to put that wee mic there just to help pick up what you're saying okay?

LS 69 There was a few things that I remembered em from the last session em that em involved em one of the other patients and involved the pool room em it was the time in the last session I said myself and some of the other em patients went up to the pool room with one of the nurses and em eventually everybody came down except one girl that was left in the pool room em and she came down to the door for me to let her into, into the, into the kitchen or into the dining area and was very upset and as I was letting in through the door I remember seeing cause you could see from the pool room to the dining room because it was only across like a playground sort of outside at the back a hilly, grassy you know playground there was a see saw and stuff out the back and I remember seeing the member of staff as one of the patients was coming in through the door who was very upset em I remember him standing at the door of the pool room which was all glass, you could, you could see from the dining area to the pool room because the light was on, the door was all glass and I could see him, there was nobody else in the pool room after one of the girls going down from the pool room very upset em and you could see him standing watching down to the dining room door and em there was no one else with him only himself there and something I thought that was funny about it he stayed there for about 10 minutes on his own and there was no other patients or children or anything else up in the pool room. I found that kinda strange because you know he should have been on duty in the ward and em he waited about 10 minutes

before he came down.

Okay?

LS 69 Cause the, the girl that em come down was quite upset.

I'm I right in saying the girl you're talking about here is now living in England is that the girl?

LS 69 That's right yes.

Yes okay em I know you gave me a name her name and I can't remember it?

LS 69 that's right yes. She's in London now is she?

LS 69 Yeah.

Yes, yes I remember that. Em and I think we discussed then last time that she never actually said anything to you?

LS 69 That's right.

That right?

LS 69 Yeah.

Em and do you remember the name of the staff member?

LS 69 was the name.

That's right okay grand. Can you think of anything else then from Lissue or do you want to move on to?

LS 69 Em.

If something comes to mind later on you know we can go back to it?

LS 69 Okay em. The name I remembered em I wasn't sure of the three names that I gave you the last time for a particular one of the member's of staff that threw myself and I into tables. I gave you the name LS 44 but it could have been

LS 69 It's one of the three but I just couldn't remember but the second surname came into my head.

Okay?

TRANSCRIPTION OF: [redacted]

[redacted] Just you know, just to make sure, it's one of the three the surname's one of the three.

Yeah and that was at Lissue?

[redacted] That was in Lissue yeah.

Okay?

[redacted] Em.

Do you know, you moved on from Lissue it's because Lissue closed down is that?

[redacted] Yeah.

Yeah can you remember when that was?

[redacted] Em I'm not sure, I'm not sure I must have been about maybe 13, 14 maybe I moved.

Okay and then can you remember where you moved to?

[redacted] Forster Green. Sorry there's still some things about Lissue.

Sorry do you right okay?

[redacted] I still haven't said, there's.

No problem?

[redacted] Some of them is in the notes.

Oh right okay? Now and I know that you have made some notes that you had with you last time but you didn't show us but em we photocopied them here this afternoon and I think what we were going to do was Mary was just going have a look over some of them and if necessary read some out. Now I haven't, although I photocopied them I haven't read them. Are those em done in what way have you got your notes written out?

[redacted] Just scribbled down the way I could remember different articles.

Okay so it's not all particular year or it's not all particular?

[redacted] No.

Location?

[redacted] No.

It's mixed.

Okay these are photocopied version of notes that [redacted] had in the notebook on her knee em and has asked for me to read them out em I'm going to read them as written em and em if you need me to stop at any time [redacted] f you would just ask me to stop or [redacted] if you need me to stop just say okay. Em it says in the top left hand side just names check which is you've just said [redacted] [redacted] or [redacted] So you're just confirming well those names need to be checked?

[redacted] Yeah.

Em Lissue was a locked ward em you could not get out em kids would not get swimming em?

[redacted] That's from Forster Green sorry.

That's from Forster Green okay. If you tell me what refers to Forster Green and what refers to Lissue [redacted]

[redacted] Okay.

Em blackmailed Naïve said I was seeking tablets?

[redacted] That's Forster Green.

Okay [redacted] [redacted] n corner and him banging his head off the wall?

[redacted] Lissue.

Lissue?

We discussed that I think?

[redacted] Yeah.

Didn't we yeah.

Okay morning meeting [redacted] standing on the chair and being shouted remember we did that?

[redacted] That's Lissue.

Em okay yourself and [redacted] physically assaulted and being thrown into tables. We had talked I think a bit about that. [redacted] being locked in his room and going to the toilet under the bed?

[redacted] Yeah that was in Lissue.

Okay em [redacted] uld not talk unless the threats stopped and that w[redacted]

[redacted] That was Lucy.

[redacted]re?

LS 69

Staff.

Staff okay. Em LS 79 the nightmares we were told about, the ghosts and body story you talked about that. The dormitories punishment if running away, striped naked, no blanket, pillow or anything and locked in?

LS 69

Yeah.

You'd spoken about that last time. Em being internally examined if you run away, [redacted]was that?

LS 69

Yeah.

E, by the doctor but you had said that had not happened to you?

LS 69

Yeah.

Last time. LS 79 coming into toilets no locks on doors and being watched getting dressed and undressed. Him coming into the shower and bath when naked em not being allowed to cry to feel ashamed and shouted at. The dirty talk we were accused of and threatened to tell parents. Okay I think you'd spoken about that. LS 79 about stories he said he was told that I left, let [redacted] see me naked and let him touch me and we had sex. I think you spoke about that last time we were here yeah. Okay did we?

No on reading that out did you say we had sex?

No em [redacted] about stories he said he was told that I let [redacted] see me naked and let him touch me and we had sex?

LS 69

That was in Lissue.

Okay?

Don't think we talked about that?

It that you mentioned the last time clarify this for me [redacted] LS 79 was accusing you of this?

LS 69

Yeah.

Okay and when it says here em and let him touch me and we had sex, is that LS 79 accusing you of doing that?

LS 69

Yeah.

Rather than you had sex with [redacted]

LS 69

Yeah.

OCD-19-(75pg [LS 69]

TRANSCRIPTION OF: [LS 69]

Okay [ ] making me sit on his knee and him running his fingers through my curly hair. Em making me comb his hair, we talked about that?

Yes?

The last time okay and I'm just going to put this sheet here okay. Em I also remember in Lissue as we were waiting to go swimming [ ] and T[ ]em pressurising me into asked John one of the nurses if he was em a good old ride and if he would ride me and they kept on and kept on and [ ] then turned round and said if I get the chance I will ride the fuck clean out of you talking about me and then him and [ ] starting laughing okay. It says then Forster Green here but it says Lissue later on on down the page so what I'll do is refer to Lissue first?

[LS 69] Yeah.

Is that okay. The pool room after [ ] came back to the door upset and I let her in and co[LS 79] looking down from the pool room when [ ]came in, also [ ] not come back from the pool room for about 10 minutes which I thought was odd because he was on [redacted]

[LS 69] No.

No? Let me just [ ] I'm not sure what that other word is em they're names on the left hand side because staff wanted to talk being in one room with 15 children every night. Not sure [LS 69] if you want to expand on any of this say. Em staff eating kids meals?

[LS 69] Yeah.

Okay Bridget telling me I would be locked up for the rest of my life em in a locked up lunatic asylum. Bridget is who?

[LS 69] One of the nurses I don't remember her second name.

Okay Ella?

[LS 69] Yeah one of the nurses.

Okay lying naked on the floor and her applying cream without my consent?

[LS 69] That was Lissue.

Okay?

[LS 69] She's one of the nurses.

Is this at Lissue?

[redacted] Yeah.

Do you want to expand on that or?

Tell us a wee bit about that cause I don't think we've mentioned that at all?

No?

You said [redacted] is that a member of staff?

[redacted] Ella.

Sorry Ella?

Lying naked on the floor and her applying cream without my consent who's lying naked on the floor [redacted]

[redacted] Me.

What floor were you on?

[redacted] In the bathroom.

Sorry [redacted] did you say bathroom?

[redacted] Yeah.

Thank you.

Had you not been well?

[redacted] Em I had em I had em a rash and em after I came out of school em Ella made me go and have a bath and em and em when I got out of the bath and she made me lie on the floor and em she applied cream to me and I said I can do it myself but she applied it. She said I wouldn't do it right.

And where did she apply the cream [redacted]

[redacted] On private parts of my body.

And just so I know what you mean by private parts what would you do on your private part? What would you use it for?

[redacted] Going to the bathroom.

To do ones or twos?

[redacted] Ones.

Ones okay. Now did this happen regularly or was it a one off?

LS 69 Em it happened once.

And did she hurt you?

LS 69 Don't know.

And you said she was a member of staff?

LS 69 Yeah.

Was she medical staff then?

LS 69 Yeah.

Can you remember what age you would have been roundabout?

LS 69 Twelve.

Okay. Can you remember how that finished?

LS 69 When, when she finished then she said you me you can get dress now. She was in with me while I was in the bath.

She was in the same room you mean?

LS 69 Yeah.

Do you know what the cream was that she put on you?

LS 69 I can't remember.

But it was to help a rash of some sort?

LS 69 Yeah.

Okay. In the bathroom is this a room literally just with a bath?

LS 69 Yes.

Yes just a single bath and a wash hand basin or something like that?

LS 69 Yeah.

Was there anything else in the room?

LS 69 No.

And she stayed in the room while you bathed is that right?

LS 69 Yeah.

Yeah would that be the norm, would staff do that?

LS 69 Em sometimes.

Okay.

LS 69 would you like me to move on and read some more from this?

LS 69 Yeah.

Em being terrified to go to the toilet in case being locked in room. Una.

LS 69 That's Forster Green.

Okay em okay LS 79 m two way screen so got dressed in wardrobe?

LS 69 That was in Forster Green.

Okay em Harry in bedrooms at night for hours?

LS 69 Em more so Forster Green.

Okay em eh being yelled at for talking about staff by Roger Gordon's.

LS 69 That's Forster Green.

Okay the Action Group

LS 69 That was Lissue.

Okay being made to sit outside the circle then being made to apologise?

LS 69 That was in Lissue.

I think you mentioned that the last time?

LS 69 Yeah.

Yeah em okay getting his hair combed, making me sit on his knee and touching my hair, you talked about that the last time. Em being terrified to go to the toilet, bedroom doors being locked, if dirty underwear having lectures and made to bath even though parents were waiting outside.

LS 69 That was in Lissue.

Okay, okay says here on the right hand side by esson on how to wipe your bottom on going to the toilet?

LS 69 Yeah that was in Lissue.

OCD-19-(75pg [LS 69]

TRANSCRIPTION OF: [LS 69]

Do you want to tell us about that

[LS 69] Em basically em it was with some of the boys who hadn't went to the toilet properly and we got out of school at 3 o'clock and em it was either a Tuesday or a Thursday because that was parents visiting days and from school we came in at 3 o'clock to the unit and em we were all brought into one room and sat down and there was a drawing board like a big sketch board that they would have sitting on a floor and em would always take these meetings and em because some of the boys had had accident in their underwear and stuff we were all brought into one room and em basically given a lecture on how to got to the toilet properly and she had a teddy bear in her hand and em a piece of tissue paper and it was just like you know showing everyone on how to clean yourself properly when you went to the bathroom and then em that went on for about half an hour or so and then everybody was made to take a bath after that and I always remember my it was visiting day that day, it was a Tuesday or a Thursday and even though my dad was sitting waiting on me to see me I still had to stay in to the lecture and then I had to go and take a bath and my daddy was still waiting on me and this was something we were all made to do even though parents were visiting, it was something we had to do. So I could hardly spending any time with them at all until this was all completed so nobody was allowed to go anywhere or do anything until all this was done.

I think it refers to that here em okay and ends this being terrified to go to the toilet, bedroom doors being locked, if dirty underwear having lectures and made to bath even when parents were waiting outside?

[LS 69] Yeah.

Okay me not being able to go to the toilet if on red card because staff were too busy chatting outside?

[LS 69] That's Forster Green.

Okay em sometimes [LS 79] would get someone to help him make the night supper usually it was in another part of the building em it isn't desperate clear here em it was kept locked, something was kept locked?

[LS 69] The doors. Yeah the doors were kept locked.

And only staff had the keys to open and lock the doors?

[LS 69] Yeah.

Okay who was kept locked?

[LS 69] All the doors were kept locked.

Okay, okay em being told that your parents did not want you anymore

because they were too old, daddy crying.

[redacted] LS 69 That was Forster Green.

Okay em everything else here says Forster Green on it do you want me to read out about Forster Green I just need to check how you are [redacted] LS 69 are you okay to continue?

[redacted] LS 69 Yeah.

Okay.

Before maybe you do that could you maybe tell me em and I know you've progressed from Lissue to Forster Green em when that might have been and how long you would have stayed, was it the same sort of idea you maybe stayed for a short period of time, long period of time or just so I know?

[redacted] LS 69 Just depended from it could be anything from two or three weeks maybe to 6, 7 weeks at different times.

Okay so you were never a day patient as such?

[redacted] LS 69 I was a day patient yes as well.

As well?

[redacted] LS 69 Yeah.

Right what's your first memory of Forster Green, what age would you have been?

[redacted] LS 69 Eleven.

Eleven okay so you're em you not still at Lissue at 11 no?

[redacted] LS 69 Pardon.

Were you still not at Lissue at 11?

[redacted] LS 69 Yeah.

Was Forster Green and Lissue all at the same time, no?

[redacted] LS 69 No Lissue was em over the years I was in and out of Lissue.

Okay?

[redacted] LS 69 And then Lissue moved when I was around 13 to Forster Green, they moved the unit to Forster Green.

Okay I'm just a wee bit confused then sorry. You're saying at 11 you were in Forster Green?

TRANSCRIPTION OF: LS 69

LS 69 No when I was 11 I was in Lissue.

Okay and what's your first memory then of Forster Green?

LS 69 Em I think I was about 13 em very, very sunny day went in in the summer and em majority some of the same staff em went in was there em very small TV rooms, a lot of rooms down the side em like TV rooms, dining room, small tables and stuff as that were in Lissue, same chairs that were in Lissue em. It was downstairs was a lot smaller.

So your first memory of going to Forster Green was that as an in patient?

LS 69 Yeah.

Yeah do you remember how long you would have stayed there for on the first occasion?

LS 69 No.

If you can't remember it's okay?

LS 69 It may have been a few weeks, a month or two I'm not sure.

Okay and in Forster Green what was the set up, was it in dorms or did you have your own room or what was the sleeping accommodation like?

LS 69 Em there was em there was five single rooms round at the back of the hospital. There was a family and parent suite and then you'd go round by the corridor and it was all single rooms right up to the very top. There was no dormitories.

Okay so you had your own room?

LS 69 Yeah.

Okay just by yourself?

LS 69 Yeah.

Didn't have to share with anybody?

LS 69 No.

Okay and you said then a lot of the small staff would have transferred over as well?

LS 69 Yeah.

Yeah okay and em how did you feel about moving to Forster Green?

LS 69 Em very nervous.

Was it a bigger hospital?

LS 69 Yeah.

Yeah so there's more patients then?

LS 69 Em there was roughly I would say about maybe less, there might have been 18.

Okay?

LS 69 Maybe yeah, 17, 18 patients ranging from the ages of babies right up to 15.

Okay of boys and girls?

LS 69 Yeah.

Okay and whenever you stayed there did you have a daily routine what you would have done, what was a typical day like for you?

LS 69 Em when I went there it was the summer. I remember going in in the summer time em you would have got up about em I'd say about em half eight, 9 o'clock, got dressed, came downstairs, had breakfast. Then went for medication em then there was the morning meeting em.

With the staff or for?

LS 69 That was the children and the staff sat in. It was basically the children had any em faults or complaints or anything like that to try to get it sorted out em and a few of the staff sat in, in the morning meeting just to see if there was any grievances or anything that happened and to try and be sorted out.

Okay?

LS 69 Then after that we would go the TV room, a pretty small TV room and em remained there for a few hours with the whole of the unit in that room watching television and em the staff would be there as well em a few members of the staff and they would sit and chat em. They they'd maybe sometimes make decisions in the afternoon if anybody was going anywhere, if there was going to be day trips out or places to go or anything like that and em you basically stayed in the television room until something was decided and it could have been the afternoon or whatever.

And did you have any special friends?

LS 69 Em well I already knew and I were very close. Em, em

there was a couple there, another couple of girls in at the time as well and quite a lot of younger children, young children around our age too so it was mixed really so. I got on pretty well with everybody.

Good so so far what you've been saying to me that em you moved, you had your own room em there was quite a set routine of getting up, getting your breakfast, having your morning meeting where people would give any complaints or worries, concerns to staff, go to the TV room and then there would have been outings sometimes, something like that?

LS 69 Yeah.

So for what you're saying it seems to be quite, quite positive?

LS 69 Yeah.

Okay and then did something happen you didn't like?

LS 69 Well basically em majority of the time we spent a lot of the time in the television room because it was easier for the staff to manage everyone so the TV room was after lunch you went to the television room, after tea you went to the television room, after breakfast you went to the television room, when you came downstairs in the morning before breakfast you went to the television room and the staff would sit and chat then the whole time. You'd have to ask permission to go to the toilet, you weren't allowed to walk out of the room or leave the room. You had to ask permission em you weren't allowed to go upstairs during the day. Em we spent a lot of time in the television room.

Okay and was that okay for you to be in the television room or did that annoy you in any way?

LS 69 Well it was a very small television room with about maybe 16 other children in it. That's a pretty small room and the television cartoons or whatever was on and that would have went on the whole day sometimes.

Okay did you feel quite claustrophobic, small room with so many children all watching TV?

LS 69 It was quite monotonous, it was quite boring em but you had no choice that's where you had to go to.

Okay and everyone would have been there, there was no option of?

LS 69 No.

No em I'm very conscious of the time here what I was going to just do is pop next door just to make sure the tapes are going to change over. Do you need a wee drink of water or anything?

TRANSCRIPTION OF: [redacted]

[redacted] Take a wee break just first.

Just have a wee break?

[redacted] Yeah please.

That would be grand. Do you want to go down to the wee room there or?

[redacted] Yeah.

Okay?

[redacted] Thanks.

Mary are you waiting there or are you coming out?

I'll come out in a wee second.

Okay?

Okay [redacted] do you want to come in and sit yourself down and then I'll move your zimmer?

[redacted] Yeah.

Okay are you alright, settled.

I was just listening to the sound there and it seems okay not a problem. It 1535 hours by me, twenty five to four?

Yeah.

And we had a wee break there just to make sure tapes and everything were okay. [redacted] you were down, you had a wee five minute break as well?

[redacted] Yeah.

And happy enough to proceed?

[redacted] Yeah.

Okay and really what we were saying at the conclusion of the last em talk was your time in Forster Green whatever you'd said it was quite a structured day, primarily a lot of it was spent watching TV in a small TV room and you sort of relayed to me there was maybe about 16 children be in there okay?

[redacted] Yeah.

Is that right?

OCD-19-(75pg [LS 69]

TRANSCRIPTION OF: [LS 69]

[LS 69] Yeah that's right.

Yeah and you've said to me that you would have been in for period of maybe six weeks at a time?

[LS 69] Yeah.

And then I take it whenever you weren't there you were out with your , where were you living whenever you weren't?

[LS 69] With my parents.

Your parents okay. Was that locally in the Greater Belfast area?

[LS 69] Em.

Without being specific?

[LS 69] Yeah.

Yeah okay and then is there anything specific then in relation to Forster Green you know that you can remember that annoyed you or you felt it shouldn't have happened to you? Either by member of staff or by any of the other patients?

[LS 69] Em there were a few things yeah.

Okay I know sometimes it's maybe a bit hard to know where to start em is there something in particular that maybe you could tell me a wee bit about and then I can maybe ask you some questions on it?

[LS 69] Em one of them was going to bed at night em because my dress was really bad when I was younger and when everybody was in bed at night everybody had to be in bed by I think it was about half nine and lights were out and em because I was quite noisy with my tourettes it would have, the staff would have shouted a lot at me and em you know things would have been said like if you don't stop making that stupid noise em you'll be locked away for the rest of your life, you'll end up in the lunatic asylum and you'll never been let out, you'll be in a locked ward. Very, very frightening stuff em, em and another problem I had when I was nervous I would go to the bathroom a lot with my nerves so it's, I need to go to the toilet frequently if I was nervous so especially when this was getting shouted at me or I was being, or my room door was closed tight. I didn't, I was afraid of, I was afraid of the dark and even at home my mum and dad kept the bathroom light on for me all night. So when it was lights out everybody's door was sort of left open but once I started making the tourettes or whatever the room door was slammed shut and it was very dark, it was frightening and then you had staff shouting at you so my nerves would get bad, I would need to go to the toilet and I went once or twice and I was told then the third time if I came out, if I come out of my room again do use the bathroom I'd be locked in my room and so I got back into bed again and my nerves were so bad I didn't

know what to do cause my nerves started again, I needed to go to the bathroom again and I didn't know what to do because I was afraid of the staff. I didn't know what was going to happen so em there was a waste paper bin in the room and em I didn't know what to do so em I knew I wasn't allowed cause the room door was closed tight had to go to the toilet in the waste paper bin because I knew I was going, I didn't really know what was going to happen if I had of went up to the bathroom again. So I had to go to the toilet in the waste paper bin and then em in the mornings then before the staff came into your room I would throw it out the window so as they wouldn't know but I always remember my parents coming to visit and because I was terrified at night about you know going to the toilet and stuff I remember my parents coming into the bedroom one day and saying there's a funny smell in this room and em but I couldn't tell them why, I didn't tell them what the smell was or what was going on because I was afraid of getting into trouble because the night staff were em when you found out whoever was on on night staff you were basically terrified. There was some staff who was worse than others and how they treated you and at that age and em especially with me having the tourettes so bad for, from I was 11 and there was a lot of staff who wouldn't accept my tourettes and em would give me a very bad time like in particular one of the nurses who said I would be locked up for the rest of my life and because you hear it so many times and you were living there and coming in and out in different occasions like different admissions and em you began to believe it. It was basically drummed into you and then you'd have nurses shouting at you and em door slamming em em also I remember what they called em a red card was em if you had any thoughts of self harming or feeling suicidal you were put on what was called em close observation. Which means that you had to tell a nurse everywhere you were going, wherever you were going and a red card meant that em you were on 24 hour supervision which meant a nurse went with you everywhere you went and em they were the worst to be on because em you would have no privacy whatsoever and it was worst at night time because the male staff would come into the toilets with you, come into the shower with you em I distinctly remember the office upstairs in, on the, up in the bedrooms there was a two way screen and I distinctly remember there was a bed in the room, there was no locker, it was just one of the observation rooms and it had two way screen and I remember em I don't, a know a lot of times em I was in the bedroom and there was a built in wardrobe. There was only a build in wardrobe and a bed in the room and a two way screen and I remember lots, on lots of occasions [redacted] behind the two way screen watched me getting dressed and undressed. So one morning I was so terrified of getting undressed because I could see him watching through the two way screen cause you could see the figure and you could see basically see once the light was on you could see through the two way screen. So I actually got into the wardrobe, I actually got myself into the wardrobe and got dressed and undressed in the wardrobe cause you were terrified.

Is a two way screen like a partition is it I'm not sure?

TRANSCRIPTION OF: LS 69

LS 69 It's like em a two way mirror.

Two way mirror type screen.

Right?

LS 69 Where the people would be behind the screen and they could see into the room but you couldn't see out.

Okay?

LS 69 You couldn't see through it but if you put the light on you could see shadows and people moving behind it.

Okay right and the idea of this was that staff could monitor you?

LS 69 Yeah.

In your room?

LS 69 Yeah.

Right okay and you believe that LS 79 that's one of the staff members he was watching you getting changed and unchanged?

LS 69 I could see him because the light was on.

Okay?

LS 69 Because when the light was off then you couldn't see through the two way screen.

Right did he ever speak to you, did he ever say anything to you?

LS 69 No.

Okay did you ever say to anybody that you objected to him watching you?

LS 69 Em there was a particular time em [redacted] was the Charge Nurse at the time in Forster Green and he had lots of meetings with all of the older children at night time, sometimes when he was on duty and I happened to he said does anybody want to bring anything up or talk about it and I basically said I would like to bring something up and I'd said about, I said about em Harry walking into the rooms without knocking when you were getting dressed and undressed and coming into the rooms and immediately as soon as I said those words the galder he let out of him at me how dare you, how dare I mention a member of staff's name without any evidence or any proof of anything happening and how dare I say something like that without any proof you know basically and I got yelled at and I just broke down in tears. I was basically trying to say to him that there was people coming in and out of the rooms without knocking, they were getting undressed

trying to tell him what was happening and I got told off and yelled at so badly that I broke down. So then em we were all told to make a sign for our doors, please knock before you enter. So everybody made a sign for their door, it didn't make any difference em staff still came in, LS 79 still came into the rooms em and still carried on so I didn't want to say anything again because of the first time the reaction with [redacted] first reaction to that so I knew I was wouldn't get any help because I was so terrified the first time that I'd said anything.

Okay so what you're saying em there's times whenever your tourettes were very bad and eh you were in your own room, the door was closed it was night and you're too scared to go to the toilet and you would have used the waste paper basket in your room to go to the toilet in?

LS 69

Yeah.

And then you've also said that em whenever you had a red card basically and you were monitored 24/7 and one of the members of staff he would have been looking at you getting changed and unchanged and then you said you brought this to the attention of the?

LS 69

Charge Nurse at the time.

Charge Nurse is that one of the bosses the Charge Nurse?

LS 69

Yeah.

And he shouted at you for mentioning a member of his staff without any proof or evidence is that right?

LS 69

Yeah.

Okay em can you think of anything else then in Forster Green that's annoyed you?

LS 69

Em there em there were lots of times when, when LS 79 would spend a lot, then one of the nurses would spend a lot of time in the girls bedrooms.

Uh huh?

LS 69

Em like it would be lights out maybe half nine, I can't remember whether it was 10 or half nine but em he could be in the bedrooms for hours. You're talking maybe 2 hours and I couldn't understand how he could be in the bedrooms for two hours whenever body else was lights out and the other staff members didn't say anything.

So was he in your own room for 2 hours maybe at a time, your own bedroom?

LS 69

No.

Not your room?

[redacted] No.

Em how would you be aware that he was in other rooms? Is it the case you all talked about it?

[redacted] Em

Other patients?

[redacted] It sort of depended on what, on what part of the corridor you were on. If you were at the front you would see him going up the corridor and he wouldn't come back down.

Right?

[redacted] Or em sorry it's hard to explain just at the moment why?

You're okay?

[redacted] I can't really remember.

I'm just thinking em the doors would they have been em solid doors or could, would there be glass in them so you could see through?

[redacted] No they were solid doors.

Solid doors?

[redacted] Yeah.

And you've mentioned that the doors em were closed at night would that be right?

[redacted] No the doors were open but if you were noisy sometimes the doors were closed tight.

Okay right so obviously then on the times that the door was open you could see out?

[redacted] Yeah.

And to see people going up and down the corridor?

[redacted] Yeah.

Okay and that was [redacted]

[redacted]

Or [redacted] okay. Em he was also at Lissue wasn't he?

OCD-19-(75pg LS 69

TRANSCRIPTION OF: LS 69

LS 69 Yeah.

Didn't he transfer with them?

LS 69 Yeah.

Was he a permanent night shift worker?

LS 69 Yeah.

He was?

LS 69 Yeah.

Okay how did you get on with him?

LS 69 Em fine.

Good?

LS 69 Fine.

So you'd no problems with him at all?

LS 69 No he, he always used to call me

LS 69 His pet name for me.

Why's that?

LS 69 I don't know that's just what he always called me.

So em you're in bed for half nine, 10 'clock and then lights out and that was you sort of right through until 8 o'clock?

LS 69 Till em.

Next morning?

LS 69 Till about ten past seven the next morning some of us got up earlier than others em, em there was reasons why some of us got up earlier than others because em myself and got up earlier em would have been up from about half six in the morning and I would be up about seven because em we both had problems with bedwetting and would always waken earlier than anybody else even earlier than me cause the beds had to stripped and you'd have to have a shower and everything but em I didn't. I didn't realise for a long time even in Lissue I didn't realise that was up so early in the morning but it was always Harry that wakened He always seemed to be on duty when she was up earlier and em because room was absolutely perfect there wasn't one thing out of

place and the beds were made completely to perfection and I would get up about ten past seven and there would be no sounds of anything wrong in the room. There would be no reason you know when I would get up she would be dressed and everything and em when you would get up in the morning em he would be in and out of the bathrooms and stuff and the showers and the baths.

And do think something happened t

LS 69 Yeah.

Did she say anything to you?

LS 69 It wasn't just her it was em she never said anything directly to me but I could tell there was something wrong.

Okay?

LS 69 And not just her but a few other girls as well.

Well if you have a feeling that something wasn't just right with and some of the other girls did anything happen to you?

LS 69 No.

Okay but you just had a feeling about and the other girls?

LS 69 Yeah.

Okay and can you remember when, in your last period of time was at?

LS 69 Pardon.

Can you remember your last time there at Forster Green?

LS 69 Em I remember eh I was 16, I was just going, it was just before my 16th birthday and em speaking to the social workers em I can't remember his name at the time, he had ginger hair and one day he called me to a meeting to speak to him and he told me that em when I left hospital the best thing for me to do was to move into a hostel because em my parents didn't want me home any more and em because they were too old to look after me and em I was too much hassle for them with the tourettes and eh he told me that they didn't love me any more and they wanted for the best for me they wanted me to move into a hostel and em basically not see them again?

And so I've got this right this is a social worked told you this?

LS 69 Yeah.

About your parents okay?

TRANSCRIPTION OF: [redacted]

[redacted]

And my dad came up em a few days later I remember it was a, it was a Friday and I sat on the bench outside in Forster Green with my daddy and I told him what he said and my daddy started to cry and em he said, he said to me [redacted] do you really think that your mum and I don't love you and we would want anything like that for you and I says daddy well that's what he said so I began to believe it and my daddy said to me do you believe what he said and I had to turn round and say to my daddy I don't know I'm not sure and em my daddy sat and he cried and that, then I was 16 two days later and that was the only time in my life I seen my daddy cry.

And is that your last memory then of Forster Green?

[redacted]

That would be the last thing yeah.

Okay?

[redacted]

I think there's a few other things that we just in the notes basically a few things from Forster Green.

Do you want to have a wee look at those again Mary?

Sure?

What I'm going to do I'm just conscious of the time?

Do you want to check the tape?

I'm just going to make sure the tape changes over so do you want to have a wee quick read over those and then?

Okay yeah?

I think that should turn in another 4 minutes.

I'm just checking through [redacted] what you've just told us em and if there's anything else that you haven't spoken about okay. Em okay everything on that sheet, that's the same sheet photocopied twice because. The only thing on this sheet [redacted] is em in [redacted] and [redacted] and can remember falling out with [redacted] and arguing because [redacted] thought that I was being dislodged?

[redacted]

Discharged.

Discharged and she said she was afraid to be left on her own so it's better for her to be friends with [redacted] and spend all her time with her rather than me because she said she would be afraid to be left on her own because she knew I was leaving em rather than us being friends she fell out with me and spent all her time with [redacted] so as she would not be alone because [redacted] would still be in hospital/

[redacted]

That's right yeah.

TRANSCRIPTION OF: LS 69

Okay that's everything that says about Forster Green and everything else on those sheets you've talked about , LS 69

LS 69 Okay.

So is that some sort of fall out you had with Joanne?

LS 69 Em it wasn't so much a fall out it was more so that em I told that I was leaving, that there was some discussion that I was being discharged.

Yeah?

LS 69 And em Vivien was there in Forster Green and there was another girl called Joanne was there at the same time.

Can you remember her other name?

LS 69 and em we were all friends but when I arrived were already there and they were good friends and then I arrived and we were all you know, all friends but then there was after a while of me being there em, em I wasn't going to be as long there as what I'd expected to be so I kinda said to you know I wasn't going to be there as long and she said to me eh one day that I know you're going to be discharged but it's better for me if I stay friends with

Yeah?

LS 69 Because I know that you're leaving and going to be here and I have to be friends with because I'll end up getting left here on my own because not getting discharged so I don't want to be left here on my own so it's better if I be, I'm sorry , LS 69 but it's better if I be friends with than be friends with you because she didn't want to be left on her own.

Okay that's understandable. I take it she was a long term patient was she?

LS 69 Yeah.

Right. Mary was there anything else from reading those?

No.

No okay so really from what you're saying then Forster Green em you'd quite at the time and they would have closed you, they would put you in your room, closed the door because you were noisy basically and you were frightened to go to the toilet so you used the toilet or you used waste paper basket as a toilet and emptied it the following morning out the window and you've said about getting changed and how uncomfortable that made you feel with the two way screen people could see you and you've talked about em going

up the corridor for quite a period of time and how you found that strange and he was the permanent night shift worker?

LS 69 Yeah.

Yeah and then you've mentioned about they were bonding as a relationship because you were being discharged and I just hear that buzzing next door, I'm just going to check with the tape, I'll just be with you one minute I do apologise.

Takes me a while to catch up with?

LS 69 There's another part that I remembered.

Have a look at those LS 69

LS 69 Pardon.

You have a wee look, read through those?

LS 69 That part there.

Oh right down the side of the page okay.

Okay apologise about that, that seems to be having a difficulties with one of the tapes but em I think we're okay now. Did you have a wee read over that?

LS 69 Yeah.

Is there anything else you wanted to say about it?

LS 69 Em there was another incident that I remember just looking back at my notes em it was eh the first time that I took an overdose of medication. I was 13 and em, eh I was very stressed and I had to go to the hospital to get my stomach pumped.

This Forster Green?

LS 69 Yeah and em I was in em hospital for 2 days and I came back to the ward 2 days later and as soon as I came back to Forster Green I was taken straight upstairs to the bedroom, excuse me, by 2 other staff eh and basically em I had hid the packets of the tablets that I had taken I hid the boxes and stuff so as you know they wouldn't find them but they were empty cause the ones I had taken and em eh they said to me they wanted, first of all they told me that the room had to be searched because em they said that em I was, I was saving tablets and selling them to other children in the ward and my room had to be searched and I was asked I don't know how many times where were the tablets and I said I don't have any tablets. I just said I have the ones that I took and they said well that's not what we've been told, so they told me that em this was around, it must have been around 3 o'clock, quarter past three some days the kids

would go swimming after school, usually on a Wednesday and [redacted] anc [redacted] old me that if I didn't tell where the rest of the tablets were or show them that em the kids wouldn't get swimming and that I, they would tell the kids it was my fault that they wouldn't get to swimming. So they searched everything in the room, they took every single thing out of the wardrobe, every single thing out of the drawer. I was very weak after the overdose em, had a lot of side affects to the medication that I took em I was very tired, very weak, they took everything out of the wardrobes, stripped the bed, emptied all the cupboards, emptied every single bag out and kept saying to me we want the tablets, they went through absolutely everything in my stuff. Em they were searching and tearing the room apart for the tablets, clothes everywhere. The room was like a bomb site. Em they wouldn't let me rest or lie down or anything and then when they never found any tablets I was then ordered to pick every single thing back up again, fold it and put it back in the wardrobes and the drawers and everything and I wasn't allowed to lie down or sit down. I just wrote down and ordered me to clean the room spotless or no swimming for kids so.

Okay thank you for that. Mary is there anything at this stage from yourself?

No sorry I missed that [redacted] LS 69 on the sheet?

[redacted] LS 69

Oh you're okay.

Sorry I missed that. No. [redacted] LS 69 s there anything else that you need to tell us about your experience at Lissue or Forster Green that you think it's important or crucial that we would know about. You've told us a lot about your experience at both places?

[redacted] LS 69

Can't think just the moment of.

It's okay no problem at all. Now em obviously I photocopied the note that you made there em could I maybe get you to just sign each page em to say that is a copy of your original note. Could you just each page there, can I borrow this pen?

Yeah.

Thank you, just anywhere at all it doesn't really matter. And there's two pages very similar except one hasn't got the top on, so if you wouldn't mind signing both of them. Thank you. Great thank you. I'm conscious of time it's nearly an hour and three quarters since we actually first started this. Than you very much. Em and just from what Mary said there she asked you is there anything else that you wanted to say to us but you've intimated there's nothing at the minute anyway else?

[redacted] LS 69

I just can't think of anything.

That's okay. Have you any plans for the rest, we'll not talk about any

of that now then. Any plans for the rest today, go out and enjoy the rest of the nice weather cause it's been lovely hasn't it?

[redacted] Yeah.

The last time we were talking to you there was a possibility that you were going to get em your own place is that right?

[redacted] Yeah.

Is that still on the cards, is it still possible?

[redacted] Yeah.

Are you anyway closer to that?

[redacted] Just found that one the flats is has damp at the moment so.

Oh right?

[redacted] So it needs to get damp proof.

Damp proof?

[redacted] To get down a new floor to be put down.

Oh right so that will take a wee while?

[redacted] So, yeah.

Are you expecting what the next month or two then?

[redacted] Yeah.

Yeah that would be good. I'm sure you're looking forward to it?

[redacted] Yeah.

Is that a one bed roomed flat you'll be getting or?

[redacted] Yeah.

Yeah brilliant, brilliant. Okay well eh the time on my watch is 1620 hours, twenty past four so are you happy enough we finish for today anyway?

[redacted] Yeah.

And then we'll go and have a wee chat?

[redacted] Yeah.

Okay I'll just go next door and turn off those tapes. Thank you.

OCD-19-(75pg [redacted]

TRANSCRIPTION OF: [redacted]

I'll get your, I was going to say strimmer. Open the door for you.

OCD-19-(75pg [LS 69]

STATEMENT OF WITNESS

STATEMENT OF: Paul McConnell (*Name*) Detective Constable (*Rank*)

AGE OF WITNESS *(If over 18 enter "over 18"):* Over 18

To be completed when the statement has been written

I declare that this statement consisting of 2 pages, each signed by me is true to the best of my knowledge and belief and I make it knowing that, if it is tendered in evidence at a preliminary enquiry or at the trial of any person, I shall be liable to prosecution if I have wilfully stated in it anything which I know to be false or do not believe to be true.

Dated this 1st day of March 2009

A Dempsey

SIGNATURE OF MEMBER *by whom statement was recorded or received*

AJE DEMPSEY.

PRINT NAME IN CAPS

Paul McConnell

SIGNATURE OF WITNESS

Paul McConnell

I am a Detective Constable in the Police Service of Northern Ireland currently attached to the Public Protection Unit, Child Abuse Investigation Unit based at Antrim PSNI station. I am a trained specialist interviewer under Achieving Best Evidence in Criminal Proceedings (Northern Ireland). On 23rd May 2008 I was lead interviewer during the interview of [LS 69] Mary O'Brien was second interviewer. The interview commenced at 1524 hours and terminated at 1711 hours and took place at Garnerville Care Suite, Belfast. The interview suite consists of an interview room with an adjacent control room, which contains recording and monitoring equipment. The equipment used is the NEAL 4000 DRD Interview Recorder, which is purpose built and compatible with the requirements of guidance under the Criminal Evidence (NI) Order 1999 Achieving Best Evidence in Criminal Proceedings, but has no rewind/playback facility. There are two wall mounted cameras used, one providing a fixed panoramic range of the room using a moveable picture facility. The main image is provided by the other camera, which is adjustable and has a zoom pan tilt facility. Button microphones are fitted to the wall/ceiling. An additional standing/clip on microphone was used to enhance sound quality. The equipment produced two identical audio/DVDr copies and one audio taped copy of the interview. At the end of the interview I sealed the DVD marked master copy with tape seal serial number 98-07-DVDr-1658 and marked item

SIGNATURE OF WITNESS: Paul McConnell

Paul McConnell

STATEMENT OF: Paul McConnell

PMcC1. On 3rd June 2008 I again was lead interviewer during the interview of LS 69 LS 69 ,while Mary O'Brien was second interviewer. The interview commenced at 1435 hours and terminated at 1620 hours and took place at Garnerville Care Suite, Belfast. At the end of the interview I sealed the DVD marked master copy with tape seal serial number 98-07-DVDr-1659 and marked item PMcC2. On 27th October 2008 I was lead interviewer during the interview of Thomas Moran, DOB 28/10/86, while Mary O'Brien was second interviewer. The interview suite consists of an interview room with an adjacent control room, which contains recording and monitoring equipment. The equipment used is the NEAL 3000 Video Interview Recorder, which is purpose built and compatible with the requirements of guidance under the Criminal Evidence (NI) Order 1999 Achieving Best Evidence in Criminal Proceedings, but has no rewind/playback facility. There are two wall mounted cameras used, one providing a fixed panoramic range of the room using a moveable picture facility. The main image is provided by the other camera, which is adjustable and has a zoom pan tilt facility. Button microphones are fitted to the wall/ceiling. An additional standing/clip on microphone was used to enhance sound quality. The equipment produced two identical audio/video copies and one audio taped copy of the interview. The interview commenced at 1124 hours and terminated at 1158 hours and took place at Garnerville Care Suite, Belfast. At the end of the interview I sealed the Video marked master copy with tape seal serial number 05560 and marked item PMcC3. I later had a transcript of LS 69 ABE interview on 23/05/08 transcribed. This I have marked with identification mark PMcC4. I later had a transcript of LS 69 ABE interview on 3rd June transcribed. This is have marked with the identification mark PMcC5.

SIGNATURE OF WITNESS Paul McConnell

Paul McConnell

OCD-19-(75pg LS 69 Page 1 of 2

STATEMENT OF WITNESS

STATEMENT OF: Mary O'Brien
Name *Rank*

AGE OF WITNESS *(If over 18 enter "over 18"):* Over 18

To be completed when the statement has been written

I declare that this statement consisting of 2 page, signed by me is true to the best of my knowledge and belief and I make it knowing that, if it is tendered in evidence at a preliminary enquiry or at the trial of any person, I shall be liable to prosecution if I have wilfully stated in it anything which I know to be false or do not believe to be true.

Dated this 22nd day of October 2008

Paul McConnell
SIGNATURE OF MEMBER *by whom statement was recorded or received*

PAUL MCCONNELL
PRINT NAME IN CAPS

SIGNATURE OF WITNESS

Mary O'Brien

I am a Assistant Service Manager, Community Mental Health Teams based at the Everton Complex, Belfast. I am a trained specialist interviewer under Achieving Best Evidence in Criminal Proceedings (Northern Ireland). On Monday 27th October 2008 I was second video interviewer during the interview of Thomas Moran, DOB 17/01/77, Detective Constable McConnell was First interviewer. The interview commenced at 1124 hours and terminated at 1158 hours and took place at Garnerville Care Suite, Belfast. No other persons were present in the room during the interview.. The interview suite consists of an interview room with an adjacent control room, which contains recording and monitoring equipment. The equipment used is the NEAL 3000 Video Interview Recorder, which is purpose built and compatible with the requirements of guidance under the Criminal Evidence (NI) Order 1999 Achieving Best Evidence in Criminal Proceedings, but has no rewind/playback facility. There are two wall mounted cameras used, one providing a fixed panoramic range of the room using a moveable picture facility. The main image is provided by the other camera, which is adjustable and has a zoom pan tilt facility. Button microphones are fitted to the wall/ceiling. An additional standing/clip on microphone was used to enhance sound quality. The equipment produced two identical audio/video copies and one audio taped copy of the interview. At the end of

SIGNATURE OF WITNESS:

Mary O'Brien

STATEMENT OF: Mary O'Brien

the interview D/C McConnell sealed the video marked master copy with tape seal serial number 98-07-05560 and marked item PMcC3.

SIGNATURE OF WITNESS

Mary O'Brien

Operator	Date	Log
P016558	28-02-2008 15:21:00	Data for 28/02/08
P016558	28-02-2008 15:21:00	NO ATTENDANCE REQUIRED
P016558	28-02-2008 15:21:42	OFFICER ASSIGNED DATA ADDED.
P016558	28-02-2008 15:21:43	INCIDENT CLOSED

CC2008022800641

OCD-19-(75pg [redacted]

Prosecutorial Decision for
[redacted]

Decision Type
No prosecution

Reason
1

Comments
I NOTE FROM THE POLICE OUTLINE OF CASE THAT POLICE ENQUIRIES HAVE ESTABLISHED THAT THE ACCUSED WAS NEVER IN LISSUE HOSPITAL AT A TIME WHEN BOTH [redacted] AND [redacted] WERE ALSO THERE. IN THE CIRCUMSTANCES, THERE IS NO REASONABLE PROSPECT OF OBTAINING A CONVICTION.

Made By
Phone: 028 9262 5474

Causeway #: 436537202 | 29/09/2009

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 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

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Belfast Health and Social Care Trust

Investigation Report into Allegations made by JH against [redacted]

LS 79

Investigating Officers:

- Anne McClean, Assistant Principal Social Worker
- Geraldine Sweeney, Child Protection Nurse Advisor

This report is the findings of an investigation carried out under the Belfast Health Social Care Trust's Disciplinary Procedure into allegations made by LS 69 a former patient against LS 79 an employee of the Belfast Health and Social Care Trust.

Nature of the Compliant

LS 69 who had been in Lissue Hospital and Forster Green Hospital between 1987 and 1991 made historic allegations against LS 79 an employee of the Belfast Health and Social Care Trust. These allegations were made during an admission to the Psychiatry Unit, Mater Hospital in February 2008. LS 69 made a formal compliant to the Police and completed Vulnerable Adult Interviews. While the PSNI have decided not to proceed with a criminal investigation at this stage, the Trust are required to investigate these allegations under its Disciplinary Procedure.

Timeline of admissions of LS 69

Hospital	Status	Admission Date	Discharge date	Length of admission
Lissue	Inpatient	23.03.87	27.03.87	4 days
Lissue	Inpatient	17.09.87	24.09.87	7 days
Lissue	Day Patient	23.10.87	06.11.87	14 days
Lissue	Inpatient	09.02.88	31.03.88	51 days
Forster Green	Inpatient	20.07.89	Transferred to inpatient	22 days
Forster Green	Day Patient	12.08.89	Transferred to inpatient	29 days
Forster Green	Inpatient	11.09.90	09.02.90	151 days
Forster Green	Day Patient	20.08.90	24.08.90	4 days
Forster Green	Inpatient	30.04.91	17.05.91	17 days

On 23rd of May 2008 and 3rd of June 2008 LS 69 outlined her allegations during Joint Protocol / Vulnerable Adult interviews that LS 79

- watched her dressing and undressing through a dormitory window and that she tried to avoid this by, on occasions, getting dressed and undressed in a wardrobe
- watched her bathing
- encouraged her to sit on his knee and would then stroke her hair
- spent an inappropriate amount of time with [redacted] n the pool room following which [redacted] would return to other parts of the Unit in a distressed/upset state"

On the 13th of June 2007 as a result of these allegations LS was informed by Mr Rodney Morton, CAMHS Manager of the Trust's need to investigate these issues. This is in line with Co-operating to Safeguard (DHSSPS 2003) section 6.16 'Where an allegation or suspicion of abuse arises involving a member of staff, employers should consider whether action is necessary to ensure that person does not have unsupervised access to children during the course of the investigation. In some cases where it is concluded that the staff member should be prevented from having access to children, it may be possible to find alternatives duties for him.'
LS 79 was offered alternative work however since this date LS 79 has been on sick leave.

Terms of Reference for the Investigation

1. To investigate allegations recently made by LS 69 relating to the period 1987 to 1991 when LS 69 was an inpatient at the Child & Family Centre and to report accordingly. These allegations are that LS 79

   - watched her dressing and undressing through a dormitory window and that she tried to avoid this by, on occasions, getting dressed and undressed in a wardrobe
   - watched her bathing
   - encouraged her to sit on his knee and would then stroke her hair
   - spent an inappropriate amount of time with [redacted] in the pool room following which [redacted] would return to other parts of the Unit in a distressed/upset state"

2. To immediately report to the Trust any other matter of concern which arises during the course of the investigation into the allegations referred to above.
3. To immediately report to the Trust any matter which may undermine the objectivity or robustness of the investigation
4. To recommend what action, if any, should be taken into matters investigated.

The Investigation Team will, if required, have access to all policies and procedures which applied to the Unit during this period and will also have access, if required, to client and staff files.

Files Reviewed

- Medical, Nursing, Psychology and Lindsay School Records – LS 69
- Medical, Nursing, Family Therapy and Lindsay School Records – [redacted]
- Staff File – LS 79 which contained details of previous investigations into incidents, allegations and complaints made against LS 79 Induction & appraisal records, sickness records,
- Records of two Joint Protocol Interviews held on the 23rd of May 2008 and 3rd of June 2008 with LS 69

Policies relevant to nursing care in the Period 1987 until 1991

- Child Protection Procedures
- Lissue and Forster Green' s Operational Policies relating to the day to day functioning of the Units
- Intimate Care Policy for Lissue and Forster Green
- Staff Supervision Policies
- Code of Professional Conduct UKCC 1984 – for the Nurse, Midwife and Health Visitor

We contacted Jim Livingstone, South Eastern Trust and Jacquie Wilson, Nursing Manager, Minnowburn to access the above policies but were advised they were not available.

Despite extensive searches the investigation team were only able to identify three documents pertaining to the period in question. These were:

- Co-operating to Protect (DHSS 1989)
- Code of Professional Conduct UKCC 1984 – for the Nurse, Midwife and Health Visitor
- Child Protection Policy and Procedures (EHSSB May 1991)

Interviews

Having reviewed the records it was decided to interview [LS 69] and [LS 79] in relation to the allegations. These were arranged as follows:
[LS 69] - 3rd of October 2008, Woodstock Lodge
[LS 79] - 7th of October 2008, Woodstock Lodge

[LS 69] Interview
On the 3rd of October [LS 69] decided that she did not wish to present for interview. Mary O'Brien, Assistant Service Manager for Community Mental Health Services met with [LS 69] to encourage her to attend the interview. However [LS 69] decided she was unable to attend at this point in time. The investigating officers advised Mary O'Brien, Assistant Service Manager for Community Mental Health Services should [LS 69] wish to be interviewed before the end of the investigation that this could be arranged.

We decided that it would be prudent to write to [LS 69] and offer her another opportunity to meet ourselves to discuss her concerns. A letter was sent to her on 24thOct 08, however on writing this report we have had no response.

HL Interview
On the 7th of October 2008 [LS 71] presented for interview with his professional association representative, Ms Laurie Jones.
Ms McClean outlined the purpose of the interview. [LS 79] indicated that he understood the purpose of the interview. A copy of the Terms of Reference was given to [LS 79] and
[LS 79] was first asked to give a response to each of the allegations.

- **Watched [LS 69] dressing and undressing through a dormitory window and that she tried to avoid this by, on occasions, getting dressed and undressed in a wardrobe.** [LS 79] denied this allegation. [LS 79] reported that his time was spent mostly with the boys upstairs. May

McManus was the nurse manager at that time and she placed the male staff with the boys upstairs and female staff with the girls downstairs. He described this allegation as 'alien'.

- **Watched LS bathing.** LS denied this allegation. HL described the layout of the toilets and bathrooms of the two hospitals. He reported that in Lissue the bathroom was downstairs at the end of a corridor while in Forster Green there were 2 rooms and that to get to the shower area you had to go though the room with the wash hand basins and toilets. He went on to say that 'no way would we have supervised females showering'.
- **Encouraged L to sit on his knee and would then stroke her hair.** (b) (8) reported that this 'Never happened' and stated that 'the late May McManus would never allow this happen'. He said that on occasions '4 to 5 year olds may have jumped on your knee and you may have played with them'
- **Spent an inappropriate amount of time wit[redacted]n the pool room following which [redacted] ould return to other parts of the Unit in a distressed/upset state.**
  LS 79 denied this allegation. LS 79 reported that he got on well with [redacted] He distinctly remembered [redacted] and that spent a lot of time with her when she was on special observations. He would have sat in the corridor and talked into her. LS 79 went on that say at that time there was a strict regime for children with anorexia. If they did not maintain their weight they would be put on bed rest. He recalls that [redacted] would have been distressed if she did not put on the required amount of weight. With regard to the poolroom he stated that in Forster Green Hospital the poolroom was inside while in Lissue Hospital the poolroom was outside. He reported that the boys were mostly in the poolroom but that he could not recall i[redacted]vas there or not.

The interview went on to clarify the regimes on the ward at that time. LS 79 reported there was a tough and tight regime in those days. He said there were a lot of children in hospital with social problems and that it was possible that

they were wrongly placed. There were no set rules for managing the children's behaviour.
HL felt that there was an issue regarding use of restraint. He reported that staff were not trained in the use of restraint and that there was not a consistent approach it. Although he indicated that staff were not provided with training he had accessed training in this area.

The interview went on to enquire if LS 79 was aware of any reasons why LS 69 might have made these allegations.
LS 79 reported that he was not aware of any issues with LS 69 and that the only reason he remembered her was because of her Tourette syndrome. He recalled that the first time he met LS 69 was when he came on night duty he heard what he thought was a dog barking but then realised it was LS 69 who had just been admitted. He went on to say that he did not have any rows with LS 69

When asked if it was routine practice that male staff supervised female patients during personal care LS 79 reported that this was not routine practice. He went on to say that male staff were not involved in the intimate care of female patients. The female staff stayed downstairs with females.
LS 79 was not aware of any written policy on intimate care. He reported that there was a 'Common sense policy'. If a female child was on special observation and they needed to use the bathroom a female member of staff would have been called to accompany them to the bathroom.
LS 79 was aware, once reminded, of the UKCC Code of Conduct for Nurses, Midwives and Health Visitors (1984), which was in place at that time. This Code was issued by the United Kingdom Central Council (UKCC) for Nursing, Midwifery and Health Visiting. It required that these professions would practise and conduct themselves within the standards and framework provided by the Code.

On discussion of the care regime for a patient such as LS 69 LS 79 reported that he mostly worked on night duty and he was not so aware of the daytime regime. The children would get up at 7.30am and went to bed at 9.30pm. He had no recollection of LS 69 shouting at night or that the Tourette syndrome affected her

sleeping. In [LS 69] joint protocol interview records (page 17) on the 3rd of June 2008 she reported that ' when everybody was in bed at night, everyone had to be in bed by I think it was about half nine and lights were out and because I was quite noisy with my Tourettes it would have, the staff would have shouted alot at me and you know things would have been said like if you don't stop making that stupid noise you'll be locked away for the rest of your life'.

In relation to [LS 79] knowledge of child protection procedures at that time, he reported that he did not remember any procedures. He described working in this area as 'cold turkey into child psychiatry' 'using common sense','steep learning curve' and with 'no induction'.

When asked if he had any concerns about the care regime provided to the children at the time in question. HL again stated that he felt some of the children were not in an appropriate setting and practice was very different then. There was not a common approach to the use of restraint.
[LS 79] reported that each child had care plan but did not elaborate on the details.
[LS 79] reported that on occasions he did challenge aspects of the tough regime within the unit but at that time there were a number of powerful individuals who persisted with the established custom and practice.

[LS 79] was asked if he wanted to provide the names of any staff members who witnessed his practice at that time and who could corroborate his version of events. He indicated that most people are retired and in their eighties. He felt that he could not make this request of the one staff member who is still working as he felt it would cause her undue distress. In relation to the allegations he stated that 'it will be her word against mine'.
At the end of the interview [LS 79] was advised to avail of the support of Staff Care Services and his Professional Association Representative for support at this difficult time.

Staff Interviews

Following the interview with LS 79 we felt it would be important to interview other staff who were working in Lissue and Forster Green Units during the period 1987 until 1991. In the absence of having access to relevant policies and procedures, the purpose of these interviews was to attempt to establish the care regime at that time. We made contact with [redacted] current manager of Minnowburn, and requested to interview herself and any other staff member she could identify as having worked in the Units during the time in question.

On the 3rd of November 2008 we interviewed the following

- Jacquie Wilson, Manager, Minnowburn
- Eleeze McKay, Staff Nurse
- Linda McCaugherty, Staff Nurse
- Chryl Howie, Nurse Team Leader

The key themes identified from these interviews were:

The nature and number of the children admitted to the units - the staff interviewed all identified that the criteria for admission was different then, in that children with behavioural and social problems were admitted to the units. Supervision and control of these children was problematic due to their presenting problem and the number of these children present in the Unit. The issue of restraint was considered to be difficult.

Care Regime.

The staff identified a "Philosophy of Care." and " the welfare of the child is paramount" principle in their management of the children. They identified the Children's Charter and the need to respect the dignity of the child. Each child had an individual care plan and there were daily structured activities for the children. In relation to intimate care staff indicated that female staff would have supervised females and that this would not have been considered as a

role for male staff. They were not aware of any written policy and procedures regarding intimate care.

There were no concerns expressed in relation to the management of the Unit and some staff described a 'homely atmosphere'. Similarly, no concerns were raised in relation to the practice or conduct of any individual staff members.

Awareness of Child Protection Policies and Procedures

All staff indicated a lack of awareness of any formal child protection policies and procedures relevant to the period in question.

Additional Inquiry regarding

Contained in the Terms of Reference is the allegation that LS 79 spent an inappropriate amount of time with n the pool room following which would return to other parts of the Unit in a distressed/upset state". The Investigation Team have been advised that the police made contact with nd that she had no compliant to make about her care at Lissue other than to say she was shouted at once.

Conclusion

At the time of writing this report the investigating team have been unable to interview LS 69 We are mindful though that she must have felt very aggrieved and that she did pursue a formal complaint, including Joint Protocol Interviews, with the Police.

During interview with LS 79 he categorically denied the substance of the allegations and was unable to identify any witnesses who could corroborate his version of events/practice regime on the ward at that time.

In the absence of any corroborative or independent facts/evidence and any information from any other source to substantiate the allegations and given LS 69 current mental health, the investigating team have found there is no

evidence emerging within the Terms of Reference of our investigation, to support these particular allegations at this time.

However in the course of reviewing the staff file relating to LS 79 and client files relating to LS and a number of issues, which we believe are relevant, have come to light. Namely a number of reported incidents, which are similar in nature, to those allegations made by LS against LS 79 These incidents appear to have been dealt with by management when they occurred. Whilst we acknowledge that these reported incidents are not directly related to the specific allegations levelled at LS 79 by LS we believe that the number and overall pattern of these alleged incidents raise concerns relating to LS 79 general professional practice over a significant period of time.

Also in considering the themes raised by staff during interview on the 3rd of November 2008 it is evident that staff were unaware of clear guidance regarding Operational Policies and Child Protection Procedures at this time. Never the less the Code of Professional Conduct UKCC 1984 – for the Nurse, Midwife and Health Visitor and Co-operating to Protect 1989 was in place and it would be reasonable to expect that staff would have adhered to these Policies and Guidance in relation to the children in their care.

Recommendations

A. Prior to LS 79 returning to his duties in the Unit we would recommend that the Trust Management should:

1. review with LS 79 any training and staff development issues arising from the investigations and ensure that steps are taken to address these. We feel that this should be a phased approach, as this would ensure that his rehabilitation into the work place is managed in a safe and supportive way, affording him adequate protection and direction in resuming his duties.

B. In addition to this we would recommend that the Trust Management should

1. ensure staff ongoing attendance at Child Protection training

2. ensure that staff are aware of the Trust's Intimate Care Policy
3. ensure that staff are fully aware of the procedures for the management of complaints and Child Protection Investigations.

Litigation claims which the Directorate of Legal Services is aware or has had dealings in relation to Lissue

Name	Date of claim	Nature of Claims of Abuse	Identity of Alleged Abuser	OUTCOME
LS 115 [redacted]	15.5.13	That the Plaintiff was assaulted, indecently assaulted, abused and endured inappropriate touching Failure to properly care for the Plaintiff Failed to take any or adequate steps to prevent the Plaintiff from being assaulted, abused or inappropriately touched Failed to take any or adequate steps to prevent the Plaintiff from suffering digital penetration of the anal area Failed to take any or adequate steps to prevent the Plaintiff being force fed That the Plaintiff was neglected and exposed to unnecessary suffering and injury to health Failure to protect the Plaintiff's welfare and ensure his physical well being That the Plaintiff suffered the following personal injuries: 1.Post Traumatic Stress Disorder (PTSD) with the following symptoms: 2.Repeated episodes of trauma in the form of intrusive memories, flashbacks and nightmares 3. Poor sleeping patterns 4. Difficulty controlling bowels and urine 5. A clear history of mood symptoms, including depression 6. Difficulty with alcohol and illicit drug use including a reported overdose in 1997 and an attempted suicide in 2004 Plaintiff diagnosed with an acute distressing adjustment disorder stress reaction.	None given	ongoing

HIA 220 [redacted]	[redacted]	That the Plaintiff was assaulted, threatened, sexually assaulted and raped That the Plaintiff was subjected to repeated assault, battery, trespass and sexual abuse Failure to take any steps to prevent said incidents from taking place Failure to provide adequate care for the Plaintiff Failure to keep the Plaintiff safe and free from harm Failure to investigate staff member complaints Failure to ensure staff were properly and adequately trained and supervised Particulars of assault, battery and trespass: 1. Striking of the Plaintiff 2. Forcing the Plaintiff to eat soap 3. Immersing the Plaintiff in ice-cold baths 4. Rape of the Plaintiff That the Plaintiff suffered the following personal injuries: 1. Post-Traumatic Stress Disorder 2. Depression 3. Suicidal ideation	None given	on-going
LS 116 [redacted]	Statement of claim not yet issued	Abuse by staff members	none given	N/A
DL 435 [redacted]	16.6.14	That the Plaintiff suffered assault, trespass , negligence and false imprisonment Breach of Statutory duty Particulars of assault, battery and trespass:	none given	ongoing

1. Plaintiff was placed in a restraining jacket and helmet
2. Physical restraint of Plaintiff
3. Physical abuse of the Plaintiff by slapping and thrown against walls
4. Psychological and physical abuse of the Plaintiff
5. Failure to justify said behaviour
6. Restraint and imprisonment of the Plaintiff

That the Plaintiff suffered the following negligence:

1. Failure to ensure the Plaintiff's wellbeing
2. Failure to have regard to the psychological welfare of the Plaintiff
3. That the Plaintiff suffered great distress
4. Failure to ensure the home was carried out in a responsible manner
5. Failure to supervise the home either adequately or at all
6. Failure to employ appropriate and adequate staff
7. Failure to have any or adequate regard for the wellbeing of the Plaintiff

Index of documentation relating to the Litigation claims which the Directorate of Legal Services is aware or has had dealings in relation to Lissue

LS 115

1. Letter of claim	25 November 2011
2. Statement of Claim	15 May 2013
3. Psychologist Report by Dr Best	24 August 2013

HIA 220

1. Letter of Claim	24..11.2011
2. Writ of Summons	6 March 2014
3. Statement of Claim	30 March 2015

LS 116

1. Letter of Claim	27 January 2012

DL 435

1. Letter of Claim	4 July 2013
2. Writ of Summons	16 June 2014
3. Statement of Claim	16 June 2014
4. Psychiatric Report by Dr Mangan	12 June 2014
5. Psychiatric Report by Dr Mangan	20 May 2015

LIS-45005

CASEY & CASEY
Solicitors

TEL 028 [illegible] 66214
FAX 028 [illegible]2 60909
DX 2071 NR NEWRY
EMAIL law@caseysolicitors.co.uk
WEBSITE www.caseysolicitors.co.uk

LEGAL HOUSE
25/27 LWR CATHERINE ST
NEWRY
BT35 6BE

Belfast Health & Social Care Trust
Saintfield Road
Belfast
County Antrim BT8 8BH

Your Ref:

Our Ref: GC/L 2614

Date: 25 November 2011

Dear Sir/Madam,

We act on behalf of [redacted] LS 115 who has instructed us to intimate a claim for personal injury, loss and damage arising out of his stay in Lissue House Hospital Lisburn in or about 1984 until 1986 approximately.

According to our client's instructions he was physically and sexually abused by your servants or agents at or about the said location on or about the said dates.

Unless we receive into this office within twenty-one days of the date hereof confirmation that liability is not an issue together with confirmation that you are prepared to compensate our client in respect of his said personal injury, loss and damage, we have instructions to commence legal proceedings against the Trust without further notice.

Yours faithfully,

Casey & Casey

South Eastern [illegible] Risk Management & Corporate
Litigation Actions/Authorisations

File:

Open ☐ Payment/Action agreed: ☐
Close ☐ Authorisation Attached: ☐
Reopen ☐ Countersign Req. ☐

Detail
Comment:

J. McCafferty LSSM
14/12/11

[illegible] CRD, MD, DF, CE)

PARTNERS: SIMON CASEY, GERARD CUNNINGHAM
CONSULTANT: MARGARET CASEY
ASSISTANT SOLICITOR: EDEL CASEY

2013 NO. 51232

IN THE HIGH COURT OF JUSTICE IN NORTHERN IRELAND
QUEEN'S BENCH DIVISION

Between:

[redacted] LS 115

Plaintiff

And

THE REGIONAL HEALTH AND SOCIAL CARE BOARD

Defendant

Writ of Summons issued 15th day of May 2013
By Casey & Casey, Solicitors, Legal House, 25/27 Lower Catherine Street, Newry, County Down, BT35 6BE

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1. [redacted] LS 115

2. The Plaintiff was a resident of Lissue House Hospital from in and about 1984 to in and about 1986. The aforesaid establishment being a Psychiatric Hospital. At all material times from 1984 to 1986 the Plaintiff was under the care, control, supervision and management of the Defendant.

3. Owing to the negligent acts and omissions of the Defendant, its servants and agents in and about the supervision, custody, care and control of the Plaintiff, while under their care as aforesaid, the Plaintiff was bullied, neglected, assaulted, battered and mistreated.

PARTICULARS OF NEGLIGENCE

The Defendant, its servants and agents were negligent in that they;

(a) Failed to properly care for the Plaintiff;
(b) Caused or allowed the Plaintiff to be assaulted;
(c) Caused or allowed the Plaintiff to be abused;
(d) Caused or allowed the Plaintiff to endure inappropriate touching;
(e) Caused or allowed the indecent assault of the Plaintiff;
(f) Failed to take any or adequate steps to prevent the Plaintiff from being assaulted;
(g) Failed to take any or adequate steps to prevent the Plaintiff from being abused;
(h) Failed to take any or adequate steps to prevent the Plaintiff from being inappropriately touched;

(i) Failed to take any or adequate steps to prevent the Plaintiff from suffering digital penetration of his anal area;
(j) Failed to take any or adequate steps to prevent the Plaintiff from being force fed;
(k) Neglected the Plaintiff;
(l) Exposed the Plaintiff to unnecessary suffering;
(m) Exposed the Plaintiff to unnecessary injury to health;
(n) Failed to protect the welfare of the Plaintiff;
(o) Failed to ensure the physical well being of the Plaintiff;
(p) Allowed and or caused the Plaintiff personal injuries;

The Plaintiff will further rely, in proof of the alleged negligence, on such facts as may be known to the Defendant but not to the Plaintiff and as may appear in the evidence of the Defendant and its witnesses at the trial of this action.

4. By reason of the aforesaid acts and omissions of the Defendant, its servants and agents the Plaintiff has suffered and will continue to suffer pain and discomfort and his enjoyment of the amenities of life have and will continue to be adversely effected.

PARTICULARS OF PERSONAL INJURIES

The Plaintiff suffers from Post Traumatic Stress Disorder (PTSD). Over a number of years he has experienced the following symptoms of PTSD:

(i) Repeated episodes of trauma in the form of intrusive memories, flashbacks and nightmares;
(ii) Poor sleeping patterns;
(iii) Difficulty controlling bowels and urine; and
(iv) A clear history of mood symptoms, including depression - has cut himself when in moods of depression and at times has felt suicidal;
(v) Difficulty with alcohol and illicit drug use;

The Plaintiff had a reported overdose in 1997 and attempted hanging in 2004.

The Plaintiff's condition has had, and continues to have, a major impact on his social functioning.

The Plaintiff has been diagnosed as having *an* acute distressing adjustment disorder stress reaction. It led to behavioural difficulties in childhood and early adolescent life. It has contributed to a life-long tendency to depression.

Mr Best concludes that it is his opinion that LS 115 was sexually abused. He was greatly distressed at the time. It contributed to nightmares, bed wetting, soiling and behavioural disturbance.
Full particulars of the Plaintiff's injuries are set out in the following medical report served herewith;

Dr Stephen Best MB Bch MRCPsych, Consultant Psychiatrist, dated 24th August 2013;

AND THE PLAINTIFF CLAIMS DAMAGES AND INTEREST THEREON IN ACCORDANCE WITH SECTION 33A OF THE JUDICATURE (N.I) ACT 1978.

KEVIN MAGILL B.L

BLUESTONE UNIT
Craigavon Area Hospital
68 Lurgan Road
Portadown
Co Armagh
BT63 5QQ

Tel No: 028 38 366794

Your Ref: GC/SC LIT 2440
Our Ref: sb/ag

24 August 2013

Casey & Casey Solicitors
Legal house
25/27 Lower Catherine Street
Newry
BT35 6BE

Confidential Psychiatric Report on

LS 115 LS 115

Date of Interview
5 June 2013

I assessed LS 115 at HMP Maghaberry on the 5 June 2013 at the request of his solicitor. LS 115 has instructed his solicitor to initiate a claim for personal injury and loss and damage against the Belfast Health and Social Care Trust arising out of his stay in Lissue House Hospital, Lisburn in and around 1984 until 1986. LS 115 instructed his solicitor that he was physically and sexually abused by staff members at Lissue Hospital.

I was provided with a copy of LS 115 statement to the police in connection with the matter. I was also supplied with a copy of the computer printout of General Practitioner records including some letters from hospital specialists.

LS 115 LS 115 berry Prison. He was convicted of robbery, burglary, theft and dangerous driving. He has been in prison for 5 years and was due release in the near future.

Description of Abuse

LS 115 claimed that he was sexually abused while placed at Lissue Hospital, Lisburn around the age of 7 or 8. He alleged 3 or 4 staff members, male and female, where involved in the sexual and physical abuse. The abuse took place in the bedroom used by LS 115 as a child. LS 115 was kept in his pyjamas most of the time at Lissue and his mother had complained about this. LS 115 was kept in pyjamas to prevent him from running away.

He described the abuse. Several members of staff would be in the room. Someone stood at the door. He was forced to undress. A member of staff touched his genitalia and at times there was digital penetration of his anal area. This was painful and led to bleeding.

LS 115 recalls being distressed and tearful and being very afraid. "I was afraid at what they might do". There was no oral sexual contact. Some of the abusers exposed themselves or masturbated.

The abuse went on for months and throughout his period at Lissue LS 115 kept trying to run away.

LS 115 was eventually placed with an aunt Kathleen.

LS 115 told me that this father was an alcoholic and his mother had difficulty coping with the children and they were placed with other relatives or in foster care together. He was the second eldest of 3 boys and 4 girls. He appears to have been the only one placed at Lissue Hospital.

Psychological Reaction

LS 115 remembers having difficulty controlling bowels and urine. He soiled himself and wet the bed while staying with his aunt. He also had ongoing behavioural difficulties. "I ended up in a foster home, I was uncontrollable for her, I had nightmares and was squealing the place down". He does not remember the content of the dreams. It frightened him.

LS 115 recalls being very embarrassed by the experience of abuse and never disclosed it until recent years while in prison.

Background Information

Family history - Father died in 2005 at the age of 50 with liver failure. He had been an alcoholic. He had no trade. Mother remains alive aged 56 and a housewife. As mentioned there were 6 siblings. He was not aware of any other family history of mental disorder and is in contact with most of his siblings.

He recalled domestic violence with father's alcoholism. Violence was directed at mother not at the children. He believes they all went into care but he was the only one that went to Lissue Hospital. LS 115 would maintain that there were no difficult behaviours exhibited by him prior to going to Lissue.

Education - He attended ordinary primary school. He continued to attend ordinary schooling when in the care of his aunt Kathleen in Dublin.

LS 115 had some education at Lissue. He attended a school in Dublin while living with his aunt. He then went to secondary school in Belfast Gort Na Mona and eventually St Patrick's Training school between the ages of 12 and 14.

LS 115 lived with his parents until the age of about 8. He then spent time in Lissue. He then lived with his aunt Kathleen. He then spent time with foster parents. He lived with grandparents at the age of 12. He was then in training school and Lisnevin and on release from Lisnevin lived with his mother.

Employment - LS 115 has never been able to hold down employment. He returned to education in prison and has a level 3 qualification in English and maths. He has worked an orderly in the prison setting.

Relationships - LS 115 has a 17 year old daughter [redacted] but has not been in contact for 9 years. The child's mother [redacted] ended their relationship when he was in prison.

LS 115 has a son [redacted] child's mother and ha[redacted] visits with LS 115 current partner [redacted]

Past medical history [redacted] was involved in a serious road traffic accident in 1999. He injured his hip and had a hip replacement. He had fracture to his right leg. He had a lot of surgery. He also has an asthmatic tendency.

Past psychiatric history - [redacted] would report experiencing depression throughout most of his adult life. He has generally been on an antidepressant. They have changed on a number of occasions. He has cut himself when in moods of depression.

[redacted] has not received inpatient treatment but did attend a psychologist and the mental health department at Newry for treatment of depression. He did not disclose sexual abuse until recent months.

Previous traumatic experiences [redacted] was involved in a serious road traffic accident in 1999. He was charged with causing death by dangerous driving and was sentenced to 8 years imprisonment. He has a lot guilt feelings about the accident. Alcohol had been taken.

Alcohol and drugs - [redacted] would admit he does not handle alcohol well. He no longer drinks regularly. He occasionally goes on a binge lasting a night. Occasionally he will have a binge lasting a weekend. He generally drinks spirits. [redacted] has not reported any withdrawal symptoms with alcohol. He does not experience tremors, cravings or hallucinations.

[redacted] did admit to illicit drug use in his youth and in adult life he has tried cocaine and cannabis. He does not inject.

Hobbies and interests - [redacted] enjoys cooking and would like to have employment as a chef.

Criminal record - [redacted] reported his previous criminal record. He broke windows in 1989 and he threw a bottle and broke a car window. There are a lot of driving offences and he has stolen cars. He had been 'drunk in charge' on a number of occasions. He has actually been caught with no insurance driving while disqualified. There are no previous crimes of violence. He most recently was involved in stealing a car while under the influence of alcohol "I was full of drink at the time".

LS 115 would deny behavioural problems at school. He does not recall getting involved in fighting. He remembers throwing paint in the art room. He does not blame his parents for his difficult behaviours.

He was in St Patrick's training school and Lisnevin because he kept running away from his placements wishing to be with his mother. He denies the experience of any abuse in Lisneven or St Patricks training school "I was not aware of it, I knew what to look out for".

Consequences of abuse

LS 115 would claim that the sexual abuse experience did not have a big affect on his appreciation of normal sexual life.

LS 115 decided to disclose his abuse. He was aware that allegations were being made against staff who had worked there. He had been undergoing counselling with the psychologist in the prison service and had not disclosed the abuse at that stage but had undergone an alcohol management course and a drug awareness course. He had hoped to get some counselling qualifications and was determined not to return to alcohol or drug use on release from prison.

Mental State Examination

LS 115 was normal in appearance. There was no abnormality to his dress. There was no evidence of thought disorder, delusional thinking or perceptual disturbance and he was of normal intelligence.

LS 115 mentioned the experience of depressed moods in the past. He has nightmares at times. At times he has felt suicidal but was looking forward to discharge from prison. Sleep was broken but depended on how much he slept during the day. Appetite was normal.

LS 115 ***Statement to the Police 26 January 2012***

The statement corresponded to what LS 115 told me during my interview. He had lived with his parents in Andersonstown two brothers and 3 sisters. Father was a drinker and mother could not cope and the children were taken into care. Others went to family members. He was sent to Lissue Hospital for about a year at the age of 7 or 8. He described being sexually abused by a number of staff, mainly male. He was also physically abused and force fed potatoes. There was emotional abuse. He had few friends.

He was threatened with loss of the privilege of visiting if he did not comply with treatment. There was inappropriate touching. There was also digital penetration of his anal area.

He was too afraid to disclose what was going on. It led to bed wetting on release from Lissue Hospital. He tried to escape on a number of occasions.

General Practitioner Records

There is a computer printout of GP records beginning around 2006. By that stage he was a regular user of antidepressants. Venlafaxine and a mood stabiliser Chlorpromazine. He required Tramadol for pain following the road traffic accident.

He was not a diligent attender at outpatients. There is a letter dated 11 October 2007 following an assessment by the mental health team at Newry presenting with depression and anxiety. The fatal road traffic accident in 1999 was mentioned. In 1996 he was the victim of a punishment beating with multiple fractures in his right leg. Since that attack he has had panic attacks. He was referred to a CPN for counselling.

There was a reported overdose in 1997 and attempted hanging in 2004. It was mentioned that he was admitted to the child and adolescent mental health unit for behaviour problems but could not remember much about it.

His difficulty with alcohol was noted and the bad affect it had on his personality declared. He did admit to some illicit drug use in the past.

He talked about being in care because his mother could not cope. Father had alcohol problems and died of liver failure and heart disease.

LS 115 mentioned depressed mood with periods of poor appetite and low energy and motivation. The diagnosis was one of mild to moderate depression and he was advised to remain on Venlafaxine and Chlorpromazine. He failed to attend for psychology counselling and was eventually discharged around 2007.

Diagnosis

Mental Health problems secondary to Neglect, Physical and Emotional and Sexual Abuse of Childhood.

7

Opinion

LS 115 reports experience of sexual abuse while in care in Lissue hospital back in the mid 80's. I am assuming there is some ongoing investigation into the unit and that LS 115 is not the only one making allegations.

I have no idea as to his behaviour as a child back at the time and whether there were difficult behaviours which highlighted him as a candidate for Lissue when the other brothers and sisters went to family members or foster homes. Certainly Mr LS 115 feels that his difficult behaviours are linked to his enforced time at Lissue.

I have no reason not to believe LS 115 His account is believable. There is no unrealistic detail recalled. Much of it is vague but yet he did not give me the feeling it was a 'false memory'.

I quote from the Oxford Text book of Psychiatry "*early emotional consequences of sexual abuse include anxiety, fear, depression, anger, inappropriate sexual behaviour*". "*Long term effects are said to include depressed mood, low self esteem, self harm difficulties in relationship and sexual mal adjustment*". "*Effects of abuse are generally greater when the abuse has involved physical violence and penetrative intercourse. Some of the long term effects are probably related to the events surrounding the disclosure of the abuse including legal proceedings*".

The dilemma in this case is was LS 115 a difficult child before he went to Lissue? In assessing these long term effects GP remembered that sexual abuse often occurs in families with severe and chronic problems which are likely to have their own adverse long term consequences. Never the less even when these other factors are controlled for, sexual abuse in childhood seems to be associated with psychiatric disorder in adult life especially with depressive disorders".

It is my opinion that LS 115 was sexually abused. He was greatly distressed by it at the time. It contributed to nightmares, bed wetting, soiling and behavioural disturbance.

I am of the opinion that much of his behavioural disturbance is also due to the break up of the family witnessing the results of the domestic violence.

Research would show that many of the victims of sexual abuse in childhood will suffer from post traumatic stress disorder 82%, alcoholism 21%, mood related disorders 25%, a third have chronic sexual problems and over half have a history of criminal behaviour.

If LS 115 was indeed sexually abused and I believe he was it wasn't the most serious of abuse but was deeply distressing for such an isolated young child. I feel that it is likely to have caused his tendency to depression.

I am uneasy about blaming all of his anti social behaviour over the years on the sexual abuse. It is more likely to be due to the chaotic family that he came from and the poor example set by his parents.

So in summary I believe this man went through an acute distressing 'adjustment disorder' stress reaction. It led to behavioural difficulties in childhood and early adolescent life. It has contributed to a lifelong tendency to depression.

I would not go as far as saying that all of LS 115 personality difficulties are caused by this abuse. I feel that the bigger influence on his inadequate personality is due to genetic influence and the example set to him by his parents.

Dr S Best MB Bch MRCPsych
Consultant Psychiatrist

Report Concerning LS 115 [redacted]

Date of Report *24 August 2013*

I declare that

1 I understand that my primary duty in furnishing written reports and giving evidence is to assist the court and that this takes priority over any duties, which I may owe to the part or parties by whom I have been engaged or by whom I have been paid or am liable to be paid. I confirm that I have complied and will continue to comply with this duty.

2 I have endeavoured in my reports and in my opinions to be accurate and to have covered all relevant issues concerning the matters stated, which I have been asked to address and the opinions expressed represent my true and complete professional opinion.

3 I have endeavoured to include in my report those matters of which I have knowledge and which I have been made aware which might adversely affect the validity of my opinion.

4 I have indicated sources of all information I have used.

5 I have where possible formed an independent view on matters suggested to me by others including my instructing lawyers and their client, where I have relied upon information from others, including my instructing lawyers and their client, I have so disclosed in my report.

6 I will notify those instructing me immediately and confirm in writing if, for any reason, my existing report or opinion requires any correction or qualification.

7 I understand that

a) My report subject to any correction before swearing as to its correctness, will form the evidence which I will give under oath or affirmation.

b) I may be cross-examined on my report by a cross-examiner assisted by an expert.

c) I am likely to be subject of public adverse criticism by the judge if the court concludes that I have not taken reasonable care in trying to meet the standard set out above.

8 I confirm that I have not entered into any arrangement whereby the amount or payment of my fees, charges or expenses is in any way dependent upon the outcome of this case.

Dr S Best MB Bch MRCPsych
Consultant Psychiatrist

Enquiry
Subject: HIA 220

Our Ref : ONE0320007/FS/FMCC

Your Ref:

24 November
2011

By e-mail and 1st Class Post
e-mail : enquiry.hscb@hscni.net

The Chief Executive
Health & Social Care Board Headquarters
12-22 Linenhall Street
BELFAST
BT2 8BS

Dear Sirs,

We act on behalf of HIA 220 HIA 220

It is our instructions that our client was injured whilst under your care as a resident in Lissue Hospital, Lisburn, from in and around 1975 to 1976.

We now write to claim damages on behalf of our client for the personal injury, loss and damage sustained as a result of the negligence, assault, battery and trespass to the person by you, your servants and agents.

At this stage of our enquires we would expect you to disclose any documentation you hold relevant and material to this action, in particular, our client's records whilst resident at Lissue Hospital, Lisburn.

We expect an acknowledgement of this letter within 21 days by yourself or your Insurers otherwise proceedings may be issued against you without further notice and costs may be awarded against you.

Yours faithfully,

HIGGINS HOLLYWOOD DEAZLEY
SOLICITORS

ORIGINAL

2014 No. 25364

IN THE HIGH COURT OF JUSTICE IN NORTHERN IRELAND

QUEEN'S BENCH DIVISION

BETWEEN: [redacted] HIA 220

PLAINTIFF

AND

REGIONAL HEALTH & SOCIAL CARE BOARD

DEFENDANT

ELIZABETH THE SECOND, by the Grace of God, of the United Kingdom of Great Britain and Northern Ireland and of Our other realms and territories Queen, Head of the Commonwealth, Defender of the Faith:

To :- **Regional Health & Social Care Board whose address for service is situate at 12-22 Linenhall Street, Belfast, BT2 8BS.**

We command you, that within 14 days after the service of this writ on you, inclusive of the day of service, you do cause an appearance to be entered for you in action at the suit of

[redacted] HIA 220

and take notice that in default of your so doing, the plaintiff may proceed therein, and judgment may be given in your absence.

WITNESS, The Right Honorable **SIR DECLAN MORGAN**, Knight, Lord Chief Justice of Northern Ireland, the 6th of March 2014.

Note:- This writ may not be served later than 12 calendar months beginning with the above date unless renewed by order of the Court.

DIRECTIONS FOR ENTERING APPEARANCE

The defendant may enter an appearance in person or by a solicitor either (1) by handing in the appropriate forms, duly completed, at the Central Office or Chancery office (as appropriate), Royal Courts of Justice, Chichester Street, Belfast BT1 3JF, or (2) by sending them to that Office by post. The appropriate forms may be purchased at H.M. Stationery Office, Chichester House, Chichester Street, Belfast, BT1 1PS.

The Plaintiff's claim is for damages for personal injuries, loss and damages sustained by him and caused by reason of the:

1. Assault, battery and trespass to the Plaintiff whilst a resident together with sexual assault

AND

2. Negligence of the Defendant in and about the safekeeping of the Plaintiff whilst under the care and control of the Defendant, its servants or agents.

And the Plaintiff claims damages and interest thereon pursuant to statute.

(Signed) ...Donnelly t Knaggs...

~~And £ (or such sum as may not be allowed on taxation) for costs, and also, if the plaintiff obtains an order for substituted service, the further sum of £ (or such sum as may not be allowed on taxation). If the amount claimed and costs be paid to the plaintiff or his solicitor within 14 days after service hereof (inclusive of the day of service), further proceedings will be stayed.~~

This Writ was issued by **Donnelly & Kinder Solicitors**

of **Fourth Floor, 22 Adelaide Street, Belfast BT2 8GD, in the County of the City of Belfast.**

Solicitor for the said plaintiff whose address [redacted] HIA 220 County Antrim.

~~OR~~

~~This writ was issued by the said plaintiff who resides at~~

~~and (if the plaintiff does not reside within the jurisdiction) whose address for service is~~

2014 No.

IN THE HIGH COURT OF JUSTICE IN NORTHERN IRELAND

QUEEN'S BENCH DIVISION

BETWEEN: [redacted] HIA 220

PLAINTIFF

AND

REGIONAL HEALTH & SOCIAL CARE BOARD

DEFENDANT

WRIT OF SUMMONS

GENERAL FORM

Donnelly & Kinder Solicitors
Fourth Floor
22 Adelaide Street
Belfast BT2 8GD

IN THE HIGH COURT OF JUSTICE IN NORTHERN IRELAND

QUEEN'S BENCH DIVISION

BETWEEN

HIA 220

PLAINTIFF

AND

THE REGIONAL HEALTH AND SOCIAL CARE BOARD

DEFENDANT

WRIT OF SUMMONS
Issued on 6th March 2014

STATEMENT OF CLAIM
Delivered this 30th day of March 2015
By Donnelly & Kinder, Solicitors

---

1. The Plaintiff HIA 220 and is employed by Belfast City Council.

2. At all times material to this action, the Defendant was responsible for the provision of care at Lissue Hospital, Lisburn and for the safekeeping of the Plaintiff while a resident therein.

3. Between 1975 to 1976, the Plaintiff was placed in Lissue Hospital, Lisburn and whilst a resident therein, the Plaintiff was subjected to assault, battery and trespass to the person and sexual assaults and, as a consequence thereof, the Plaintiff has suffered serious personal injuries, loss and damage as hereinafter appears.

4. The said personal injuries, loss and damage were caused or occasioned to the Plaintiff by reason of the negligence of the Defendant in and about the safekeeping of the Plaintiff whilst a resident at the said institution.

PARTICULARS OF NEGLIGENCE

(a) Assaulting the Plaintiff.

(b) Causing and permitting the Plaintiff to be assaulted.

(c) Threatening the Plaintiff.

(d) Raping the Plaintiff.

(e) Causing, allowing or permitting the Plaintiff to be raped.

(f) Subjecting the Plaintiff to repeated assault, battery and trespass to the person.

(g) With the knowledge or means of knowledge or acquiring of that knowledge that the Plaintiff was being subject to assault, battery and trespass to the person and sexual abuse, failing to take any steps to prevent the said incidents from taking place.

(h) Failing to provide proper and adequate care for the Plaintiff whilst a resident.

(i) Failing to institute a proper or adequate system for the safekeeping of the Plaintiff whilst a resident.

(j) Failing to supervise members of staff properly, adequate or at all.

(k) Failing to investigate complaints in relation to members of staff properly, adequately or at all, if such complaints were made.

(l) Failing to ensure staff were properly and adequately trained and supervised.

(m) Failing to ensure that the Plaintiff whilst a resident was kept safe and free from harm.

(n) Failing to provide a proper and adequate level of care for the Plaintiff in all the circumstances.

The Plaintiff will further rely on proof of the negligence alleged upon all such facts as are within the knowledge of the Defendant but not to the Plaintiff and as may appear from the evidence of the Defendant's witnesses upon the trial of this action.

PARTICULARS OF ASSAULT, BATTERY AND TRESPASS TO THE PERSON

(a) Striking the Plaintiff.

(b) Forcing the Plaintiff to eat soap.

(c) Immersing the Plaintiff in ice-cold baths.

(d) Raping the Plaintiff.

(e) Striking the Plaintiff.

The Plaintiff will further rely on proof of the assault, battery and trespass to the person upon all such facts as are within the knowledge of the Defendant, and its witnesses but not of the Plaintiff and as may be given in evidence by the Defendant's witnesses upon the trial of this action.

5. By reason of the aforesaid wrongful acts and omissions, the Plaintiff has suffered serious personal injuries, loss and damage.

PARTICULARS OF PERSONAL INJURIES

The Plaintiff has developed a post-traumatic stress disorder in childhood which continue to run a chronic fluctuating course in adulthood. As a result, the Plaintiff has significant problems with sleep disturbance. He experiences hyper-vigilance; he has irritability mood swings, difficulty controlling his temper. These difficulties have affected his personal relationships. He continues to report emotional constriction and avoidance behaviours. He continues to lead a restrictive lifestyle due to previous experience. The Plaintiff was, prior to admission to Lissue House, a vulnerable individual. The problems with post-traumatic stress disorder were a significant factor in the Plaintiff's behavioural disturbance in adulthood. Throughout the Plaintiff's adulthood, he had recurrent problems with depression, suicidal ideation, the Plaintiff took two deliberate overdoses of medication; he has relationship difficulties and physical health problems. In short, the Plaintiff has a lifelong disturbed mental health. He remains on anti-depressant medication; he attends psychiatric out-patient clinics. The prognosis remains uncertain.

And the Plaintiff claims damages and interest thereon pursuant to Section 33(a) of the Judicature Act (NI) 1978

MICHAEL McCREA

LIS-45026

SOLICITORS
MCP
ESTD. 1949

HARRY McPARTLAND & SONS
SOLICITORS

PRINCIPAL

PATRICK McPARTLAND B.Sc (HONS)

BRONAGH McPARTLAND LL.B.
ORLAGH MALLON LL.B.
CAROLE McPARTLAND LLB.

11 Market Street, Lurgan, Co. Armagh, BT66 6AR
Telephone: (028) 38322452 (6 Lines)
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DX 2108 NR LURGAN

Niagara Buildings, Tonagh Drive, Lisburn, BT28 1DY
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Our ref: PMcP/JQ

27 January 2012

South Eastern Health and Social Care Trust
Lagan Valley Hospital
Hillsborough Road
LISBURN
Co Antrim

Dear Sir

We have been instructed by LS 116 of LS 116 Antrim to write to you in regard to his treatment while he was in care at Lissue House, Lisburn when he was a young boy. Our client's LS 116 and his national insurance number is LS 116 According to our instructions whenever our client was around 11 years old he was taken into care. He initially stayed in a home in Carrickfergus for nearly one year and was then transferred to Lissue House, Lisburn when he stayed for a period of approximately seven months.

According to our instructions he was abused by members of staff at Lissue House. He has now instructed us to look into this matter on his behalf as it is his intention to claim for all personal injury, loss and damage sustained and in the circumstances we would advise you to pass this letter onto your appropriate department or Insurance Company in order that they may contact us to discuss the same.

Yours faithfully

H. McPartland & Son

HARRY McPARTLAND & SONS

pmcpartland@mcpartlands.com
jquinn@mcpartlands.com

SOUTH EASTERN HEALTH & SOCIAL CARE TRUST
02 FEB 2012
RISK MANAGEMENT

OFFICIAL-SENSITIVE-PERSONAL

LIS-45027

ARCHER, HEANEY & MAGEE
Solicitors

Joseph Magee LL.B.
Brian Archer LL.B. LL.M.

2nd Floor,
18 - 22 Hill Street
Belfast BT1 2LA
Tel: 028 9033 0000
Fax: 028 9033 1000
DX 423 NR Belfast 1
Email law@archerheaneymagee.com

Our Ref: McARDLE/0026240001/HS/BA/COH
Your Ref:

04 July 2013

The South Eastern Health & Social Care Trust,
Ulster Hospital,
Upper Newtownards Road,
Dundonald,
Belfast BT16 LRH

SOUTH EASTERN HEALTH & SOCIAL CARE TRUST
10 JUL 2013
RISK MANAGEMENT

Dear Sirs,

Re: Our Client - DL 435
DL 435

I refer to the above named who instructs me that he was a resident in the Lissue Psychiatric Hospital, Lisburn at around aged 6. He instructs that he spent some nine months at this residence. 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. Consequently, he instructs that he was moved to Shore House, Fortwilliam Park, Belfast in and around December 1976. Whilst in Shore House, he was sexually abused by a man in his 40's. He instructs that he was sexually abused about ten times whilst at the said facility.

Subsequent to this he was moved to Nazareth House, Ravenhill Road, Belfast. At this establishment he was assaulted for not eating his breakfast. He would have wet the bed and he would have been punished with canes and straps until he bled.

Subsequent to this he was moved to Kircubben House, which was run by the Institute of the Brothers of Christian Schools, also known as the De La Salle Order. At this establishment he was raped in a shed and sexually assaulted at another location on the grounds of this establishment.

Consequently, it is apparent that my client sustained personal injury, loss and damage arising out of the physical beatings and psychiatric injuries which have continued with him to the present day and are as a result as the negligence and breach of statutory duty of your organisation, its servants and agents, in and about the care and management of same.

RECEIVED
JUL 2013

lease note that a similar letter has been forwarded to the Institute of the Brothers of Christian Schools, Belfast Health and Social Care Trust and the Sisters of Nazareth. Failing an open admission of liability from you, use will be made of this letter to fix any unsuccessful defendant with the costs of any successful defendant to this action.

Yours faithfully,

C O'Hare

CIARAN O'HARE
ARCHER HEANEY & MAGEE

In the High Court of Justice in Northern Ireland
Queen's Bench Division

COURT OF JUDICATURE 16 JUN 2014 NORTHERN IRELAND

Queen's Bench Division
2014 No. 62425.

Between

DL 435

Plaintiff

-and-

Belfast Health & Social Care Trust

1st Named Defendant

The South Eastern Health & Social Care Trust

2nd Named Defendant

Sisters of Nazareth

3rd Named Defendant

The Institute of the Brothers of Christian Schools

4th Named Defendant

ELIZABETH THE SECOND, By the Grace of Good of the United Kingdom of Great Britain and Northern Ireland and of Our other realms and territories Queens, Head of the Commonwealth, Defender of the Faith:

to: Belfast Health & Social Care Trust

of Headquarters, Knockbracken Health Care Park, Saintfield Road, Belfast BT8 8BH:

to: The South Eastern Health & Social Care Trust

of: Ulster Hospital, Upper Newtownards Road, Dundonald, Belfast BT16 1RH

to: Sisters of Nazareth

of: Nazareth House, 174 Bishop Street, Londonderry BT48 6UP

to: The Institute of the Brothers of Christian Schools

C/O Napier & Son Solicitors, 1-9 Castle Arcade, High Street, Belfast BT1 5DF

We command you, that within 14 days after the service of this writ on you, inclusive of the day of service, you do cause an appearance to be entered for you in an action at the suit of DL 435

DL 435

And take notice that in default of you doing so, the plaintiff may proceed therein and judgement may be given in your absence.

WITNESS, The Right Honourable SIR DECLAN MORGAN, Lord Chief Justice of Northern Ireland, the 16th day of June, 2014.

Note: This writ may not be served later than 12 calendar months beginning with the above date unless renewed by order of the Court.

DIRECTIONS FOR ENTERING APPEARANCE

The defendant may enter an appearance in person or by a solicitor either (1) by handing in the appropriate forms, duly completed, at the Central Office or Chancery Office (as appropriate), Royal Courts of Justice, Chichester Street, Belfast BT1 2JF or (2) by sending them to that Office by post. The appropriate forms may be purchased at HM Stationery Office, Chichester Street, Belfast, BT1 1PS.

If the Plaintiff sues, or the defendant is sued, in a representative capacity, this must be stated in the endorsement of claim.

The Plaintiffs claim is for damages for personal injuries, loss and damage sustained by him by reason of the negligence, breach of statutory duty, assault, battery and trespass to the person of the plaintiff by/of the:

i. **First and Second Defendants, their servants and agents and predecessors in title, in and about the care, management, control and supervision of Lissue Hospital, Lisburn and Shore House, Fortwilliam Park, Belfast respectively and the Plaintiff, from in and about 1976 until in and about 1978 whilst the Plaintiff was a resident therein.**

ii. **Further, the Third Named Defendants, in and about the care, management, control and supervision of Nazareth House, Ravenhill Road, Belfast and the Plaintiff, whilst the Plaintiff was a resident therein.**

iii. **Further, the Third Named Defendants, in and about the care, management, control and supervision of Nazareth House, Ravenhill Road, Belfast and the Plaintiff, whilst the Plaintiff was a resident therein.**

iv. **Further or in the alternative, the Fourth Named Defendant, its servants or agents; in and about the care management, control and supervision of Kircubbin House, County Down and the Plaintiff, whilst the Plaintiff was a resident therein.**

And the Plaintiff claims aggravated and exemplary damages.

(Signed) Archer & Magee. ARCHER + MAGEE

This paragraph should be deleted if the plaintiff's claim is not for a debt or liquidation demand only.

~~And £ ——— (or such sum as may be allowed on taxation) for costs, and also, if the plaintiff obtains an order for substituted service, the further sum of £ ——— (or such sum as may be allowed on taxation. If the amount claimed and costs to be paid to the plaintiff or his solicitor within 14 days after service hereof (inclusive of the day of service further proceedings will be stayed.~~

This writ was issued by Archer & Magee

Solicitor for the said plaintiff whose address is

[redacted]
DL 435

This writ was issued by the said plaintiff who resides at

DL 435	DL 435

and (if the plaintiff does not reside within the jurisdiction)

whose address for service is

In The High Court of Justice for Northern Ireland
Queen's Bench Division

Between

DL 435

Plaintiff

And

South Eastern Health & Social Care Trust

1st Defendant

And

Belfast Health & Social Care Trust

2nd Defendant

And

Sisters of Nazareth

3rd Defendant

And

Institute of Brother of Christian Schools

4th Defendant

STATEMENT OF CLAIM

Delivered by Archer Magee Solicitors, Hill Street, Belfast

Writ issued the 16th June 2014

1. DL 435 DL 435

2. The First and Second named defendants ,their servants and agents and predecessors in title were responsible for the care management and control and supervision of Lissue Hospital, Lisburn and Shore House, Fortwilliam Park, Belfast respectively when the plaintiff in and about 1976 until in and about 1978 was a resident therein. Further the said Homes were voluntary Homes as defined by Section 126 of the Children and Young Persons Act Northern Ireland 1968, in that it was a home used in whole or in part for the boarding, protection, care and maintenance of poor children or children otherwise in need of help being a home partly supported by voluntary contributions and was subject to that Act and the relevant regulations made under it and so registered.

3. Further the Third defendants were responsible for the care, management, control and supervision of Nazareth House, Ravenhill Road, Belfast whilst the plaintiff was a resident therein. Further it is said the home was a voluntary Home as defined by Section 126 of the Children and Young Persons Act Northern Ireland 1968, in that it was a home used in whole or in part for the boarding, protection, care and maintenance of poor children or children otherwise in need of help

and to which was subject to that Act and the relevant regulations made under it.

4. Further the Fourth named defendants, their servants or agents were responsible for the care, management, control and supervision of Kircubbin House, Co Down whilst the plaintiff was a resident therein to which the aforesaid regulations applied.

First Defendant's Liability

5. The Plaintiff was placed in Lissue Psychiatric Hospital in and around the age of 6. He spent approximately 9 months at this residence. He states whilst he was there he was placed in a restraining jacket and helmet. He was physically restrained in a chair for a period of hours. He was frequently slapped and thrown against the walls. This home was under the control of the First named defendants.

6. By reason of the abuse suffered the plaintiff suffered personal injuries loss and damage due to the assault, trespass to the person, false imprisonment, negligence and breach of statutory duty.

Particulars of Assault, Battery and Trespass of the First Defendant

a. Placing the plaintiff in a restraining jacket and helmet with no justification for doing so.

b. Physically restraining him in a chair for hours.

c. Slapping the plaintiff and throwing him against the walls.

d. Causing the plaintiff to be physically and psychologically abused.
e. Failing to have any justifications for the said behaviour.
f. Restraining and imprisoning the plaintiff

Particulars of Negligence of the First Defendants

a. Failing to ensure the wellbeing of the plaintiff either adequately or at all.

b. Failing to have any or adequate regard for the psychological welfare of the plaintiff.

c. Causing the plaintiff to suffer great distress.

d. Failing to ensure that the said home was carried out in a responsible manner.

e. Failing to supervise the said home adequately or at all.

f. Failing to employ staff that was appropriate and adequate.

g. Failing to have any or adequate regard for the wellbeing of the plaintiff.

Second Defendant's Liability

7. Further the plaintiff was later removed to Shane House, Fortwilliam Park, Belfast in and around December 1976. Whilst he was there he was sexually abused by a man in his 40's referred to as "Uncle Joe". The plaintiff is unaware of the identity of the assailant .He was there with the permission and knowledge of servants or agents of the said home. This abuse would happen in his bedroom and he would be assaulted in other bedrooms. He alleges that approximately 10 times he was sexually assaulted by this individual, who was involved in abusing other residents. He claimed that this individual touched his penis and made him touch his exposed penis. The plaintiff reported the matter at the time but nothing was done. He was locked in a bathroom on occasions over night as a form of punishment. The matter was reported but was not acted upon. The said home was under the management and control of the second defendants.

8. By reason of the abuse suffered therein the plaintiff suffered personal injuries loss and damage due to the assault, trespass to the person, false imprisonment, negligence and breach of statutory duty, of the defendant's servants or agents.

Particulars of Assault, Battery, false imprisonment and Trespass

(i) Sexually abusing the plaintiff
(ii) Sexually assaulting the plaintiff
(iii) Falsely imprisoning the plaintiff during the said assaults
(iv) Locking the plaintiff in a bathroom as a punishment.

Particulars of Negligence of the Second Defendant

h. Failing to ensure the wellbeing of the plaintiff either adequately or at all.

i. Failing to have any or adequate regard for the psychological welfare of the plaintiff.

j. Causing the plaintiff to suffer great distress.

k. Failing to ensure that the said home was administered in a responsible manner.

l. Causing the plaintiff to be sexually assaulted.

m. Failing to supervise the said home adequately or at all.

n. Failing to employ staff that was appropriate and adequate.

o. Failing to have any or adequate regard for the wellbeing of the plaintiff.

Particulars of Breach of Statutory Duty of Second Defendant

9. Further the plaintiff states the defendants were in breach of the Children and Young Persons (Voluntary Homes) Regulation 1975 as follows:

The defendants were in breach of Regulation 4 of the said Regulations in that they failed to conduct their home in such a manner and such principles as to further the wellbeing of the children in the home.

Third Defendants Liability

10. Thereafter the plaintiff moved to Nazareth House, Ravenhill Road, Belfast. Therein he was beaten with leather straps and a cane. On occasions he would wet the bed. He was thereafter beaten with canes and straps until he bled. He was cruelly scrubbed and washed. Regularly beaten and abused.

11. By reason of the of abuse suffered the plaintiff suffered personal injuries loss and damage due to the assault, trespass to the person, false imprisonment, negligence and breach of statutory duty.

Particulars of Assault, Battery and Trespass of the Third Defendant

(i) Physically abusing the plaintiff
(ii) Assaulting the plaintiff
(iii) Falsely imprisoning the plaintiff during the said assaults
(iv) Subjecting him to cruel treatment

Particulars of Negligence of the Third Defendants

p. Failing to ensure the wellbeing of the plaintiff either adequately or at all.

q. Failing to have any or adequate regard for the psychological welfare of the plaintiff.

r. Causing the plaintiff to suffer great distress.

s. Failing to ensure that the said home was carried out in a responsible manner.

t. Causing the plaintiff to be assaulted.

u. Failing to supervise the said home adequately or at all.

v. Failing to employ staff that was appropriate and adequate.

w. Failing to have any or adequate regard for the wellbeing of the plaintiff.

Particulars of Breach of Statutory Duty

12. Further the plaintiff states the defendants were in breach of the Children and Young Persons (Voluntary Homes) Regulation 1975 as follows:

The defendants were in breach of Regulation 4 of the said Regulations in that they failed to conduct their home in such a manner and such principals as to further the wellbeing of the children in the home.

Fourth Defendants Liability

13. The plaintiff was subsequently moved to Kircubbin House. Therein he was raped by 2 Christian Brothers, namely Brother Igneous and Brother Florence on multiple occasions. The plaintiff was raped in a shed. He was struck across the face by Brother Ignatius and taken to the shed for such purposes.

14. By reason the aforesaid the plaintiff suffered grave psychological and psychiatric injuries and states that same is due to the negligence, assault, battery and trespass to the person, breach of statutory, by servants and agents of the fourth defendants and each of them whilst he was present in the respective homes.

Particulars of Assault, Battery and Trespass of the Fourth Defendant

(i) Physically abusing the plaintiff
(ii) Assaulting the plaintiff
(iii) Falsely imprisoning the plaintiff during the said assaults
(iv) Raping the plaintiff

Particulars of Negligence of the Fourth Defendant

a. Failing to ensure the wellbeing of the plaintiff adequately or at all.

b. Causing the plaintiff to suffer distress.

c. Causing the plaintiff to be abused.

d. Failing to supervise the said home adequately or at all.

e. Failing to have any regard for the plaintiffs' wellbeing.

f. Causing the plaintiff to be physically abused.

g. Causing the plaintiff to be sexually abused.

h. Failing to employ staff who were adequate and suitable.

i. Causing the plaintiff to suffer great distress.

Particulars of Breach of Statutory Duty

Further the plaintiff states the defendants were in breach of the Children and Young Persons (Voluntary Homes) Regulation 1975 as follows:

The defendants were in breach of Regulation 4 of the said Regulations in that they failed to conduct their home in such a manner and such principles as to further the wellbeing of the children in the home.

15. By reason of all of the aforesaid the plaintiff suffered grave psychological and psychiatric injuries and suffered loss and damage. His enjoyment of the amenities of life has been interfered with and he has will suffer same.

Particulars of personal injury

Childhood emotional and behavioural disorder. The abusive experiences contributed significantly to his emotional and behavioural

disturbance. The said experiences caused him to suffer great emotional ill health during the period as a consequence.
The plaintiff adverse experiences in care were a factor in him engaging in antisocial behaviour at an early stage. The plaintiff has continuing difficulties in sexual intimacy. He has reduced survival throughout his life. The plaintiff continues to have sleep disturbance and distressing recollection of his childhood experience, fluctuated moods, diminished appetite and weight loss. Prognosis uncertain.
The plaintiff's ability to engage in meaningful employment has been greatly compromised permanently.
The plaintiff claims aggravated damages.
And the plaintiff claims damages with interest thereon pursuant to Section 33a of the Judicature Act Northern Ireland 1978.

Signed: _____

Dated: 30/4/15

To: Solicitors for the Second and Third Named Defendants
Directorate of Legal Services
2 Franklin Street
Belfast
BT2 8DQ

To: Solicitors for the Third Named Defendant
Jones & Company Solicitors
4TH Floor
The Potthouse
1 Hill Street
Belfast
BT1 2LB

To: Solicitors for the Fourth Named Defendant
Napier & Son
Solicitors
1-9 Castle Arcade
High Street
BELFAST
BT1 5DF

DR BRIAN MANGAN MD FRCPsych
CONSULTANT PSYCHIATRIST

MUSGRAVE HOUSE
10 Stockman's Lane
Belfast
BT9 7JA

BLUESTONE UNIT
Craigavon Area Hospital
Lurgan Road
Craigavon
BT62 5QQ

Appointments and Correspondence to:
Musgrave House,
10 Stockman's Lane,
Belfast,
BT9 7JA.
Tel: 07981 388229
Email: manganmedical@googlemail.com

Your Ref: DL 435
Our Ref: BM/ML/5612

12 June 2014

Archer & Magee Solicitors
2nd Floor
18-22 Hill Street
Belfast
Antrim
BT1 2LA

MEDICO-LEGAL REPORT ON:

DL 435
DL 435

INTRODUCTION:

I interviewed the above named plaintiff at Musgrave House, 10 Stockman's Lane, Belfast, on 12th June 2014 at the request of Archer & Magee Solicitors for the purposes of preparing this medicolegal report. I understand the plaintiff is seeking compensation for psychological injuries he developed as a consequence of physical, emotional and sexual abuse whilst in care. I had access to a copy of his General Practitioner notes and records.

PLAINTIFF'S ACCOUNT OF ABUSIVE EXPERIENCES IN CARE AND SUBSEQUENT PSYCHOLOGICAL IMPACT:

DL 435 informed me that he was placed in Lissue Psychiatric Hospital in and around the age of 6. He explained that he spent approximately 9 months at this residence. He explained whilst he was in Lissue he was placed in a restraining jacket and helmet. He explained he was physically restrained in a chair for a period of hours. He alleges that he was frequently slapped and thrown against walls. He was later moved to Shore House, Fortwilliam Park, Belfast, in and around December 1976. He explained that when he was in Shore House he was sexually abused by a man in his 40s referred to [redacted] He alleges that approximately 10 times he was sexually assaulted by this individual. He explained that he touched his penis and made him touch his exposed penis. The plaintiff reported this at the time but was not believed. He explained that if he did not do what he was told he was locked in the room with a toilet and sink and was left there until the next morning.

He explained that he later moved to Nazareth House, Ravenhill Road, Belfast. He explained that if he didn't eat his breakfast he was beaten with leather straps and a cane. He explained on occasions he would wet the bed. When this happened he would be hit on the bottom with canes and straps until he bled. He was subsequently moved to Kircubbin House. He alleges that he was raped by 2 Christian Brothers, Brother Ignatius and Brother Florence, on multiple occasions. He explained that he was later moved to St Patrick's Training School and was not subjected to abusive experiences whilst in this facility.

The plaintiff explained that when he was a child he had informed adults about the abusive experiences but nothing was done. "Staff didn't believe you…I got used to it". He felt very angry. He explained as a child he remembers sticking darts into his arm trying to pull his veins out. He explained that he chose this method of self-harm as he was unable to get glass. He explained that there were periods where he would not speak for days after being abused. He explained that he went around in a daze. He explained he tried to block out what had happened. When he was in Kircubbin he had particular problems sleeping as he was fearful that Brother Ignatius was going to come and seek him out and abuse him. He explained that throughout his time in care before he went to St Patrick's Training School he was unhappy. He felt that no-one cared about what was happening to him. He had no interest in school. He remembers being at St Mary's Primary School on Divis Street on the

Falls Road before being taken into care. He explained subsequently he attended schools in Nazareth House and later in Fortwilliam Park. He explained that he frequently missed lessons. "I didn't go to school...I left school". He subsequently transferred to St Patrick's Training School and noticed a vast change in the environment. The place was "brilliant, the only place I was happy in". He explained he had been placed on a Care & Protection Order. He passed 3 GCSE examinations in 1985.

The plaintiff explained that whilst in care he kept himself to himself. He explained he was a loner. He took his anger out on Social Services and his mother when they visited. He explained he blamed his mother for being placed in care.

The plaintiff explained that as a consequence of his abusive experiences in care he avoided sexual relationships. He didn't go out with girls until the age of 18. For 18 years on and off he was in a relationship with his partner Kerry, aged 36. He reports a reduced sexual libido throughout most of the relationship. He believes his abusive experiences in care had put him off sexual relationships.

Approximately 3 years ago the plaintiff became aware of cases involving individuals who had been sexually abused whilst in care. He explained he began to think more and more about what had happened when he was younger and in care. He sat for long periods alone and dwelled on the past. He reports that he had sleep disturbance. He explained some nights he wasn't sleeping until 5am. He was unable to relax. He was irritable, moody and withdrawn. He explained in the last year he has lost a lot of weight. His appetite has been diminished. He explained that his weight has fallen from approximately 15 stone to 9 ½ stone. A year ago he took a deliberate overdose of medication. He reports that he has used cannabis to try to relax. He explained he has been argumentative, irritable and moody. He explained this contributed to the breakdown of his relationship with his partner Kerry a year ago. He lost interest in his normal activities. Previously he had enjoyed walking with his partner and walking his dog. He also enjoyed swimming. He has found it difficult to talk about his experiences.

PERSONAL HISTORY:

The plaintiff was born in Belfast. He attended St Mary's Primary School on Divis Street on the Falls Road and schools in Nazareth House and Fortwilliam Park. He later attended

school at St Patrick's Training School. He finished education in 1985. He explained he has spent most of his adult life in prison. His last period of incarceration was 2006. Since leaving prison he has participated in NVQs in catering and hospitality and food hygiene.

The plaintiff's first relationship was at the age of 18. He was in a long term relationship with his partner Kerry, aged 36, until a year ago. He has 2 children aged 18 and 16.

FAMILY HISTORY:

DL 435

[redacted]

DL 435

[redacted]

40 and has 3 children. He sees her on a daily basis. His sister Mary is aged 35 and has 2 children. He has no contact with his 29 year old brother Jim. He informed me that he believes his uncle Jim had some form of learning disability and his grandfather had violent mood swings.

PREVIOUS MEDICAL HISTORY:

Appendectomy. The plaintiff has previously been assaulted suffering a head injury after he was struck with an iron bar. He alleges that an arm was broken by a member of staff when he was being cared for as a child. He also has suffered a fractured leg and collarbone.

PREVIOUS PSYCHIATRIC HISTORY:

The plaintiff believes that he attended a psychologist whilst in St Patrick's Training School.

MEDICATION:

Kapake.

SUBSTANCE MISUSE HISTORY:

The plaintiff started smoking cigarettes at the age of 15 or 16. He smokes 20 cigarettes per day. He first drank alcohol at the age of 16. He rarely drinks alcohol. He has been taking cannabis on a regular basis since the age of 18/19. From the age of 10/11 to 15/16 he used solvents.

MENTAL STATE EXAMINATION:

The plaintiff was co-operative throughout the interview. He was distressed when talking about his difficulties in childhood. His mood was not pervasively depressed. Some days are worse than others. He reports reduced appetite, irritability and mood swings. He describes problems with initial insomnia. He has reduced interest in his normal activities. His attention and concentration was normal and there was no abnormality of recent memory.

REVIEW OF NOTES AND RECORDS:

The plaintiff's records confirm he attended the Belfast City Hospital on 3rd May 2011. It is noted that he was walking home from work and had suffered pain to his left neck and left back. Hyperventilated. Tingling to fingers and lips. Fainted in bedroom. He was alert and orientated with a Glasgow Coma Scale of 15.

The plaintiff's records confirm he underwent an emergency appendectomy in October 2003.

The plaintiff's records contain correspondence from Dr Adrian Pendleton dated 22nd January 2009. It is documented he had 2 previous fractures involving his right arm and right leg before road traffic accident in 1982. He also describes a previous accident in the late 80s while stock-car racing when he was involved in quite a bad crash. He is unemployed, is a smoker of 20 per day and drinks 4 units of alcohol a week. His uncle and father have osteoarthritis.

The plaintiff's records confirm he attended his General Practitioner on 21st November 2000. He was assaulted Saturday past. Was delivering Chinese takeaway in Finaghy, was attacked by crowd of about 7 persons. Windows of car smashed. Pulled out through broken windows. Had to run away. Also put clips in scalp, 5.

The plaintiff attended his General Practitioner on 20th February 2001. He was prescribed Carbamazepine. It is documented he was to take 1 x 3 times a day. Probable trigeminal neuralgia.

An entry of 24th August 2009 reports was badly beaten up on Wednesday night. Attended A&E yesterday and was given 8 Tylex tablets. Requesting these again as he states he is in agony.

An entry of 28th August 2009 reports assault on 19th August 2009. Walking home and was assaulted with a bat. Extensive bruising over both thighs and in both flanks.

An entry of 6th May 2011 reports weakness symptoms left side for the past 4 days. Walking home from work and collapsed. Attended A&E Department Belfast City Hospital and told anxiety and hyperventilation. Not usually anxious and no history of panic attacks. Not stressed on this day. Has had slurred speech since although improved today and numbness on the left side persistent. ??CVA. He was referred to the Mater Hospital for investigation of weakness symptom.

The plaintiff's records confirm he was admitted to Lissue in early 1976 for further assessment. The admission was to assess the child's behaviour and assess the child/mother relationship. It is documented he settled quickly in the unit, was obedient and co-operative with staff. However in the presence of his mother it was noted on 1 occasion his behaviour was very different. He was defiant and resistant, was verbally aggressive to staff and was aggressive to other children. During most of his admission time he got on well with the other children in the unit though on several occasions he initiated fights with older children.

An entry of 28th September 1978 confirms he had problems with enuresis.

The plaintiff's records contain correspondence from Bruce Stewart, Senior Social Worker, Lisburn District, dated 6th December 1976. It is documented he was a 7 year old boy who was frequently high spirited and mischievous. At school he sometimes shows a lack of concentration but generally works well and is making satisfactory progress. His full scale IQ was 97. It is documented he is inclined to wet himself during the day. Difficult behaviour shows mainly during mother's visits to the unit or immediately afterwards. It is documented that the patient's mother was extremely immature herself. It is documented that whilst she agrees she is unable to manage [redacted] DL 435 she is rather ambivalent about him going to a children's home.

Correspondence dated 6th December 1976 from a child psychiatry unit indicates that "we reluctantly had to accept that further intensive work was unlikely to improve the mother's handling skills to the point where she could look after him on a full time basis".

Correspondence from A Kavanagh, Senior Social Worker, reports that mother visits frequently but is a disruptive influence.

OPINION:

Diagnosis: Childhood emotional and behavioural disorder

This 44 year old man reports that he was the victim of physical, emotional and sexual abuse whilst in care. He reports that he was placed in care as his mother was unable to look after him. He recognises that he had ambivalent feelings towards his mother and was resentful that she was not able to look after him, needing him to be placed in care. It is clear from the plaintiff's records that he was already having behavioural problems before being placed in Lissue Hospital. Whilst in care he reports intense feelings of unhappiness after traumatic experiences, sleep disturbance, nocturnal enuresis, episodes of deliberate self-harm, impaired concentration and behavioural problems. In my opinion the plaintiff's abusive experiences whilst in care attributed significantly to his emotional and behavioural disturbance at this time. Given the plaintiff's insecure attachment with his mother, even if he had not been placed in care at this time he would have been experiencing emotional and behavioural problems during this period. However, in my opinion given the frequency and severity of his traumatic experiences he suffered much greater emotional ill health during this period as a consequence of his adverse experiences whilst in care.

The plaintiff reports a significant improvement in his mental state after he was transferred to St Patrick's Training School. He explained that despite the discipline in the school he enjoyed the environment. He spoke positively about his experiences during this time. Nonetheless, throughout his adolescence he continued to truant from school, used solvents, and engaged in antisocial behaviour. In my opinion the plaintiff's adverse experiences in care were a factor in him engaging in antisocial behaviour at an early age. However, given his earlier adverse experiences prior to being taken into care and subsequent traumatic experiences which impacted on his family, I believe it is likely that DL 435 would have engaged in these behaviours even if he had not been abused whilst in care.

DL 435 reports difficulties with sexual intimacy. He reports reduced libido throughout his life. In my opinion these difficulties are linked to his childhood sexual abuse.

In recent years the plaintiff has reported a psychological adjustment disorder following the repeated news items regarding historical sexual abuse in institutions. He reports problems with sleep disturbance and distressing recollections of his childhood experiences, fluctuating mood including feelings of life not worth living, diminished appetite and weight

loss. The plaintiff's weight loss has been extensive. I advised the plaintiff to contact his General Practitioner with a view to investigations to establish whether there is an organic basis for his weight loss in the last 12 months. The plaintiff's long term relationship has also broken down. The breakdown of this relationship has also contributed to his mood disturbance over the last 12 months. I advised the plaintiff to consider contacting NEXUS to help deal with his ongoing emotional distress as a consequence of his childhood sexual abuse. I feel the plaintiff would benefit from trauma counselling. With appropriate psychological support I expect there will be a significant improvement in his condition over the next 12 months. Reminders of his traumatic experience in care are likely however to continue to be distressing to the plaintiff for an indefinite period.

DR BRIAN MANGAN MD FRCPsych
CONSULTANT PSYCHIATRIST

DECLARATION:

(1) I understand that my primary duty in furnishing written reports and giving evidence is to assist the court and that this takes priority over any duties which I may owe to the part or parties by whom I have been engaged or by whom I have been paid or am liable to be paid. I confirm that I have complied and will continue with this duty.

(2) I have endeavoured in my reports and in my opinions to be accurate and to have covered all relevant issues concerning the matters stated, which I have been asked to address, and the opinions expressed represent my true and complete professional opinion.

(3) I have endeavoured to include in my report those matters of which I have knowledge and of which I have been made aware which might adversely affect the validity of my opinion.

(4) I have indicated the sources of all information that I have used.

(5) I have where possible formed an independent view on matters suggested to me by others including my instructing lawyers and their client; where I have relied upon information from others, including my instructing lawyers and their client, I have so disclosed in my report.

(6) I will notify those instructing me immediately and confirm in writing if, for any reason, my existing report or opinion requires any correction or qualification.

(7) I understand that:-
- (a) My report, subject to any corrections before swearing as to its correctness, will form the evidence which I will give under oath or affirmation.
- (b) I may be cross-examined on my report by a cross-examiner assisted by an expert.
- (c) I am likely to be the subject of public adverse criticism by the judge if the court concludes that I have not taken reasonable care in trying to meet the standard set out above.

(8) I confirm that I have not entered into any arrangement whereby the amount or payment of my fees, charges or expenses is in any way dependent upon the outcome of this case.

DR BRIAN MANGAN MD FRCPsych
CONSULTANT PSYCHIATRIST

DR BRIAN MANGAN MD FRCPsych
CONSULTANT PSYCHIATRIST

MUSGRAVE HOUSE
10 Stockman's Lane
Belfast
BT9 7JA

BLUESTONE UNIT
Craigavon Area Hospital
Lurgan Road
Craigavon
BT62 5QQ

Appointments and Correspondence to:
Musgrave House,
10 Stockman's Lane,
Belfast,
BT9 7JA.
Tel: 07981 388229
Email: manganmedical@googlemail.com

Your Re DL 435
Our Ref **26240001/HS/BA/AM**
ML/5612

20 May 2015

Archer & Magee Solicitors
2nd Floor
18-22 Hill Street
Belfast
Antrim
BT1 2LA

MEDICO-LEGAL REPO ON:

DL 435

DL 435

INTRODUCTION:

I re-examined the above named plaintiff at Musgrave House, 10 Stockman's Lane, Belfast, on 20th May 2015 at the request of Archer & Magee Solicitors for the purposes of preparing this medicolegal report. I had previously prepared a report on the plaintiff's condition dated 12th June 2014. This report provides an update of the plaintiff's condition since the time of is last examination.

AINTIFF'S ACCOUNT OF PROGRESS SINCE LAST EXAMINATION:

DL 435

rmed me that there has been a deterioration in his mood si
last examination. He explained that he attend

very difficult to talk about the past and could not face further appointments. He explained that he was prescribed antidepressant medication Fluoxetine by his General Practitioner but only took 1 course of the treatment. He explained that he remains withdrawn. He has not seen his children since August 2014. He explained he doesn't want his children to see him in such a poor state. He reports feelings of life not to be worth living. He denies any suicidal thinking. He reports ongoing problems with sleep disturbance. He explained he finds it difficult to get over to sleep. He explained his appetite is very poor. For a 2 ½ week period last month he hardly ate at all. He explained he couldn't face eating. He explained he is anxious and on edge. He experiences panic attacks approximately once or twice a month. He finds reminders of his childhood sexual abuse very stressful. He explained there are constant news items. He finds this upsetting.

MENTAL STATE EXAMINATION:

DL 435 was co-operative throughout the interview. He was distressed when talking about his current difficulties. His mood was depressed but reactive. He reports occasional feelings of life not to be worth living. He reports problems with initial insomnia. He complained of tiredness and loss of interest in his normal activities. He is unable to relax. His attention and concentration was normal and there was no abnormality of recent memory.

OPINION:

There has been a significant deterioration in DL 435 mental health since the time of his last examination. He explained his mood has become more depressed. He continues to be upset by reminders of his experiences in care. He finds it very difficult to talk about his experiences. He explained that he attended a counsellor but did not find this productive. In my opinion his adjustment disorder has been complicated by the development of a moderate depressive episode. His depressive illness has been characterised by sleep disturbance, diminished appetite, weight loss, loss of interest in his normal activities, social withdrawal, and he has experienced panic attacks. At the time of my reassessment of DL 435 condition I did not have access to his updated General Practitioner notes and records. I reserve giving judgement with regard to his prognosis until I have had access to these materials.

DR BRIAN MANGAN MD FRCPsych
CONSULTANT PSYCHIATRIST

DECLARATION:

I Dr Brian Mangan MD FRCPsych DECLARE THAT:

1. I understand that my duty in providing written reports and giving evidence is to help the Court, and that this duty overrides any obligation to the party by whom I am engaged or the person who has paid or is liable to pay me. I confirm that I have complied and will continue to comply with my duty.
2. I confirm that I have not entered into any arrangement where the amount or payment of my fees is in any way dependent on the outcome of the case.
3. I know of no conflict of interest of any kind, other than any which I have disclosed in my report.
4. I do not consider that any interest which I have disclosed affects my suitability as an expert witness on any issues on which I have given evidence.
5. I will advise the party by whom I am instructed if, between the date of my report and the trial, there is any change in circumstances which affect my answers to points 3 and 4 above.
6. I have shown the sources of all information I have used.
7. I have exercised reasonable care and skill in order to be accurate and complete in preparing this report.
8. I have endeavoured to include in my report those matters, of which I have knowledge or of which I have been made aware, that might adversely affect the validity of my opinion. I have clearly stated any qualifications to my opinion.
9. I have not, without forming an independent view, included or excluded anything which has been suggested to me by others, including my instructing lawyers.
10. I will notify those instructing me immediately and confirm in writing if, for any reason, my existing report requires any correction or qualification.
11. I understand that -

a. my report will form the evidence to be given under oath or affirmation;
b. questions may be put to me in writing for the purposes of clarifying my report and that my answers shall be treated as part of my report and covered by my statement of truth;
c. the Court may at any stage direct a discussion to take place between experts for the purpose of identifying and discussing the expert issues in the proceedings, where possible reaching an agreed opinion on those issues and identifying what action, if any, may be taken to resolve any of the outstanding issues between the parties;
d. the Court may direct that following a discussion between the experts that a statement should be prepared showing those issues which are agreed, and those issues which are not agreed, together with a summary of the reasons for disagreeing;
e. I may be required to attend Court to be cross-examined on my report; and
f. I am likely to be the subject of public adverse criticism by the judge if the Court concludes that I have not taken reasonable care in trying to meet the standards set out above.

STATEMENT OF TRUTH

I confirm that I have made clear which facts and matters referred to in this report are within my own knowledge and which are not. Those that are within my own knowledge I confirm to be true. The opinions I have expressed represent my true and complete professional opinions on the matters to which they refer.

Signature .....

Date 20-5-15

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 [redacted]. 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 [redacted] whom 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 DL 435 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.

LIS-45005

CASEY & CASEY
Solicitors

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FAX 028 302 60909
DX 2071 NR NEWRY
EMAIL law@caseysolicitors.co.uk
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LEGAL HOUSE
25/27 LWR CATHERINE ST
NEWRY
BT35 6BE

Brenda.
Ring Lorraine @ BCH

Belfast Health & Social Care Trust
Saintfield Road
Belfast
County Antrim BT8 8BH

Your Ref:

Our Ref: GC/L 2614

Date: 25 November 2011

Dear Sir/Madam,

We act on behalf of [redacted] LS 115 who has instructed us to intimate a claim for personal injury, loss and damage arising out of his stay in Lissue House Hospital Lisburn in or about 1984 until 1986 approximately.

According to our client's instructions he was physically and sexually abused by your servants or agents at or about the said location on or about the said dates.

Unless we receive into this office within twenty-one days of the date hereof confirmation that liability is not an issue together with confirmation that you are prepared to compensate our client in respect of his said personal injury, loss and damage, we have instructions to commence legal proceedings against the Trust without further notice.

Yours faithfully,

Casey & Casey

South Eastern [illegible] Risk Management & Governance
Litigation Actions/Authorisations
File:
Open ☐ Payment/Action agreed: ☐
Close ☐ Authorisation Attached: ☐
Reopen ☐ Countersign Req. ☐
Detail
Comment: J McCafferty LSSM
14/12/11
[illegible] CRD, MD, DF, CE)

PARTNERS: SIMON CASEY, GERARD CUNNINGHAM
CONSULTANT: MARGARET CASEY
ASSISTANT SOLICITOR: EDEL CASEY

2013 NO. 51232

IN THE HIGH COURT OF JUSTICE IN NORTHERN IRELAND
QUEEN'S BENCH DIVISION

Between:

[redacted] LS 115

Plaintiff

And

THE REGIONAL HEALTH AND SOCIAL CARE BOARD

Defendant

Writ of Summons issued 15th day of May 2013
By Casey & Casey, Solicitors, Legal House, 25/27 Lower Catherine Street, Newry, County Down, BT35 6BE

---

1. [redacted] LS 115

2. The Plaintiff was a resident of Lissue House Hospital from in and about 1984 to in and about 1986. The aforesaid establishment being a Psychiatric Hospital. At all material times from 1984 to 1986 the Plaintiff was under the care, control, supervision and management of the Defendant.

3. Owing to the negligent acts and omissions of the Defendant, its servants and agents in and about the supervision, custody, care and control of the Plaintiff, while under their care as aforesaid, the Plaintiff was bullied, neglected, assaulted, battered and mistreated.

PARTICULARS OF NEGLIGENCE

The Defendant, its servants and agents were negligent in that they;

(a) Failed to properly care for the Plaintiff;
(b) Caused or allowed the Plaintiff to be assaulted;
(c) Caused or allowed the Plaintiff to be abused;
(d) Caused or allowed the Plaintiff to endure inappropriate touching;
(e) Caused or allowed the indecent assault of the Plaintiff;
(f) Failed to take any or adequate steps to prevent the Plaintiff from being assaulted;
(g) Failed to take any or adequate steps to prevent the Plaintiff from being abused;
(h) Failed to take any or adequate steps to prevent the Plaintiff from being inappropriately touched;

(i) Failed to take any or adequate steps to prevent the Plaintiff from suffering digital penetration of his anal area;
(j) Failed to take any or adequate steps to prevent the Plaintiff from being force fed;
(k) Neglected the Plaintiff;
(l) Exposed the Plaintiff to unnecessary suffering;
(m) Exposed the Plaintiff to unnecessary injury to health;
(n) Failed to protect the welfare of the Plaintiff;
(o) Failed to ensure the physical well being of the Plaintiff;
(p) Allowed and or caused the Plaintiff personal injuries;

The Plaintiff will further rely, in proof of the alleged negligence, on such facts as may be known to the Defendant but not to the Plaintiff and as may appear in the evidence of the Defendant and its witnesses at the trial of this action.

4. By reason of the aforesaid acts and omissions of the Defendant, its servants and agents the Plaintiff has suffered and will continue to suffer pain and discomfort and his enjoyment of the amenities of life have and will continue to be adversely effected.

PARTICULARS OF PERSONAL INJURIES

The Plaintiff suffers from Post Traumatic Stress Disorder (PTSD). Over a number of years he has experienced the following symptoms of PTSD:

(i) Repeated episodes of trauma in the form of intrusive memories, flashbacks and nightmares;
(ii) Poor sleeping patterns;
(iii) Difficulty controlling bowels and urine; and
(iv) A clear history of mood symptoms, including depression - has cut himself when in moods of depression and at times has felt suicidal;
(v) Difficulty with alcohol and illicit drug use;

The Plaintiff had a reported overdose in 1997 and attempted hanging in 2004.

The Plaintiff's condition has had, and continues to have, a major impact on his social functioning.

The Plaintiff has been diagnosed as having *an* acute distressing adjustment disorder stress reaction. It led to behavioural difficulties in childhood and early adolescent life. It has contributed to a life-long tendency to depression.

Mr Best concludes that it is his opinion that LS 115 was sexually abused. He was greatly distressed at the time. It contributed to nightmares, bed wetting, soiling and behavioural disturbance.
Full particulars of the Plaintiff's injuries are set out in the following medical report served herewith;

Dr Stephen Best MB Bch MRCPsych, Consultant Psychiatrist, dated 24th August 2013;

AND THE PLAINTIFF CLAIMS DAMAGES AND INTEREST THEREON IN ACCORDANCE WITH SECTION 33A OF THE JUDICATURE (N.I) ACT 1978.

KEVIN MAGILL B.L

BLUESTONE UNIT
Craigavon Area Hospital
68 Lurgan Road
Portadown
Co Armagh
BT63 5QQ

Tel No: 028 38 366794

Your Ref: GC/SC LIT 2440
Our Ref: sb/ag

24 August 2013

Casey & Casey Solicitors
Legal house
25/27 Lower Catherine Street
Newry
BT35 6BE

Confidential Psychiatric Report on

LS 115 LS 115

Date of Interview
5 June 2013

I assessed LS 115 at HMP Maghaberry on the 5 June 2013 at the request of his solicitor. has instructed his solicitor to initiate a claim for personal injury and loss and damage against the Belfast Health and Social Care Trust arising out of his stay in Lissue House Hospital, Lisburn in and around 1984 until 1986. LS 115 instructed his solicitor that he was physically and sexually abused by staff members at Lissue Hospital.

I was provided with a copy o LS 115 statement to the police in connection with the matter. I was also supplied with a copy of the computer printout of General Practitioner records including some letters from hospital specialists.

LS 115 berry Prison. He was convicted of robbery, burglary, theft and dangerous driving. He has been in prison for 5 years and was due release in the near future.

Description of Abuse

LS 115 claimed that he was sexually abused while placed at Lissue Hospital, Lisburn around the age of 7 or 8. He alleged 3 or 4 staff members, male and female, where involved in the sexual and physical abuse. The abuse took place in the bedroom used by LS 115 as a child. LS 115 was kept in his pyjamas most of the time at Lissue and his mother had complained about this. LS 115 was kept in pyjamas to prevent him from running away.

He described the abuse. Several members of staff would be in the room. Someone stood at the door. He was forced to undress. A member of staff touched his genitalia and at times there was digital penetration of his anal area. This was painful and led to bleeding.

LS 115 recalls being distressed and tearful and being very afraid. "I was afraid at what they might do". There was no oral sexual contact. Some of the abusers exposed themselves or masturbated.

The abuse went on for months and throughout his period at Lissue LS 115 kept trying to run away.

LS 115 was eventually placed with an aunt Kathleen.

LS 115 told me that this father was an alcoholic and his mother had difficulty coping with the children and they were placed with other relatives or in foster care together. He was the second eldest of 3 boys and 4 girls. He appears to have been the only one placed at Lissue Hospital.

Psychological Reaction

LS 115 remembers having difficulty controlling bowels and urine. He soiled himself and wet the bed while staying with his aunt. He also had ongoing behavioural difficulties. "I ended up in a foster home, I was uncontrollable for her, I had nightmares and was squealing the place down". He does not remember the content of the dreams. It frightened him.

LS 115 recalls being very embarrassed by the experience of abuse and never disclosed it until recent years while in prison.

Background Information

Family history - Father died in 2005 at the age of 50 with liver failure. He had been an alcoholic. He had no trade. Mother remains alive aged 56 and a housewife. As mentioned there were 6 siblings. He was not aware of any other family history of mental disorder and is in contact with most of his siblings.

He recalled domestic violence with father's alcoholism. Violence was directed at mother not at the children. He believes they all went into care but he was the only one that went to Lissue Hospital. [redacted] would maintain that there were no difficult behaviours exhibited by him prior to going to Lissue.

Education - He attended ordinary primary school. He continued to attend ordinary schooling when in the care of his aunt Kathleen in Dublin.

LS 115 had some education at Lissue. He attended a school in Dublin while living with his aunt. He then went to secondary school in Belfast Gort Na Mona and eventually St Patrick's Training school between the ages of 12 and 14.

LS 115 lived with his parents until the age of about 8. He then spent time in Lissue. He then lived with his aunt Kathleen. He then spent time with foster parents. He lived with grandparents at the age of 12. He was then in training school and Lisnevin and on release from Lisnevin lived with his mother.

Employment - LS 115 has never been able to hold down employment. He returned to education in prison and has a level 3 qualification in English and maths. He has worked an orderly in the prison setting.

Relationships - LS 115 has a 17 year old daughter [redacted] but has not been in contact for 9 years. The child's mother [redacted] ended their relationship when he was in prison.

LS 115 has a son [redacted] LS 115 child's mother and ha[redacted] visits with LS 115 current partner [redacted]

Past medical history LS 115 was involved in a serious road traffic accident in 1999. He injured his hip and had a hip replacement. He had fracture to his right leg. He had a lot of surgery. He also has an asthmatic tendency.

Past psychiatric history - LS 115 would report experiencing depression throughout most of his adult life. He has generally been on an antidepressant. They have changed on a number of occasions. He has cut himself when in moods of depression.

LS 115 has not received inpatient treatment but did attend a psychologist and the mental health department at Newry for treatment of depression. He did not disclose sexual abuse until recent months.

Previous traumatic experiences LS 115 was involved in a serious road traffic accident in 1999. He was charged with causing death by dangerous driving and was sentenced to 8 years imprisonment. He has a lot guilt feelings about the accident. Alcohol had been taken.

Alcohol and drugs - LS 115 would admit he does not handle alcohol well. He no longer drinks regularly. He occasionally goes on a binge lasting a night. Occasionally he will have a binge lasting a weekend. He generally drinks spirits. LS 115 has not reported any withdrawal symptoms with alcohol. He does not experience tremors, cravings or hallucinations.

LS 115 did admit to illicit drug use in his youth and in adult life he has tried cocaine and cannabis. He does not inject.

Hobbies and interests - LS 115 enjoys cooking and would like to have employment as a chef.

Criminal record - LS 115 reported his previous criminal record. He broke windows in 1989 and he threw a bottle and broke a car window. There are a lot of driving offences and he has stolen cars. He had been 'drunk in charge' on a number of occasions. He has actually been caught with no insurance driving while disqualified. There are no previous crimes of violence. He most recently was involved in stealing a car while under the influence of alcohol "I was full of drink at the time".

LS 115 would deny behavioural problems at school. He does not recall getting involved in fighting. He remembers throwing paint in the art room. He does not blame his parents for his difficult behaviours.

He was in St Patrick's training school and Lisnevin because he kept running away from his placements wishing to be with his mother. He denies the experience of any abuse in Lisneven or St Patricks training school "I was not aware of it, I knew what to look out for".

Consequences of abuse

LS 115 would claim that the sexual abuse experience did not have a big affect on his appreciation of normal sexual life.

LS 115 decided to disclose his abuse. He was aware that allegations were being made against staff who had worked there. He had been undergoing counselling with the psychologist in the prison service and had not disclosed the abuse at that stage but had undergone an alcohol management course and a drug awareness course. He had hoped to get some counselling qualifications and was determined not to return to alcohol or drug use on release from prison.

Mental State Examination

LS 115 was normal in appearance. There was no abnormality to his dress. There was no evidence of thought disorder, delusional thinking or perceptual disturbance and he was of normal intelligence.

LS 115 mentioned the experience of depressed moods in the past. He has nightmares at times. At times he has felt suicidal but was looking forward to discharge from prison. Sleep was broken but depended on how much he slept during the day. Appetite was normal.

LS 115 ***Statement to the Police 26 January 2012***

The statement corresponded to what [redacted] told me during my interview. He had lived with his parents in Andersonstown two brothers and 3 sisters. Father was a drinker and mother could not cope and the children were taken into care. Others went to family members. He was sent to Lissue Hospital for about a year at the age of 7 or 8. He described being sexually abused by a number of staff, mainly male. He was also physically abused and force fed potatoes. There was emotional abuse. He had few friends.

He was threatened with loss of the privilege of visiting if he did not comply with treatment. There was inappropriate touching. There was also digital penetration of his anal area.

He was too afraid to disclose what was going on. It led to bed wetting on release from Lissue Hospital. He tried to escape on a number of occasions.

General Practitioner Records

There is a computer printout of GP records beginning around 2006. By that stage he was a regular user of antidepressants. Venlafaxine and a mood stabiliser Chlorpromazine. He required Tramadol for pain following the road traffic accident.

He was not a diligent attender at outpatients. There is a letter dated 11 October 2007 following an assessment by the mental health team at Newry presenting with depression and anxiety. The fatal road traffic accident in 1999 was mentioned. In 1996 he was the victim of a punishment beating with multiple fractures in his right leg. Since that attack he has had panic attacks. He was referred to a CPN for counselling.

There was a reported overdose in 1997 and attempted hanging in 2004. It was mentioned that he was admitted to the child and adolescent mental health unit for behaviour problems but could not remember much about it.

His difficulty with alcohol was noted and the bad affect it had on his personality declared. He did admit to some illicit drug use in the past.

He talked about being in care because his mother could not cope. Father had alcohol problems and died of liver failure and heart disease.

LS 115 mentioned depressed mood with periods of poor appetite and low energy and motivation. The diagnosis was one of mild to moderate depression and he was advised to remain on Venlafaxine and Chlorpromazine. He failed to attend for psychology counselling and was eventually discharged around 2007.

Diagnosis

Mental Health problems secondary to Neglect, Physical and Emotional and Sexual Abuse of Childhood.

Opinion

LS 115 reports experience of sexual abuse while in care in Lissue hospital back in the mid 80's. I am assuming there is some ongoing investigation into the unit and that LS 115 is not the only one making allegations.

I have no idea as to his behaviour as a child back at the time and whether there were difficult behaviours which highlighted him as a candidate for Lissue when the other brothers and sisters went to family members or foster homes. Certainly Mr LS 115 feels that his difficult behaviours are linked to his enforced time at Lissue.

I have no reason not to believe LS 115 His account is believable. There is no unrealistic detail recalled. Much of it is vague but yet he did not give me the feeling it was a 'false memory'.

I quote from the Oxford Text book of Psychiatry "*early emotional consequences of sexual abuse include anxiety, fear, depression, anger, inappropriate sexual behaviour*". "*Long term effects are said to include depressed mood, low self esteem, self harm difficulties in relationship and sexual mal adjustment*". "*Effects of abuse are generally greater when the abuse has involved physical violence and penetrative intercourse. Some of the long term effects are probably related to the events surrounding the disclosure of the abuse including legal proceedings*".

The dilemma in this case is was LS 115 a difficult child before he went to Lissue? In assessing these long term effects GP remembered that sexual abuse often occurs in families with severe and chronic problems which are likely to have their own adverse long term consequences. Never the less even when these other factors are controlled for, sexual abuse in childhood seems to be associated with psychiatric disorder in adult life especially with depressive disorders".

It is my opinion that LS 115 was sexually abused. He was greatly distressed by it at the time. It contributed to nightmares, bed wetting, soiling and behavioural disturbance.

I am of the opinion that much of his behavioural disturbance is also due to the break up of the family witnessing the results of the domestic violence.

Research would show that many of the victims of sexual abuse in childhood will suffer from post traumatic stress disorder 82%, alcoholism 21%, mood related disorders 25%, a third have chronic sexual problems and over half have a history of criminal behaviour.

If [redacted] was indeed sexually abused and I believe he was it wasn't the most serious of abuse but was deeply distressing for such an isolated young child. I feel that it is likely to have caused his tendency to depression.

I am uneasy about blaming all of his anti social behaviour over the years on the sexual abuse. It is more likely to be due to the chaotic family that he came from and the poor example set by his parents.

So in summary I believe this man went through an acute distressing 'adjustment disorder' stress reaction. It led to behavioural difficulties in childhood and early adolescent life. It has contributed to a lifelong tendency to depression.

I would not go as far as saying that all of [redacted] personality difficulties are caused by this abuse. I feel that the bigger influence on his inadequate personality is due to genetic influence and the example set to him by his parents.

Dr S Best MB Bch MRCPsych
Consultant Psychiatrist

LIS-45017

Report Concerning LS 115 [redacted]

Date of Report *24 August 2013*

I declare that

1 I understand that my primary duty in furnishing written reports and giving evidence is to assist the court and that this takes priority over any duties, which I may owe to the part or parties by whom I have been engaged or by whom I have been paid or am liable to be paid. I confirm that I have complied and will continue to comply with this duty.

2 I have endeavoured in my reports and in my opinions to be accurate and to have covered all relevant issues concerning the matters stated, which I have been asked to address and the opinions expressed represent my true and complete professional opinion.

3 I have endeavoured to include in my report those matters of which I have knowledge and which I have been made aware which might adversely affect the validity of my opinion.

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5 I have where possible formed an independent view on matters suggested to me by others including my instructing lawyers and their client, where I have relied upon information from others, including my instructing lawyers and their client, I have so disclosed in my report.

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7 I understand that

a) My report subject to any correction before swearing as to its correctness, will form the evidence which I will give under oath or affirmation.

b) I may be cross-examined on my report by a cross-examiner assisted by an expert.

c) I am likely to be subject of public adverse criticism by the judge if the court concludes that I have not taken reasonable care in trying to meet the standard set out above.

8 I confirm that I have not entered into any arrangement whereby the amount or payment of my fees, charges or expenses is in any way dependent upon the outcome of this case.

Dr S Best MB Bch MRCPsych
Consultant Psychiatrist

Enquiry
Subject: HIA 220

Our Ref : ONE0320007/FS/FMCC

Your Ref:

24 November
2011

By e-mail and 1st Class Post
e-mail : enquiry.hscb@hscni.net

The Chief Executive
Health & Social Care Board Headquarters
12-22 Linenhall Street
BELFAST
BT2 8BS

Dear Sirs,

We act on behalf of HIA 220

It is our instructions that our client was injured whilst under your care as a resident in Lissue Hospital, Lisburn, from in and around 1975 to 1976.

We now write to claim damages on behalf of our client for the personal injury, loss and damage sustained as a result of the negligence, assault, battery and trespass to the person by you, your servants and agents.

At this stage of our enquires we would expect you to disclose any documentation you hold relevant and material to this action, in particular, our client's records whilst resident at Lissue Hospital, Lisburn.

We expect an acknowledgement of this letter within 21 days by yourself or your Insurers otherwise proceedings may be issued against you without further notice and costs may be awarded against you.

Yours faithfully,

HIGGINS HOLLYWOOD DEAZLEY
SOLICITORS

ORIGINAL

2014 No. 25364

IN THE HIGH COURT OF JUSTICE IN NORTHERN IRELAND

QUEEN'S BENCH DIVISION

BETWEEN: [redacted] HIA 220

PLAINTIFF

AND

COURT OF JUDICATURE - 6 MAR 2014 NORTHERN IRELAND

REGIONAL HEALTH & SOCIAL CARE BOARD

DEFENDANT

ELIZABETH THE SECOND, by the Grace of God, of the United Kingdom of Great Britain and Northern Ireland and of Our other realms and territories Queen, Head of the Commonwealth, Defender of the Faith:

To :- **Regional Health & Social Care Board whose address for service is situate at 12-22 Linenhall Street, Belfast, BT2 8BS.**

We command you, that within 14 days after the service of this writ on you, inclusive of the day of service, you do cause an appearance to be entered for you in action at the suit of

[redacted] HIA 220

and take notice that in default of your so doing, the plaintiff may proceed therein, and judgment may be given in your absence.

WITNESS, The Right Honorable **SIR DECLAN MORGAN**, Knight, Lord Chief Justice of Northern Ireland, the 6th of March 2014.

Note:- This writ may not be served later than 12 calendar months beginning with the above date unless renewed by order of the Court.

DIRECTIONS FOR ENTERING APPEARANCE

The defendant may enter an appearance in person or by a solicitor either (1) by handing in the appropriate forms, duly completed, at the Central Office or Chancery office (as appropriate), Royal Courts of Justice, Chichester Street, Belfast BT1 3JF, or (2) by sending them to that Office by post. The appropriate forms may be purchased at H.M. Stationery Office, Chichester House, Chichester Street, Belfast, BT1 1PS.

The Plaintiff's claim is for damages for personal injuries, loss and damages sustained by him and caused by reason of the:

1. Assault, battery and trespass to the Plaintiff whilst a resident together with sexual assault

AND

2. Negligence of the Defendant in and about the safekeeping of the Plaintiff whilst under the care and control of the Defendant, its servants or agents.

And the Plaintiff claims damages and interest thereon pursuant to statute.

(Signed) ...Donnelly t Knaggs...

~~And £ (or such sum as may not be allowed on taxation) for costs, and also, if the plaintiff obtains an order for substituted service, the further sum of £ (or such sum as may not be allowed on taxation). If the amount claimed and costs be paid to the plaintiff or his solicitor within 14 days after service hereof (inclusive of the day of service), further proceedings will be stayed.~~

This Writ was issued by **Donnelly & Kinder Solicitors**

of **Fourth Floor, 22 Adelaide Street, Belfast BT2 8GD, in the County of the City of Belfast.**

Solicitor for the said plaintiff whose address [redacted] HIA 220 County Antrim.

~~OR~~

~~This writ was issued by the said plaintiff who resides at~~

~~and (if the plaintiff does not reside within the jurisdiction) whose address for service is~~

2014 No.

IN THE HIGH COURT OF JUSTICE IN NORTHERN IRELAND

QUEEN'S BENCH DIVISION

BETWEEN: [redacted] HIA 220

PLAINTIFF

AND

REGIONAL HEALTH & SOCIAL CARE BOARD

DEFENDANT

WRIT OF SUMMONS

GENERAL FORM

Donnelly & Kinder Solicitors
Fourth Floor
22 Adelaide Street
Belfast BT2 8GD

IN THE HIGH COURT OF JUSTICE IN NORTHERN IRELAND

QUEEN'S BENCH DIVISION

BETWEEN

HIA 220

PLAINTIFF

AND

THE REGIONAL HEALTH AND SOCIAL CARE BOARD

DEFENDANT

WRIT OF SUMMONS
Issued on 6th March 2014

STATEMENT OF CLAIM
Delivered this 30th day of March 2015
By Donnelly & Kinder, Solicitors

---

1. The Plaintiff HIA 220 and is employed by Belfast City Council.

2. At all times material to this action, the Defendant was responsible for the provision of care at Lissue Hospital, Lisburn and for the safekeeping of the Plaintiff while a resident therein.

3. Between 1975 to 1976, the Plaintiff was placed in Lissue Hospital, Lisburn and whilst a resident therein, the Plaintiff was subjected to assault, battery and trespass to the person and sexual assaults and, as a consequence thereof, the Plaintiff has suffered serious personal injuries, loss and damage as hereinafter appears.

4. The said personal injuries, loss and damage were caused or occasioned to the Plaintiff by reason of the negligence of the Defendant in and about the safekeeping of the Plaintiff whilst a resident at the said institution.

PARTICULARS OF NEGLIGENCE

(a) Assaulting the Plaintiff.

(b) Causing and permitting the Plaintiff to be assaulted.

(c) Threatening the Plaintiff.

(d) Raping the Plaintiff.

(e) Causing, allowing or permitting the Plaintiff to be raped.

(f) Subjecting the Plaintiff to repeated assault, battery and trespass to the person.

(g) With the knowledge or means of knowledge or acquiring of that knowledge that the Plaintiff was being subject to assault, battery and trespass to the person and sexual abuse, failing to take any steps to prevent the said incidents from taking place.

(h) Failing to provide proper and adequate care for the Plaintiff whilst a resident.

(i) Failing to institute a proper or adequate system for the safekeeping of the Plaintiff whilst a resident.

(j) Failing to supervise members of staff properly, adequate or at all.

(k) Failing to investigate complaints in relation to members of staff properly, adequately or at all, if such complaints were made.

(l) Failing to ensure staff were properly and adequately trained and supervised.

(m) Failing to ensure that the Plaintiff whilst a resident was kept safe and free from harm.

(n) Failing to provide a proper and adequate level of care for the Plaintiff in all the circumstances.

The Plaintiff will further rely on proof of the negligence alleged upon all such facts as are within the knowledge of the Defendant but not to the Plaintiff and as may appear from the evidence of the Defendant's witnesses upon the trial of this action.

PARTICULARS OF ASSAULT, BATTERY AND TRESPASS TO THE PERSON

(a) Striking the Plaintiff.

(b) Forcing the Plaintiff to eat soap.

(c) Immersing the Plaintiff in ice-cold baths.

(d) Raping the Plaintiff.

(e) Striking the Plaintiff.

The Plaintiff will further rely on proof of the assault, battery and trespass to the person upon all such facts as are within the knowledge of the Defendant, and its witnesses but not of the Plaintiff and as may be given in evidence by the Defendant's witnesses upon the trial of this action.

5. By reason of the aforesaid wrongful acts and omissions, the Plaintiff has suffered serious personal injuries, loss and damage.

PARTICULARS OF PERSONAL INJURIES

The Plaintiff has developed a post-traumatic stress disorder in childhood which continue to run a chronic fluctuating course in adulthood. As a result, the Plaintiff has significant problems with sleep disturbance. He experiences hyper-vigilance; he has irritability mood swings, difficulty controlling his temper. These difficulties have affected his personal relationships. He continues to report emotional constriction and avoidance behaviours. He continues to lead a restrictive lifestyle due to previous experience. The Plaintiff was, prior to admission to Lissue House, a vulnerable individual. The problems with post-traumatic stress disorder were a significant factor in the Plaintiff's behavioural disturbance in adulthood. Throughout the Plaintiff's adulthood, he had recurrent problems with depression, suicidal ideation, the Plaintiff took two deliberate overdoses of medication; he has relationship difficulties and physical health problems. In short, the Plaintiff has a lifelong disturbed mental health. He remains on anti-depressant medication; he attends psychiatric out-patient clinics. The prognosis remains uncertain.

And the Plaintiff claims damages and interest thereon pursuant to Section 33(a) of the Judicature Act (NI) 1978

MICHAEL McCREA

LIS-45026

SOLICITORS
MCP
ESTD. 1949

HARRY McPARTLAND & SONS
SOLICITORS

PRINCIPAL

PATRICK McPARTLAND B.Sc (HONS)

BRONAGH McPARTLAND LL.B.
ORLAGH MALLON LL.B.
CAROLE McPARTLAND LLB.

11 Market Street, Lurgan, Co. Armagh, BT66 6AR
Telephone: (028) 38322452 (6 Lines)
Fax: (028) 38349561
DX 2108 NR LURGAN

Niagara Buildings, Tonagh Drive, Lisburn, BT28 1DY
Telephone: (028) 92670325 (3 Lines)
Fax: (028) 92604050

Our ref: PMcP/JQ

27 January 2012

South Eastern Health and Social Care Trust
Lagan Valley Hospital
Hillsborough Road
LISBURN
Co Antrim

Dear Sir

We have been instructed by LS 116 of [redacted] Antrim to write to you in regard to his treatment while he was in care at Lissue House, Lisburn when he was a young boy. Our client's LS 116 and his national insurance number is LS 116 According to our instructions whenever our client was around 11 years old he was taken into care. He initially stayed in a home in Carrickfergus for nearly one year and was then transferred to Lissue House, Lisburn when he stayed for a period of approximately seven months.

According to our instructions he was abused by members of staff at Lissue House. He has now instructed us to look into this matter on his behalf as it is his intention to claim for all personal injury, loss and damage sustained and in the circumstances we would advise you to pass this letter onto your appropriate department or Insurance Company in order that they may contact us to discuss the same.

Yours faithfully

H. McPartland & Sons

HARRY McPARTLAND & SONS

pmcpartland@mcpartlands.com
jquinn@mcpartlands.com

SOUTH EASTERN HEALTH
& SOCIAL CARE TRUST
02 FEB 2012
RISK MANAGEMENT

OFFICIAL-SENSITIVE-PERSONAL

LIS-45027

ARCHER, HEANEY & MAGEE
Solicitors

Joseph Magee LL.B.
Brian Archer LL.B. LL.M.

2nd Floor,
18 - 22 Hill Street
Belfast BT1 2LA
Tel: 028 9033 0000
Fax: 028 9033 1000
DX 423 NR Belfast 1
Email law@archerheaneymagee.com

Our Ref: McARDLE/0026240001/HS/BA/COH
Your Ref:

04 July 2013

The South Eastern Health & Social Care Trust,
Ulster Hospital,
Upper Newtownards Road,
Dundonald,
Belfast BT16 LRH

SOUTH EASTERN HEALTH & SOCIAL CARE TRUST
10 JUL 2013
RISK MANAGEMENT

Dear Sirs,

Re: Our Client - LS 116 LS 116

I refer to the above named who instructs me that he was a resident in the Lissue Psychiatric Hospital, Lisburn at around aged 6. He instructs that he spent some nine months at this residence. 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. Consequently, he instructs that he was moved to Shore House, Fortwilliam Park, Belfast in and around December 1976. Whilst in Shore House, he was sexually abused by a man in his 40's. He instructs that he was sexually abused about ten times whilst at the said facility.

Subsequent to this he was moved to Nazareth House, Ravenhill Road, Belfast. At this establishment he was assaulted for not eating his breakfast. He would have wet the bed and he would have been punished with canes and straps until he bled.

Subsequent to this he was moved to Kircubben House, which was run by the Institute of the Brothers of Christian Schools, also known as the De La Salle Order. At this establishment he was raped in a shed and sexually assaulted at another location on the grounds of this establishment.

Consequently, it is apparent that my client sustained personal injury, loss and damage arising out of the physical beatings and psychiatric injuries which have continued with him to the present day and are as a result as the negligence and breach of statutory duty of your organisation, its servants and agents, in and about the care and management of same.

RECEIVED
JUL 2013

lease note that a similar letter has been forwarded to the Institute of the Brothers of Christian Schools, Belfast Health and Social Care Trust and the Sisters of Nazareth. Failing an open admission of liability from you, use will be made of this letter to fix any unsuccessful defendant with the costs of any successful defendant to this action.

Yours faithfully,

C O'Hare

CIARAN O'HARE
ARCHER HEANEY & MAGEE

In the High Court of Justice in Northern Ireland
Queen's Bench Division

COURT OF JUDICATURE NORTHERN IRELAND 16 JUN 2014

Queen's Bench Division
2014 No. 62425.

Between

DL 435

Plaintiff

-and-

Belfast Health & Social Care Trust

1st Named Defendant

The South Eastern Health & Social Care Trust

2nd Named Defendant

Sisters of Nazareth

3rd Named Defendant

The Institute of the Brothers of Christian Schools

4th Named Defendant

ELIZABETH THE SECOND, By the Grace of Good of the United Kingdom of Great Britain and Northern Ireland and of Our other realms and territories Queens, Head of the Commonwealth, Defender of the Faith:

to: Belfast Health & Social Care Trust

of Headquarters, Knockbracken Health Care Park, Saintfield Road, Belfast BT8 8BH:

to: The South Eastern Health & Social Care Trust

of: Ulster Hospital, Upper Newtownards Road, Dundonald, Belfast BT16 1RH

to: Sisters of Nazareth

of: Nazareth House, 174 Bishop Street, Londonderry BT48 6UP

to: The Institute of the Brothers of Christian Schools

C/O Napier & Son Solicitors, 1-9 Castle Arcade, High Street, Belfast BT1 5DF

We command you, that within 14 days after the service of this writ on you, inclusive of the day of service, you do cause an appearance to be entered for you in an action at the suit of DL 435 DL 435

And take notice that in default of you doing so, the plaintiff may proceed therein and judgement may be given in your absence.

WITNESS, The Right Honourable SIR DECLAN MORGAN, Lord Chief Justice of Northern Ireland, the 16th day of June, 2014.

Note: This writ may not be served later than 12 calendar months beginning with the above date unless renewed by order of the Court.

DIRECTIONS FOR ENTERING APPEARANCE

The defendant may enter an appearance in person or by a solicitor either (1) by handing in the appropriate forms, duly completed, at the Central Office or Chancery Office (as appropriate), Royal Courts of Justice, Chichester Street, Belfast BT1 2JF or (2) by sending them to that Office by post. The appropriate forms may be purchased at HM Stationery Office, Chichester Street, Belfast, BT1 1PS.

If the Plaintiff sues, or the defendant is sued, in a representative capacity, this must be stated in the endorsement of claim.

The Plaintiffs claim is for damages for personal injuries, loss and damage sustained by him by reason of the negligence, breach of statutory duty, assault, battery and trespass to the person of the plaintiff by/of the:

i. **First and Second Defendants, their servants and agents and predecessors in title, in and about the care, management, control and supervision of Lissue Hospital, Lisburn and Shore House, Fortwilliam Park, Belfast respectively and the Plaintiff, from in and about 1976 until in and about 1978 whilst the Plaintiff was a resident therein.**

ii. **Further, the Third Named Defendants, in and about the care, management, control and supervision of Nazareth House, Ravenhill Road, Belfast and the Plaintiff, whilst the Plaintiff was a resident therein.**

iii. **Further, the Third Named Defendants, in and about the care, management, control and supervision of Nazareth House, Ravenhill Road, Belfast and the Plaintiff, whilst the Plaintiff was a resident therein.**

iv. **Further or in the alternative, the Fourth Named Defendant, its servants or agents; in and about the care management, control and supervision of Kircubbin House, County Down and the Plaintiff, whilst the Plaintiff was a resident therein.**

And the Plaintiff claims aggravated and exemplary damages.

(Signed) Archer & Magee. ARCHER + MAGEE

This paragraph should be deleted if the plaintiff's claim is not for a debt or liquidation demand only.

~~And £ (or such sum as may be allowed on taxation) for costs, and also, if the plaintiff obtains an order for substituted service, the further sum of £ (or such sum as may be allowed on taxation. If the amount claimed and costs to be paid to the plaintiff or his solicitor within 14 days after service hereof (inclusive of the day of service further proceedings will be stayed.~~

This writ was issued by Archer & Magee

Solicitor for the said plaintiff whose address is

[redacted]

This writ was issued by the said plaintiff who resides at

DL 435

and (if the plaintiff does not reside within the jurisdiction)

whose address for service is

In The High Court of Justice for Northern Ireland
Queen's Bench Division

Between [redacted] DL 435

Plaintiff

And
South Eastern Health & Social Care Trust

1st Defendant

And
Belfast Health & Social Care Trust

2nd Defendant

And
Sisters of Nazareth

3rd Defendant

And
Institute of Brother of Christian Schools

4th Defendant

STATEMENT OF CLAIM

Delivered by Archer Magee Solicitors, Hill Street, Belfast

Writ issued the 16th June 2014

1. [redacted] DL 435

2. The First and Second named defendants ,their servants and agents and predecessors in title were responsible for the care management and control and supervision of Lissue Hospital, Lisburn and Shore House, Fortwilliam Park, Belfast respectively when the plaintiff in and about 1976 until in and about 1978 was a resident therein. Further the said Homes were voluntary Homes as defined by Section 126 of the Children and Young Persons Act Northern Ireland 1968, in that it was a home used in whole or in part for the boarding, protection, care and maintenance of poor children or children otherwise in need of help being a home partly supported by voluntary contributions and was subject to that Act and the relevant regulations made under it and so registered.

3. Further the Third defendants were responsible for the care, management, control and supervision of Nazareth House, Ravenhill Road, Belfast whilst the plaintiff was a resident therein. Further it is said the home was a voluntary Home as defined by Section 126 of the Children and Young Persons Act Northern Ireland 1968, in that it was a home used in whole or in part for the boarding, protection, care and maintenance of poor children or children otherwise in need of help

and to which was subject to that Act and the relevant regulations made under it.

4. Further the Fourth named defendants, their servants or agents were responsible for the care, management, control and supervision of Kircubbin House, Co Down whilst the plaintiff was a resident therein to which the aforesaid regulations applied.

First Defendant's Liability

5. The Plaintiff was placed in Lissue Psychiatric Hospital in and around the age of 6. He spent approximately 9 months at this residence. He states whilst he was there he was placed in a restraining jacket and helmet. He was physically restrained in a chair for a period of hours. He was frequently slapped and thrown against the walls. This home was under the control of the First named defendants.

6. By reason of the abuse suffered the plaintiff suffered personal injuries loss and damage due to the assault, trespass to the person, false imprisonment, negligence and breach of statutory duty.

Particulars of Assault, Battery and Trespass of the First Defendant

a. Placing the plaintiff in a restraining jacket and helmet with no justification for doing so.

b. Physically restraining him in a chair for hours.

c. Slapping the plaintiff and throwing him against the walls.

d. Causing the plaintiff to be physically and psychologically abused.
e. Failing to have any justifications for the said behaviour.
f. Restraining and imprisoning the plaintiff

Particulars of Negligence of the First Defendants

a. Failing to ensure the wellbeing of the plaintiff either adequately or at all.

b. Failing to have any or adequate regard for the psychological welfare of the plaintiff.

c. Causing the plaintiff to suffer great distress.

d. Failing to ensure that the said home was carried out in a responsible manner.

e. Failing to supervise the said home adequately or at all.

f. Failing to employ staff that was appropriate and adequate.

g. Failing to have any or adequate regard for the wellbeing of the plaintiff.

Second Defendant's Liability

7. Further the plaintiff was later removed to Shane House, Fortwilliam Park, Belfast in and around December 1976. Whilst he was there he was sexually abused by a man in his 40's referred to as "Uncle Joe". The plaintiff is unaware of the identity of the assailant .He was there with the permission and knowledge of servants or agents of the said home. This abuse would happen in his bedroom and he would be assaulted in other bedrooms. He alleges that approximately 10 times he was sexually assaulted by this individual, who was involved in abusing other residents. He claimed that this individual touched his penis and made him touch his exposed penis. The plaintiff reported the matter at the time but nothing was done. He was locked in a bathroom on occasions over night as a form of punishment. The matter was reported but was not acted upon. The said home was under the management and control of the second defendants.

8. By reason of the abuse suffered therein the plaintiff suffered personal injuries loss and damage due to the assault, trespass to the person, false imprisonment, negligence and breach of statutory duty, of the defendant's servants or agents.

Particulars of Assault, Battery, false imprisonment and Trespass

(i) Sexually abusing the plaintiff
(ii) Sexually assaulting the plaintiff
(iii) Falsely imprisoning the plaintiff during the said assaults
(iv) Locking the plaintiff in a bathroom as a punishment.

Particulars of Negligence of the Second Defendant

h. Failing to ensure the wellbeing of the plaintiff either adequately or at all.

i. Failing to have any or adequate regard for the psychological welfare of the plaintiff.

j. Causing the plaintiff to suffer great distress.

k. Failing to ensure that the said home was administered in a responsible manner.

l. Causing the plaintiff to be sexually assaulted.

m. Failing to supervise the said home adequately or at all.

n. Failing to employ staff that was appropriate and adequate.

o. Failing to have any or adequate regard for the wellbeing of the plaintiff.

Particulars of Breach of Statutory Duty of Second Defendant

9. Further the plaintiff states the defendants were in breach of the Children and Young Persons (Voluntary Homes) Regulation 1975 as follows:

The defendants were in breach of Regulation 4 of the said Regulations in that they failed to conduct their home in such a manner and such principles as to further the wellbeing of the children in the home.

Third Defendants Liability

10. Thereafter the plaintiff moved to Nazareth House, Ravenhill Road, Belfast. Therein he was beaten with leather straps and a cane. On occasions he would wet the bed. He was thereafter beaten with canes and straps until he bled. He was cruelly scrubbed and washed. Regularly beaten and abused.

11. By reason of the of abuse suffered the plaintiff suffered personal injuries loss and damage due to the assault, trespass to the person, false imprisonment, negligence and breach of statutory duty.

Particulars of Assault, Battery and Trespass of the Third Defendant

(i) Physically abusing the plaintiff
(ii) Assaulting the plaintiff
(iii) Falsely imprisoning the plaintiff during the said assaults
(iv) Subjecting him to cruel treatment

Particulars of Negligence of the Third Defendants

p. Failing to ensure the wellbeing of the plaintiff either adequately or at all.

q. Failing to have any or adequate regard for the psychological welfare of the plaintiff.

r. Causing the plaintiff to suffer great distress.

s. Failing to ensure that the said home was carried out in a responsible manner.

t. Causing the plaintiff to be assaulted.

u. Failing to supervise the said home adequately or at all.

v. Failing to employ staff that was appropriate and adequate.

w. Failing to have any or adequate regard for the wellbeing of the plaintiff.

Particulars of Breach of Statutory Duty

12. Further the plaintiff states the defendants were in breach of the Children and Young Persons (Voluntary Homes) Regulation 1975 as follows:

The defendants were in breach of Regulation 4 of the said Regulations in that they failed to conduct their home in such a manner and such principals as to further the wellbeing of the children in the home.

Fourth Defendants Liability

13. The plaintiff was subsequently moved to Kircubbin House. Therein he was raped by 2 Christian Brothers, namely Brother Igneous and Brother Florence on multiple occasions. The plaintiff was raped in a shed. He was struck across the face by Brother Ignatius and taken to the shed for such purposes.

14. By reason the aforesaid the plaintiff suffered grave psychological and psychiatric injuries and states that same is due to the negligence, assault, battery and trespass to the person, breach of statutory, by servants and agents of the fourth defendants and each of them whilst he was present in the respective homes.

Particulars of Assault, Battery and Trespass of the Fourth Defendant

(i) Physically abusing the plaintiff
(ii) Assaulting the plaintiff
(iii) Falsely imprisoning the plaintiff during the said assaults
(iv) Raping the plaintiff

Particulars of Negligence of the Fourth Defendant

a. Failing to ensure the wellbeing of the plaintiff adequately or at all.

b. Causing the plaintiff to suffer distress.

c. Causing the plaintiff to be abused.

d. Failing to supervise the said home adequately or at all.

e. Failing to have any regard for the plaintiffs' wellbeing.

f. Causing the plaintiff to be physically abused.

g. Causing the plaintiff to be sexually abused.

h. Failing to employ staff who were adequate and suitable.

i. Causing the plaintiff to suffer great distress.

Particulars of Breach of Statutory Duty

Further the plaintiff states the defendants were in breach of the Children and Young Persons (Voluntary Homes) Regulation 1975 as follows:

The defendants were in breach of Regulation 4 of the said Regulations in that they failed to conduct their home in such a manner and such principles as to further the wellbeing of the children in the home.

15. By reason of all of the aforesaid the plaintiff suffered grave psychological and psychiatric injuries and suffered loss and damage. His enjoyment of the amenities of life has been interfered with and he has will suffer same.

Particulars of personal injury

Childhood emotional and behavioural disorder. The abusive experiences contributed significantly to his emotional and behavioural

disturbance. The said experiences caused him to suffer great emotional ill health during the period as a consequence.
The plaintiff adverse experiences in care were a factor in him engaging in antisocial behaviour at an early stage. The plaintiff has continuing difficulties in sexual intimacy. He has reduced survival throughout his life. The plaintiff continues to have sleep disturbance and distressing recollection of his childhood experience, fluctuated moods, diminished appetite and weight loss. Prognosis uncertain.
The plaintiff's ability to engage in meaningful employment has been greatly compromised permanently.
The plaintiff claims aggravated damages.
And the plaintiff claims damages with interest thereon pursuant to Section 33a of the Judicature Act Northern Ireland 1978.

Signed: _____

Dated: 30/4/15

To: Solicitors for the Second and Third Named Defendants
Directorate of Legal Services
2 Franklin Street
Belfast
BT2 8DQ

To: Solicitors for the Third Named Defendant
Jones & Company Solicitors
4TH Floor
The Potthouse
1 Hill Street
Belfast
BT1 2LB

To: Solicitors for the Fourth Named Defendant
Napier & Son
Solicitors
1-9 Castle Arcade
High Street
BELFAST
BT1 5DF

DR BRIAN MANGAN MD FRCPsych
CONSULTANT PSYCHIATRIST

MUSGRAVE HOUSE
10 Stockman's Lane
Belfast
BT9 7JA

BLUESTONE UNIT
Craigavon Area Hospital
Lurgan Road
Craigavon
BT62 5QQ

Appointments and Correspondence to:
Musgrave House,
10 Stockman's Lane,
Belfast,
BT9 7JA.
Tel: 07981 388229
Email: manganmedical@googlemail.com

Your Ref: DL 435
Our Ref: BM/ML/5612

12 June 2014

Archer & Magee Solicitors
2nd Floor
18-22 Hill Street
Belfast
Antrim
BT1 2LA

MEDICO-LEGAL REPORT ON:

DL 435

DL 435

INTRODUCTION:

I interviewed the above named plaintiff at Musgrave House, 10 Stockman's Lane, Belfast, on 12th June 2014 at the request of Archer & Magee Solicitors for the purposes of preparing this medicolegal report. I understand the plaintiff is seeking compensation for psychological injuries he developed as a consequence of physical, emotional and sexual abuse whilst in care. I had access to a copy of his General Practitioner notes and records.

PLAINTIFF'S ACCOUNT OF ABUSIVE EXPERIENCES IN CARE AND SUBSEQUENT PSYCHOLOGICAL IMPACT:

DL 435 informed me that he was placed in Lissue Psychiatric Hospital in and around the age of 6. He explained that he spent approximately 9 months at this residence. He explained whilst he was in Lissue he was placed in a restraining jacket and helmet. He explained he was physically restrained in a chair for a period of hours. He alleges that he was frequently slapped and thrown against walls. He was later moved to Shore House, Fortwilliam Park, Belfast, in and around December 1976. He explained that when he was in Shore House he was sexually abused by a man in his 40s referred to [redacted] He alleges that approximately 10 times he was sexually assaulted by this individual. He explained that he touched his penis and made him touch his exposed penis. The plaintiff reported this at the time but was not believed. He explained that if he did not do what he was told he was locked in the room with a toilet and sink and was left there until the next morning.

He explained that he later moved to Nazareth House, Ravenhill Road, Belfast. He explained that if he didn't eat his breakfast he was beaten with leather straps and a cane. He explained on occasions he would wet the bed. When this happened he would be hit on the bottom with canes and straps until he bled. He was subsequently moved to Kircubbin House. He alleges that he was raped by 2 Christian Brothers, Brother Ignatius and Brother Florence, on multiple occasions. He explained that he was later moved to St Patrick's Training School and was not subjected to abusive experiences whilst in this facility.

The plaintiff explained that when he was a child he had informed adults about the abusive experiences but nothing was done. "Staff didn't believe you…I got used to it". He felt very angry. He explained as a child he remembers sticking darts into his arm trying to pull his veins out. He explained that he chose this method of self-harm as he was unable to get glass. He explained that there were periods where he would not speak for days after being abused. He explained that he went around in a daze. He explained he tried to block out what had happened. When he was in Kircubbin he had particular problems sleeping as he was fearful that Brother Ignatius was going to come and seek him out and abuse him. He explained that throughout his time in care before he went to St Patrick's Training School he was unhappy. He felt that no-one cared about what was happening to him. He had no interest in school. He remembers being at St Mary's Primary School on Divis Street on the

Falls Road before being taken into care. He explained subsequently he attended schools in Nazareth House and later in Fortwilliam Park. He explained that he frequently missed lessons. "I didn't go to school...I left school". He subsequently transferred to St Patrick's Training School and noticed a vast change in the environment. The place was "brilliant, the only place I was happy in". He explained he had been placed on a Care & Protection Order. He passed 3 GCSE examinations in 1985.

The plaintiff explained that whilst in care he kept himself to himself. He explained he was a loner. He took his anger out on Social Services and his mother when they visited. He explained he blamed his mother for being placed in care.

The plaintiff explained that as a consequence of his abusive experiences in care he avoided sexual relationships. He didn't go out with girls until the age of 18. For 18 years on and off he was in a relationship with his partner Kerry, aged 36. He reports a reduced sexual libido throughout most of the relationship. He believes his abusive experiences in care had put him off sexual relationships.

Approximately 3 years ago the plaintiff became aware of cases involving individuals who had been sexually abused whilst in care. He explained he began to think more and more about what had happened when he was younger and in care. He sat for long periods alone and dwelled on the past. He reports that he had sleep disturbance. He explained some nights he wasn't sleeping until 5am. He was unable to relax. He was irritable, moody and withdrawn. He explained in the last year he has lost a lot of weight. His appetite has been diminished. He explained that his weight has fallen from approximately 15 stone to 9 ½ stone. A year ago he took a deliberate overdose of medication. He reports that he has used cannabis to try to relax. He explained he has been argumentative, irritable and moody. He explained this contributed to the breakdown of his relationship with his partner Kerry a year ago. He lost interest in his normal activities. Previously he had enjoyed walking with his partner and walking his dog. He also enjoyed swimming. He has found it difficult to talk about his experiences.

PERSONAL HISTORY:

The plaintiff was born in Belfast. He attended St Mary's Primary School on Divis Street on the Falls Road and schools in Nazareth House and Fortwilliam Park. He later attended

school at St Patrick's Training School. He finished education in 1985. He explained he has spent most of his adult life in prison. His last period of incarceration was 2006. Since leaving prison he has participated in NVQs in catering and hospitality and food hygiene.

The plaintiff's first relationship was at the age of 18. He was in a long term relationship with his partner Kerry, aged 36, until a year ago. He has 2 children aged 18 and 16.

FAMILY HISTORY:

DL 435

[redacted] He believes she has 4 or 5 children. His sister Patricia is aged 40 and has 3 children. He sees her on a daily basis. His sister Mary is aged 35 and has 2 children. He has no contact with his 29 year old brother Jim. He informed me that he believes his uncle Jim had some form of learning disability and his grandfather had violent mood swings.

PREVIOUS MEDICAL HISTORY:

Appendectomy. The plaintiff has previously been assaulted suffering a head injury after he was struck with an iron bar. He alleges that an arm was broken by a member of staff when he was being cared for as a child. He also has suffered a fractured leg and collarbone.

PREVIOUS PSYCHIATRIC HISTORY:

The plaintiff believes that he attended a psychologist whilst in St Patrick's Training School.

MEDICATION:

Kapake.

SUBSTANCE MISUSE HISTORY:

The plaintiff started smoking cigarettes at the age of 15 or 16. He smokes 20 cigarettes per day. He first drank alcohol at the age of 16. He rarely drinks alcohol. He has been taking cannabis on a regular basis since the age of 18/19. From the age of 10/11 to 15/16 he used solvents.

MENTAL STATE EXAMINATION:

The plaintiff was co-operative throughout the interview. He was distressed when talking about his difficulties in childhood. His mood was not pervasively depressed. Some days are worse than others. He reports reduced appetite, irritability and mood swings. He describes problems with initial insomnia. He has reduced interest in his normal activities. His attention and concentration was normal and there was no abnormality of recent memory.

REVIEW OF NOTES AND RECORDS:

The plaintiff's records confirm he attended the Belfast City Hospital on 3rd May 2011. It is noted that he was walking home from work and had suffered pain to his left neck and left back. Hyperventilated. Tingling to fingers and lips. Fainted in bedroom. He was alert and orientated with a Glasgow Coma Scale of 15.

The plaintiff's records confirm he underwent an emergency appendectomy in October 2003.

The plaintiff's records contain correspondence from Dr Adrian Pendleton dated 22nd January 2009. It is documented he had 2 previous fractures involving his right arm and right leg before road traffic accident in 1982. He also describes a previous accident in the late 80s while stock-car racing when he was involved in quite a bad crash. He is unemployed, is a smoker of 20 per day and drinks 4 units of alcohol a week. His uncle and father have osteoarthritis.

The plaintiff's records confirm he attended his General Practitioner on 21st November 2000. He was assaulted Saturday past. Was delivering Chinese takeaway in Finaghy, was attacked by crowd of about 7 persons. Windows of car smashed. Pulled out through broken windows. Had to run away. Also put clips in scalp, 5.

The plaintiff attended his General Practitioner on 20th February 2001. He was prescribed Carbamazepine. It is documented he was to take 1 x 3 times a day. Probable trigeminal neuralgia.

An entry of 24th August 2009 reports was badly beaten up on Wednesday night. Attended A&E yesterday and was given 8 Tylex tablets. Requesting these again as he states he is in agony.

An entry of 28th August 2009 reports assault on 19th August 2009. Walking home and was assaulted with a bat. Extensive bruising over both thighs and in both flanks.

An entry of 6th May 2011 reports weakness symptoms left side for the past 4 days. Walking home from work and collapsed. Attended A&E Department Belfast City Hospital and told anxiety and hyperventilation. Not usually anxious and no history of panic attacks. Not stressed on this day. Has had slurred speech since although improved today and numbness on the left side persistent. ??CVA. He was referred to the Mater Hospital for investigation of weakness symptom.

The plaintiff's records confirm he was admitted to Lissue in early 1976 for further assessment. The admission was to assess the child's behaviour and assess the child/mother relationship. It is documented he settled quickly in the unit, was obedient and co-operative with staff. However in the presence of his mother it was noted on 1 occasion his behaviour was very different. He was defiant and resistant, was verbally aggressive to staff and was aggressive to other children. During most of his admission time he got on well with the other children in the unit though on several occasions he initiated fights with older children.

An entry of 28th September 1978 confirms he had problems with enuresis.

The plaintiff's records contain correspondence from Bruce Stewart, Senior Social Worker, Lisburn District, dated 6th December 1976. It is documented he was a 7 year old boy who was frequently high spirited and mischievous. At school he sometimes shows a lack of concentration but generally works well and is making satisfactory progress. His full scale IQ was 97. It is documented he is inclined to wet himself during the day. Difficult behaviour shows mainly during mother's visits to the unit or immediately afterwards. It is documented that the patient's mother was extremely immature herself. It is documented that whilst she agrees she is unable to manage [redacted] she is rather ambivalent about him going to a children's home.

Correspondence dated 6th December 1976 from a child psychiatry unit indicates that "we reluctantly had to accept that further intensive work was unlikely to improve the mother's handling skills to the point where she could look after him on a full time basis".

Correspondence from A Kavanagh, Senior Social Worker, reports that mother visits frequently but is a disruptive influence.

OPINION:

Diagnosis: Childhood emotional and behavioural disorder

This 44 year old man reports that he was the victim of physical, emotional and sexual abuse whilst in care. He reports that he was placed in care as his mother was unable to look after him. He recognises that he had ambivalent feelings towards his mother and was resentful that she was not able to look after him, needing him to be placed in care. It is clear from the plaintiff's records that he was already having behavioural problems before being placed in Lissue Hospital. Whilst in care he reports intense feelings of unhappiness after traumatic experiences, sleep disturbance, nocturnal enuresis, episodes of deliberate self-harm, impaired concentration and behavioural problems. In my opinion the plaintiff's abusive experiences whilst in care attributed significantly to his emotional and behavioural disturbance at this time. Given the plaintiff's insecure attachment with his mother, even if he had not been placed in care at this time he would have been experiencing emotional and behavioural problems during this period. However, in my opinion given the frequency and severity of his traumatic experiences he suffered much greater emotional ill health during this period as a consequence of his adverse experiences whilst in care.

The plaintiff reports a significant improvement in his mental state after he was transferred to St Patrick's Training School. He explained that despite the discipline in the school he enjoyed the environment. He spoke positively about his experiences during this time. Nonetheless, throughout his adolescence he continued to truant from school, used solvents, and engaged in antisocial behaviour. In my opinion the plaintiff's adverse experiences in care were a factor in him engaging in antisocial behaviour at an early age. However, given his earlier adverse experiences prior to being taken into care and subsequent traumatic experiences which impacted on his family, I believe it is likely that [redacted] would have engaged in these behaviours even if he had not been abused whilst in care.

[redacted] DL 435 eports difficulties with sexual intimacy. He reports reduced libido throughout his life. In my opinion these difficulties are linked to his childhood sexual abuse.

In recent years the plaintiff has reported a psychological adjustment disorder following the repeated news items regarding historical sexual abuse in institutions. He reports problems with sleep disturbance and distressing recollections of his childhood experiences, fluctuating mood including feelings of life not worth living, diminished appetite and weight

loss. The plaintiff's weight loss has been extensive. I advised the plaintiff to contact his General Practitioner with a view to investigations to establish whether there is an organic basis for his weight loss in the last 12 months. The plaintiff's long term relationship has also broken down. The breakdown of this relationship has also contributed to his mood disturbance over the last 12 months. I advised the plaintiff to consider contacting NEXUS to help deal with his ongoing emotional distress as a consequence of his childhood sexual abuse. I feel the plaintiff would benefit from trauma counselling. With appropriate psychological support I expect there will be a significant improvement in his condition over the next 12 months. Reminders of his traumatic experience in care are likely however to continue to be distressing to the plaintiff for an indefinite period.

DR BRIAN MANGAN MD FRCPsych
CONSULTANT PSYCHIATRIST

DECLARATION:

(1) I understand that my primary duty in furnishing written reports and giving evidence is to assist the court and that this takes priority over any duties which I may owe to the part or parties by whom I have been engaged or by whom I have been paid or am liable to be paid. I confirm that I have complied and will continue with this duty.

(2) I have endeavoured in my reports and in my opinions to be accurate and to have covered all relevant issues concerning the matters stated, which I have been asked to address, and the opinions expressed represent my true and complete professional opinion.

(3) I have endeavoured to include in my report those matters of which I have knowledge and of which I have been made aware which might adversely affect the validity of my opinion.

(4) I have indicated the sources of all information that I have used.

(5) I have where possible formed an independent view on matters suggested to me by others including my instructing lawyers and their client; where I have relied upon information from others, including my instructing lawyers and their client, I have so disclosed in my report.

(6) I will notify those instructing me immediately and confirm in writing if, for any reason, my existing report or opinion requires any correction or qualification.

(7) I understand that:-
- (a) My report, subject to any corrections before swearing as to its correctness, will form the evidence which I will give under oath or affirmation.
- (b) I may be cross-examined on my report by a cross-examiner assisted by an expert.
- (c) I am likely to be the subject of public adverse criticism by the judge if the court concludes that I have not taken reasonable care in trying to meet the standard set out above.

(8) I confirm that I have not entered into any arrangement whereby the amount or payment of my fees, charges or expenses is in any way dependent upon the outcome of this case.

DR BRIAN MANGAN MD FRCPsych
CONSULTANT PSYCHIATRIST

DR BRIAN MANGAN MD FRCPsych
CONSULTANT PSYCHIATRIST

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Your Re DL 435
Our Ref: **26240001/HS/BA/AM**
ML/5612

20 May 2015

Archer & Magee Solicitors
2nd Floor
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Belfast
Antrim
BT1 2LA

MEDICO-LEGAL REPO ON:
DL 435

INTRODUCTION:

I re-examined the above named plaintiff at Musgrave House, 10 Stockman's Lane, Belfast, on 20th May 2015 at the request of Archer & Magee Solicitors for the purposes of preparing this medicolegal report. I had previously prepared a report on the plaintiff's condition dated 12th June 2014. This report provides an update of the plaintiff's condition since the time of is last examination.

AINTIFF'S ACCOUNT OF PROGRESS SINCE LAST EXAMINATION:
DL 435

rmed me that there has been a deterioration in his mood si
last examination. He explained that he attend

very difficult to talk about the past and could not face further appointments. He explained that he was prescribed antidepressant medication Fluoxetine by his General Practitioner but only took 1 course of the treatment. He explained that he remains withdrawn. He has not seen his children since August 2014. He explained he doesn't want his children to see him in such a poor state. He reports feelings of life not to be worth living. He denies any suicidal thinking. He reports ongoing problems with sleep disturbance. He explained he finds it difficult to get over to sleep. He explained his appetite is very poor. For a 2 ½ week period last month he hardly ate at all. He explained he couldn't face eating. He explained he is anxious and on edge. He experiences panic attacks approximately once or twice a month. He finds reminders of his childhood sexual abuse very stressful. He explained there are constant news items. He finds this upsetting.

MENTAL STATE EXAMINATION:

DL 435 was co-operative throughout the interview. He was distressed when talking about his current difficulties. His mood was depressed but reactive. He reports occasional feelings of life not to be worth living. He reports problems with initial insomnia. He complained of tiredness and loss of interest in his normal activities. He is unable to relax. His attention and concentration was normal and there was no abnormality of recent memory.

OPINION:

There has been a significant deterioration in DL 435 mental health since the time of his last examination. He explained his mood has become more depressed. He continues to be upset by reminders of his experiences in care. He finds it very difficult to talk about his experiences. He explained that he attended a counsellor but did not find this productive. In my opinion his adjustment disorder has been complicated by the development of a moderate depressive episode. His depressive illness has been characterised by sleep disturbance, diminished appetite, weight loss, loss of interest in his normal activities, social withdrawal, and he has experienced panic attacks. At the time of my reassessment of DL 435 condition I did not have access to his updated General Practitioner notes and records. I reserve giving judgement with regard to his prognosis until I have had access to these materials.

DR BRIAN MANGAN MD FRCPsych
CONSULTANT PSYCHIATRIST

DECLARATION:

I Dr Brian Mangan MD FRCPsych DECLARE THAT:

1. I understand that my duty in providing written reports and giving evidence is to help the Court, and that this duty overrides any obligation to the party by whom I am engaged or the person who has paid or is liable to pay me. I confirm that I have complied and will continue to comply with my duty.
2. I confirm that I have not entered into any arrangement where the amount or payment of my fees is in any way dependent on the outcome of the case.
3. I know of no conflict of interest of any kind, other than any which I have disclosed in my report.
4. I do not consider that any interest which I have disclosed affects my suitability as an expert witness on any issues on which I have given evidence.
5. I will advise the party by whom I am instructed if, between the date of my report and the trial, there is any change in circumstances which affect my answers to points 3 and 4 above.
6. I have shown the sources of all information I have used.
7. I have exercised reasonable care and skill in order to be accurate and complete in preparing this report.
8. I have endeavoured to include in my report those matters, of which I have knowledge or of which I have been made aware, that might adversely affect the validity of my opinion. I have clearly stated any qualifications to my opinion.
9. I have not, without forming an independent view, included or excluded anything which has been suggested to me by others, including my instructing lawyers.
10. I will notify those instructing me immediately and confirm in writing if, for any reason, my existing report requires any correction or qualification.
11. I understand that -

a. my report will form the evidence to be given under oath or affirmation;
b. questions may be put to me in writing for the purposes of clarifying my report and that my answers shall be treated as part of my report and covered by my statement of truth;
c. the Court may at any stage direct a discussion to take place between experts for the purpose of identifying and discussing the expert issues in the proceedings, where possible reaching an agreed opinion on those issues and identifying what action, if any, may be taken to resolve any of the outstanding issues between the parties;
d. the Court may direct that following a discussion between the experts that a statement should be prepared showing those issues which are agreed, and those issues which are not agreed, together with a summary of the reasons for disagreeing;
e. I may be required to attend Court to be cross-examined on my report; and
f. I am likely to be the subject of public adverse criticism by the judge if the Court concludes that I have not taken reasonable care in trying to meet the standards set out above.

STATEMENT OF TRUTH

I confirm that I have made clear which facts and matters referred to in this report are within my own knowledge and which are not. Those that are within my own knowledge I confirm to be true. The opinions I have expressed represent my true and complete professional opinions on the matters to which they refer.

Signature .....

Date 20-5-15

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RETROSPECTIVE SAMPLING EXERCISE - PROFESSIONAL COMMENTS ON REPORTS

INTRODUCTION

An extensive retrospective review of all patient case files within Muckamore Abbey Hospital, completed by EHSSB/N&WBT in 2009 following a patient complaint, led to the DHSSPS instigating a retrospective sampling exercise across all Trusts to identify if there were concerns/significant prevalence of similar findings within any other mental health or learning disability inpatient hospitals.

At a meeting held in Castle Buildings on 28th June 2007, involving Departmental and Trust representatives, it was agreed that a retrospective sampling exercise should focus on those most at risk especially minors/children admitted to mental health and learning disability hospitals) over a 20 year period (1985-2005), taking a 10% sample of relevant files from each year. Trusts were asked to follow the rigorous methodology applied in the Muckamore Review although it has not been possible to retrieve any formal minutes of this meeting

As a consequence the scale and scope of sampling has been interpreted by Trusts in different ways, and it is apparent that there are significant inconsistencies and variances in both methodology and sampling applied by the Trusts and within the commissioned reports. Although this variance does not allow for a consistent and objective critique of these reports/reviews, we have identified a number of flaws and/or gaps in the reports, but it is important to consider this in the context of lack of terms of reference.

The retrospective sampling exercise encompassed the adult mental health hospitals, learning disability hospitals (excluding Muckamore Abbey Hospital which had already been reviewed) and regional child and adolescent inpatient mental health services (which included a specific investigation of Lissue and Forster Green Hospitals commissioned by the EHSSB / HSCB as a result of a

Category 8 - Issues noted – dealt with thoroughly using recognised procedures

Between April 2008 and August 2009, 8 reports were submitted covering 10 sites. In late 2011 these reports and other reporting documents, 13 in total, were handed over to the PSNI for further investigation.

It was evident from the analytical review of the available information that the scale and scope of the sampling had been interpreted by HSCTs in different ways and this resulted in significant inconsistencies and variances in both methodology and sampling applied within the commissioned reports.

2. Terms of Reference

Fionnuala McAndrew, Director of Social Care, Health and Social Care Board requested a template be developed for the Senior Management Group (SMG) to address the following key areas:-

- What was the expectation at the time of responding to the described scenarios?
- What legislation policy and practice guidance was in place?
- Were the responses in line with expectations of best practice at the time?
- Was there appropriate liaison with police and child or adult protection services?
- Are there any situations that require further investigation by the PSNI?

The PSNI carried out an investigative analysis report to determine if additional information was required for the PSNI to carry out its investigation and noted the following gaps in the submitted reports:

TRUST/HOSPITAL	DATES 1985-2005	SAMPLING	SIZE / %	CHILDREN	ADULTS	CATEGORIES	INCIDENT DETAILS
EASTERN – Lissue, Foster Green	1970-1979 1990-1999	NOT CLEAR	NOT CLEAR	YES	NO	NO	YES

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WESTERN – Stradreagh	YES	YES	10%	YES	YES	YES	YES
WESTERN – Tyrone & Fermanagh, Gransha	YES	YES	37%	NO	YES	YES	YES
BELFAST - Knockbracken	1970-1986	NO	20% + 6	YES	YES	NO	YES
SOUTHERN – Longstone	YES	NOT CLEAR	25% + 10	YES	NO	NO	NO
SOUTHERN - St Luke's, Craigavon	YES	NOT CLEAR	25%	YES	NO	NO	LIMITED
NORTHERN – Holywell	YES	NOT CLEAR	10%	NOT CLEAR	NOT CLEAR	YES	LIMITED
SOUTH EASTERN – Downshire	YES	YES	10%	NO	YES	YES	LIMITED

The PSNI report made the following comments: -

1. It is not possible to put a figure on the number of incidents reported on. This is due to some of the HSCTs reporting a number of incidents and others stating the number of patients affected.
2. It is not always clear where the patients involved are adults or children this means that the assessment of incident if criminal is difficult.
3. The lack of incident detail in some reports has made it difficult to make basic assessments of what has happened, when and where it happened and who was involved.
4. Information including patient names (whether perpetrator or victim), dates of birth, date of incident or whether the incident was reported to the police is not always recorded.
5. It has not been possible to complete the network analysis or analyse whether problems exist in particular wards or under certain staff members.

1. BACKGROUND

In June 2007, following a retrospective review of patient case files within Muckamore Abbey Hospital completed between 2005 and 2009 by the Eastern Health and Social Services Board (EHSSB) and North and West Belfast Health and Social Services Trust, the Department of Health Social Services and Public Safety (DHSSPS) instigated a retrospective sampling exercise across all 5 Health and Social Services Trusts to identify if there were concerns, significant prevalence or similar findings within any other mental health or learning disability inpatient hospital.

The DHSSPS required the retrospective sampling exercise to focus on those people most at risk especially minors (children under the age of 18 years) admitted to mental health and learning disability hospitals over a twenty year period between 1985 and 2005. A 10% sample of relevant files was agreed.

The retrospective sampling exercise encompassed long stay wards in adult mental health hospitals, learning disability hospitals (excluding Muckamore Abbey Hospital which had already been reviewed) and regional child and adolescent inpatient mental health services (which included a specific investigation of Lissue and Forster Green Hospitals commissioned by the EHSSB and latterly the Health and Social Care Board (HSCB) as a result of a complaint detailing serious allegations made when the above exercise was being planned).

Each Trust was asked to follow the methodology applied in the Muckamore Abbey Review which characterised the incidents as follows:

- Category 1: Sexualised behaviour between adult and minor
- Category 1a: Sexualised behaviour between minor and minor
- Category 2: Sexualised behaviour between adult and adult (non-consenting)
- Category 3: Sexualised behaviour between adult and adult (consent unclear)
- Category 4: Sexualised behaviour (consenting)
- Category 5: Suspected sexualised activity (general details unknown)
- Category 6: Physical abuse involving actual bodily harm and above
- Category 7: Sexualised behaviour query significance
- Category 8: Issues noted and dealt with thoroughly using recognised procedures

Between April 2008 and August 2009 eight reports were submitted to the DHSSPS covering ten sites. In late 2011 these reports and other reporting documents (thirteen in total) were handed over by the DHSSPS to the PSNI for further investigation under Operation Danzin.

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RETROSPECTIVE SAMPLING EXERCISE - PROFESSIONAL COMMENTS ON REPORTS

INTRODUCTION

An extensive retrospective review of all patient case files within Muckamore Abbey Hospital, completed by EHSSB/N&WBT in 2009 following a patient complaint, led to the DHSSPS instigating a retrospective sampling exercise across all Trusts to identify if there were concerns/significant prevalence of similar findings within any other mental health or learning disability inpatient hospitals.

At a meeting held in Castle Buildings on 28th June 2007, involving Departmental and Trust representatives, it was agreed that a retrospective sampling exercise should focus on those most at risk especially minors/children admitted to mental health and learning disability hospitals) over a 20 year period (1985-2005), taking a 10% sample of relevant files from each year. Trusts were asked to follow the rigorous methodology applied in the Muckamore Review although it has not been possible to retrieve any formal minutes of this meeting

As a consequence the scale and scope of sampling has been interpreted by Trusts in different ways, and it is apparent that there are significant inconsistencies and variances in both methodology and sampling applied by the Trusts and within the commissioned reports. Although this variance does not allow for a consistent and objective critique of these reports/reviews, we have identified a number of flaws and/or gaps in the reports, but it is important to consider this in the context of lack of terms of reference.

The retrospective sampling exercise encompassed the adult mental health hospitals, learning disability hospitals (excluding Muckamore Abbey Hospital which had already been reviewed) and regional child and adolescent inpatient mental health services (which included a specific investigation of Lissue and Forster Green Hospitals commissioned by the EHSSB / HSCB as a result of a

complaint detailing serious allegations when the above exercise was being planned).

The scope of this paper is to provide a professional overview and perspective on the following specific written reports, and our conclusions and recommendations may therefore require further examination by other agencies.

1. HSC Trust reports on adult mental health hospitals and learning disability hospitals:

   - WHSCT – Stradreagh, Tyrone and Fermanagh, and Gransha Hospitals
   - BHSCT – Knockbracken Hospital site
   - SHSCT - St Luke's, Craigavon Psychiatric Unit and Longstone Hospital
   - NHSCT - Holywell Hospital
   - SEHSCT – Downshire Hospital

HSC Trust reports on child and adolescent inpatient mental health facilities:

2. BHSCT's retrospective child protection and safeguarding audit within the regional child and adolescent inpatient service.

3. EHSSB/HSCB commissioned reports on Lissue and Forster Green Hospitals.

For each report we have provided comments under 3 broad headings;

a) Methodology
b) Key findings and circumstances of abuse/suspected abuse
d) General comments and conclusions

We have provided a summary and conclusion at the end of the report which highlight a number of options to be considered for any way forward.

1. TRUST REPORTS: ADULT MENTAL HEALTH AND LEARNING DISABILITY FACILITIES

1.1 WESTERN TRUST

The Western Trust response to the retrospective exercise has already been thoroughly and rigorously reviewed. The methodology applied was robust and was the measure against which we compared reports from the other 4 Trusts. Key points from the Western Trust are summarised below:

1.1.1 Learning Disability - Stradreagh hospital

(a) Sampling and methodology correct - 142 files identified for the period 1985 to 2005, 75% of which had at least 3-4 volumes, therefore approximately 300 files in total were examined;

(b) Evidence of initial examination, re-examination and relevant cross-referencing.

1.1.2 Adult Mental Health – Tyrone and Fermanagh, and Gransha Hospitals

(a) Appropriate methodology applied and relevant sampling;

(b) T&F - 63 male patient files and 48 female patient files were examined of which 13 were noted within report, 98 files therefore did not have any references to abuse;

(c) Gransha Hospital – 24 files examined of which 3 were noted for report falling into relevant categories;

(d) Relevant detail regarding classification into various categories;

(e) Evidence of appropriate care planning and multi-disciplinary case reviews, risk assessments ongoing;

(f) No evidence of vulnerable adult or child protection training;

(g) Overall excellent coverage and relevant detail provided.

NB. The Western Trust is satisfied that any allegation, suspicion or actual evidence of sexually inappropriate behaviour was dealt with promptly and appropriately. They have also taken the view of PSNI regarding 3 cases within the report, and the PSNI have advised that nothing further can be done and that the Trust have responded appropriately to events.

1.2 BELFAST TRUST – KNOCKBRACKEN SITE

(a) Methodology

With regard to this retrospective sample exercise, this report

- spans only 16 years (1970-1986)
- focuses only on children and does not appear to work to the 8 specific categories agreed with PSNI for the Muckamore Abbey review
- does not consider all of the mental health inpatient facilities in the Trust such as the Mater Hospital Unit and Windsor House, where children may have been admitted.

During the years 1970-1986, 195 U18s were admitted. The Trust took a sample of 20%, the equivalent of 39 patients, and also included 6 patients who were compulsorily admitted without explanation why this latter group was chosen.

The review was completed by 3 members of Belfast trust staff

(b) Key Findings and circumstances of abuse/suspected abuse

- In this report, 7 files/cases (out of a total of 45) were highlighted specifically within the report. 3 of these cases were from the adult sample of 6 (50% of the sample).
- The level of detail provided for each individual case was minimal, although the report states that there is evidence to indicate that where abuse, and any alleged criminal acts, had taken place appropriate action was taken.
- It is important to note that the outcomes of a number of these investigations were not always recorded.
- From the cases sampled in this report, we have no indication that there are victims and/or perpetrators of abuse who require to be followed up.
- 2 staff members (unnamed) were involved in 2 of the incidents. One involved allegations of being forced to eat by "staff" (no evidence of investigation) and the other centred on an allegation against a teacher, punching a 15 year old boy (evidence that this was investigated and dealt with).

(c) General comments and conclusions:

Although the predominant rationale for this report was to complete a retrospective review, Belfast Trust strongly emphasises a range of developments in relation to current and future practices:

i. General practice – this highlights compliance with procedures such as Area Child Protection Committee (ACPC) and Vulnerable Adult (VA), staff supervision, role of

RQIA, complaints procedures, untoward incidents procedures, and the plan to appoint Band 7 Social Worker to investigate VA issues;

ii. Mental Health/child care interface – this emphasises implementation of the recommendations coming out of the O'Neill report etc, Trust protocol to safeguard children, ongoing staff supervision, and the identification of 4 additional beds for U18s;

iii. Vulnerable Adults – training in this area is given emphasis, the appointment of Band 7 Social Worker for VA investigation, the re-establishment of adult protection forum, PECS checks, and the review of Shannon to be completed 2009/2010.

While the Trust does not make any specific recommendations, it has drawn up an action plan, which identifies for each action an Officer responsible for implementation. This action plan is equivalent to a series of recommendations within the context of improving practice to children and vulnerable adults, according to appropriate policies and procedures.

1.3 SOUTHERN TRUST

1.3.1 St Luke's Hospital and Craigavon Psychiatric Unit

(a) Methodology

- The focus within this exercise was completely on children/minors.

- During the period 1985-2005, 116 children were admitted and 29 were chosen for the purposes of this Review. This was a 25% sample.

- 85 files were examined relating to the 29 children chosen.

- The report does not apply the 8 specific categories agreed with PSNI. Only sexual abuse was considered.

- The report was completed by 2 senior members of staff from within the Southern Trust.

(b) Key findings and circumstances of abuse/suspected abuse

This audit uncovered records of a sexual nature in the files of five patients. However, the authors of the St Luke's report are satisfied that there is nothing within the retrospective exercise of a serious nature that would warrant further action, or which warrants a referral to any outside agency.

From the cases sampled in this report, we have no indication that there are victims and/or perpetrators of abuse who require to be followed up, and there are no indications that any staff involved at the time require to be followed up.

The Trust highlights a series of failings at the time in terms of poor documentation and communication, lack of evidence of reference to child protection procedures and vulnerable adult procedures, no evidence of multi-disciplinary assessment and care planning, no sharing of information;

These findings reflect a fair degree of self-criticism and the conclusions and recommendations made in the report are in keeping with the need to address these concerns.

(c) General comments and conclusions

There is nothing significant to add, except to point out that the issue of finding and storage of the files of mental health patients was problematic in this review, and may be an important issue to consider regionally. It should also be noted vulnerable adults were not considered.

1.3.2 Learning Disability – Longstone Hospital

(a) Methodology

- The focus within this exercise was completely on children/minors.
- During the period 1985-2005, 115 children were admitted and 22 were chosen for the purposes of this Review. This was a 20% (approx) sample.
- However, using the concentric ring principle a further 10 patients were identified. 32 children in total were considered and a total of 91 files were examined. .

- The report does not work to the 8 specific categories agreed with PSNI, however both sexual and physical abuse are considered (yet the initial brief stated sexual abuse only).

- The report was completed by 2 senior members of staff within Southern Trust

(b) Key findings and circumstances of abuse/suspected abuse

- Fifteen incidents of a sexual nature and 2 cases of physical abuse. Most of the incidents took place between 2 vulnerable people.
- Staff members were involved in 2 incidents. Outside agencies such as PSNI involved, and on each occasion, the staff member was dismissed.
- It was noted that this review followed up both perpetrators and victims and services were provided as appropriate (care packages, risk assessment, referral to psychosexual services).

(c) General comments and conclusions

- Once again, these findings support a reflective self-examination on a retrospective basis.

- The report makes a series of recommendations which have been converted into a working action plan.

- There are some anomalies in the numbers within this review. For example, it originally states that 10 further cases were followed up, and then later on, this figure changes to 11.
- Vulnerable adults were not considered.

1.4 NORTHERN TRUST – HOLYWELL

(a) Methodology

- A random sample of 27 patients were chosen (eventually reduced to 25 because of missing files).
- These were long stay patients who had been in the hospital during the period 1985 – 2005. It is unclear how the sample was chosen, and whether this is a percentage of total admissions over the 20 year period.
- There is no reference to children, so one is left to assume that the 25 patients were all adults
- Medical and nursing files were examined, but in only 18 cases was it possible to review both medical and nursing files (due to missing files).
- A range of data is provided such as date of birth, diagnosis, gender etc is provided which is mostly irrelevant.
- The report does apply the 8 specific categories agreed with PSNI.
- The specific authors of the report are not identified.

(b) Key findings and circumstances of abuse/suspected abuse

- In total, 33 incidents were identified across all of the categories. 17 of these incidents relate to sexualised/disinhibited behaviour.
- Allegations made on 3 occasions against staff. No substance (from records) to 2 allegations. The other

incident regarding sexual advances by a "porter" states that there was limited information available and no record of any action taken.

- If the 25 patients are truly a random sample, sexualised behaviour in Holywell could be perceived as being more prevalent than expected (19 patients (76%) of sample had evidence of sexualised behaviour). However, it is apparent that these were patients who had been residing in wards that routinely accommodated adults with challenging or disinhibited behaviour.

- The authors of this report state that "appropriate action/intervention would appear to have been undertaken with the exception of one patient, who is currently being followed up by mental health staff". It may be necessary that further details regarding this specific case are sought.

(c) General comments and conclusions

The report makes 5 very broad recommendations around the need for proper investigation, documentation and adherence to procedure and training in future. There is no consideration of children nor, as with the Belfast Trust, of other mental health facilities (e.g. Whiteabbey Hospital), within the Northern Trust.

1.5 SOUTH EASTERN TRUST – DOWNSHIRE

(a) Methodology

- Worked to the 10% sampling process and the timeline was 1985 – 2005.

- Focus was on adults.

- The Trust also applied the 8 categories of abuse. However, they only reported on categories 1-3, stating that there were incidents that fell into the other categories (43 patients in total), but that these were to be "subject to further internal multi-disciplinary review" and were not reported on within this report. It may be necessary that further details of these reviews are sought.

- 191 files were examined in total, 71 male and 120 female, of which 59 identified incidents that fell into categories 1 to 8.

- 16 of these (59) incidents fell into categories 1 – 3, and it is these that were reported upon.

- No indication who completed this report.

(b) Key findings and circumstances of abuse/suspected abuse

- Appendix 1 of the Downshire report provides a detailed breakdown of the 16 incidents that fell into categories 1-3 including details of the incident, the action taken (as indicated within the files), and date of the incident.

- No indication of any staff involved in any of these incidents.

- Detail provided regarding the one category 1 incident, and the one female who fell into category 2. The report states that both were dealt with appropriately.

- Some of the actions taken, or not taken, as a consequence of the incidents is concerning, but is acknowledged within the Trust report (e.g. triggering of safeguarding procedures).

(c) General comments and conclusions

- There are no recommendations made, however the report does reflect reasonable self-examination, and there is indication of training measures being put in place regarding child protection and protection of vulnerable adults.

2. BHSCT RETROSPECTIVE CHILD PROTECTION AND SAFEGUARDING AUDIT WITHIN THE REGIONAL CHILD AND ADOLESCENT INPATIENT SERVICE

This report differs from the previous Trust reports within the retrospective exercise which concern adult facilities and **would therefore benefit from specific comments by Child Care Branch.**

(a) Methodology

- The report states that it covers the years 1970 to 1999 (excluding the period 1980-1989. See below). However the retrospective exercise was intended to focus on the 20 year time period between 1985 and 2005. We also note that 3 files relate to the period 2000 to 2003.

- A separate EHSSB commissioned exercise regarding Forster Green and Lissue Hospitals (see below) is stated as addressing the 1980 to 1989 period for the purpose of the overall retrospective sampling exercise.

- Under the methodology it states there were 15 files randomly selected from each period (1970-79 and 1990-99) when in reality there were 10 selected from each

The Regulation and Quality Improvement Authority

REVIEW OF THE "SAFEGUARDS IN PLACE FOR CHILDREN AND VULNERABLE ADULTS IN MENTAL HEALTH AND LEARNING DISABILITY HOSPITALS" IN HSC TRUSTS

OVERVIEW REPORT
RQIA - JUNE 2008

CONTENTS

EXECUTIVE SUMMARY

This thematic review by the RQIA was undertaken during September and October 2007 in all five Health and Social Care (HSC) trusts and was in response to a request from the DHSSPS for independent assurance that the necessary safeguards were in place for children and vulnerable adults in learning disability and mental health hospitals.

In particular, the review drew on the matters raised in correspondence (September 2006) from the Permanent Secretary at the DHSSPS to board and legacy trust chief executives requesting assurance in relation to the procedures in place within each trust to prevent abuse and to ensure that any incidents, which may arise, are dealt with properly.

The findings from this review have highlighted key elements of the work ongoing within HSC trusts in relation to child and adult protection and provide a baseline position against which future progress can be assessed.

Reviewers were able to evidence that whilst service users and carers were engaged in a variety of ways within all trusts, their participation in the delivery and evaluation of mental health services was very limited. The involvement of service users and carers in learning disability services was much better established. The review also highlighted that in the main, there was an absence of corporate policies in relation to service user and carer involvement.

Information returned from all trusts in relation to key training was of poor quality, therefore it was not possible to make direct comparisons across trusts in respect of the numbers and percentages of staff trained.

Within all trusts, review teams were informed that the admission of a child or young person to an adult ward was considered a Serious Adverse Incident and the DHSSPS, the Mental Health Commission and the commissioning Health and Social Services Board were formally notified. Trusts also reported that constant supervision was generally put in place for such children, individual rooms were allocated as far as possible and a strong emphasis placed on risk assessment throughout their stay, both in regard to the child and for other patients on the ward.

Based on the findings from this review, RQIA are concerned at the numbers of children being admitted to adult wards and the work that remains outstanding within HSC trusts to ensure all staff receive dedicated training in the areas of child and adult protection. In particular, trusts should:

- work in collaboration with the DHSSPS to minimise the numbers of children admitted to adult wards,
- ensure that child and adult protection training is provided in accordance with regional guidance, to all staff and volunteers working in mental health and learning disability services,
- fully implement the Regional Adult Protection Policy and Procedural Guidance[1],

[1] The Regional Adult Protection Policy and Procedural Guidance (DHSSPS, 2006)

- ensure that appropriate policies and procedures are in place for Looked After Children (LAC) and that all staff work in accordance with LAC guidance,
- ensure that information in relation to the named nurse and named doctor for child protection is made available to all staff

The recommendations made within both individual HSC trust reports and this overview report continue to be underpinned by regional child and adult protection policies and procedures, DHSSPS and other publications.

The findings from this review and any subsequent follow-up review will be shared with the minister for health, social services and public safety and made available in the context of open reporting.

1 SETTING THE SCENE

1.1 Regulation & Quality Improvement Authority - Role & Responsibilities

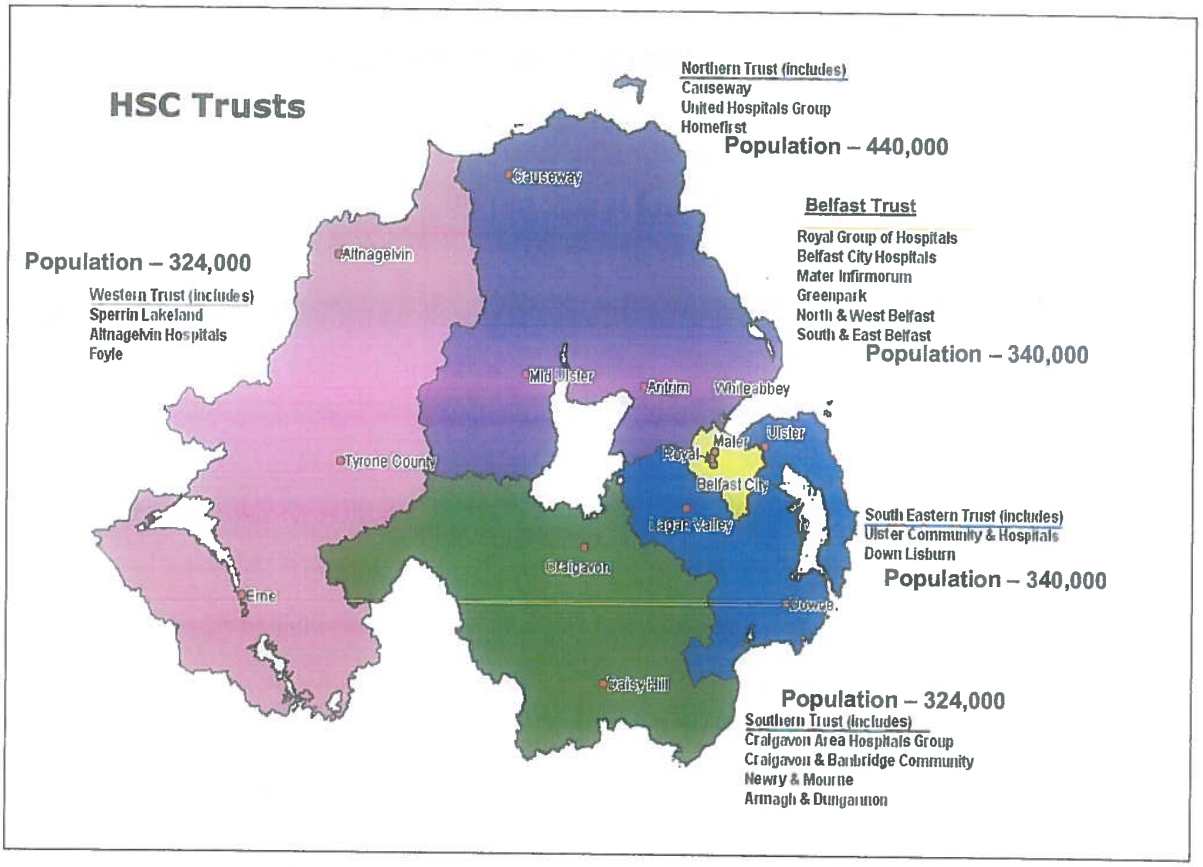
The Regulation and Quality Improvement Authority is a non-departmental public body, established with powers granted under the Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003. It is sponsored by the Department of Health, Social Services and Public Safety, with overall responsibility for assessing and reporting on the availability and quality of health and social care services in Northern Ireland and encouraging improvements in the quality of those services.

The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 places a statutory duty of quality on Health and Social Care (HSC) organisations, and requires the RQIA to encourage continuous improvement in the quality of care and services throughout all sectors in Northern Ireland.

In order to fulfil its statutory responsibilities the RQIA has developed a planned programme of clinical and social care governance reviews of mental health and learning disability services within HSC organisations in N. Ireland. RQIA will also carry out commissioned reviews at the request of the DHSSPS.

Clinical and social care governance is described as a framework within which HSC organisations can demonstrate their accountability for continuous improvement in the quality of services and for safeguarding high standards of care and treatment. Organisations must ensure that there are visible and rigorous structures, processes, roles and responsibilities in place to plan for, deliver, monitor and promote safety and quality improvements in the provision of health and social care.

Table 1: Geographical Overview of HSC Trusts Reviewed



1.2 Safeguards for Children and Vulnerable Adults in Mental Health and Learning Disability Hospitals

This thematic review was undertaken in response to a request from the DHSSPS for independent assurance that the necessary safeguards are in place for children and vulnerable adults in learning disability and mental health hospitals. In-patient mental health services are also provided in a range of units attached to general hospitals and these were also considered within the scope of this review. Throughout the report the term 'mental health hospitals' is used to describe the totality of hospital based mental health services.

This review evaluated those procedures in place within each HSC trust to prevent abuse and to ensure that any incidents, which may arise, are dealt with properly. In particular, the review drew on the matters raised in correspondence (September 2006) from the Permanent Secretary at the DHSSPS to board and legacy trust chief executives.

The review also examined the involvement of service users and carers, advocacy arrangements, voluntary sector involvement and key training for staff in relation to child and

adult protection. The review further considered the number of children and young people being admitted to adult wards in mental health and learning disability hospitals.

1.3 The Review Methodology

The RQIA operates within a value system that supports the belief that learning is at the heart of improvement. To ensure a clear focus on improvement, organisations need to have effective systems, which can identify performance standards and support the learning necessary for improvement. This review considered the systems in place within each trust to safeguard children and vulnerable adults within mental health and learning disability hospitals.

1.3.1 The Review Team

Review teams were multidisciplinary, and included both health and social care professionals (Peer Reviewers) and members of the public (Lay Reviewers) who had undertaken training as reviewers provided by the RQIA.

Lay reviewers came from a range of backgrounds and from all over Northern Ireland. They each played a vital role in review teams, bringing new insights and providing a lay person's perspective on all aspects of the provision of health and social care services.

Peer reviewers worked at a senior level in both clinical and non-clinical roles in HSC organisations. For this review, they had particular expertise in the areas of mental health, learning disability, child/adult protection and governance and possessed a commitment to improving health and social care.

Review teams were managed and supported by RQIA project managers and project administrators.

An identified leader for each review team worked closely with the RQIA project manager during the review to guide the team in its work and ensure that team members were in agreement about the assessment reached.

1.3.2 The Review Process

The review process had three key elements; self-assessment (including completion of self declaration), pre-visit analysis and the validation visit by the review team.

1.3.3 Self Assessment

Self-assessment is based on the statutory duty of quality as enshrined in the legislation and the underpinning requirements for HSC organisations to self assess their progress against the quality standards for health and social care. Self-assessment as a technique is used widely in health and social care regulation, accreditation and licensing across the UK and internationally.

The methodology adopted within this review required trusts to complete self-assessment pro-forma and return this information to RQIA for analysis prior to validation visits by peer and lay reviewers. The questions asked within pro-forma were designed specifically by the RQIA to

capture relevant information and provide opportunity for trusts to present evidence of the safeguards in place for children and vulnerable adults within mental health and learning disability hospitals.

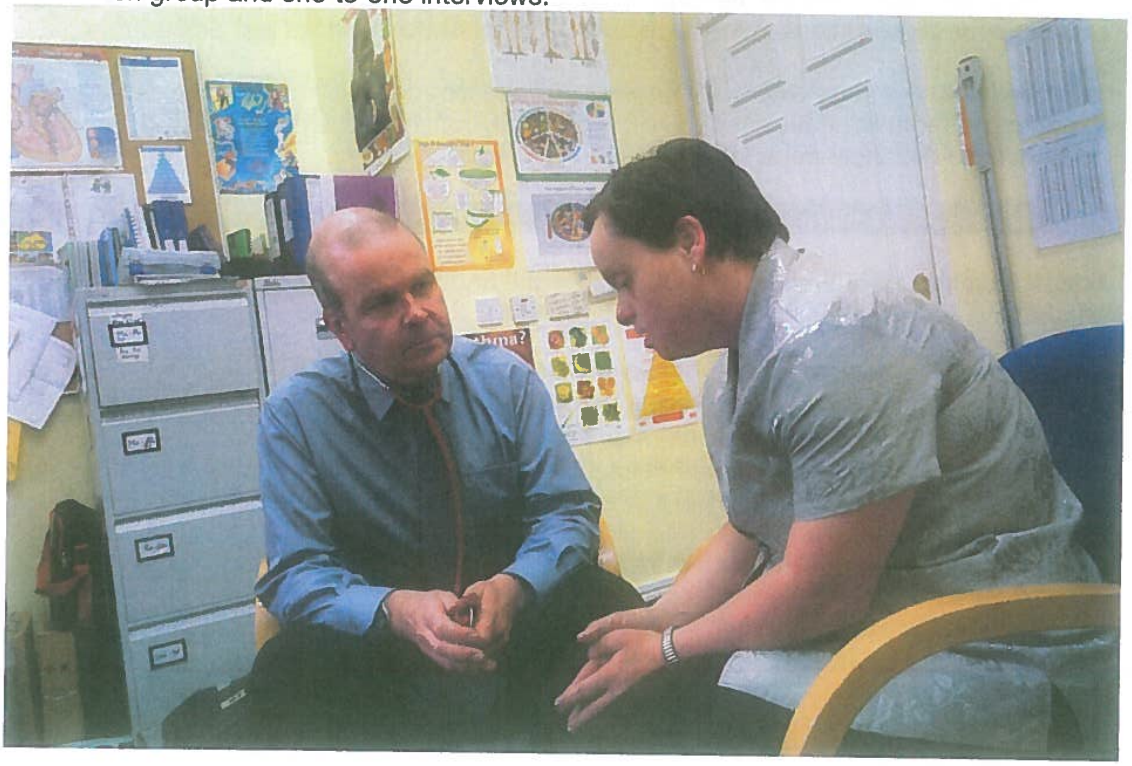
Article 34 of the HPSS (Quality Improvement and Regulation) (NI) Order 2003, places a statutory duty of quality on statutory organisations to; "put and keep in place arrangements for the purpose of monitoring and improving the health and personal social services that it provides to individuals; and the environment in which it provides them". In meeting this legislative responsibility, the trust chief executive signed a declaration confirming the accuracy of the self-assessment return to RQIA.

1.3.4 Pre-visit Analysis of Self Assessment

Self-assessment pro-forma and supporting evidence documentation were analysed by the RQIA review team prior to validation visits. The relevant information was collated onto an information system with commentary on the quality of information and evidence outlined in narrative on an analysis framework, which was then used by the review teams during validation visits.

1.3.5 The Review Visit

Review teams carried out reality testing of the self-assessment during the visits. Based on the initial analysis, review teams used a semi-structured interview schedule in relevant clinical and non-clinical areas. Enquiry was directed at staff, service users and their carers and centred on group and one-to-one interviews.



Reviewers also examined records (clinical/non clinical), relevant policies, procedures and protocols and directly observed clinical and non-clinical environments.

Initial feedback from the review team was given to each HSC trust at the end of the review visit outlining the findings of the review under the headings - strengths, challenges and exemplars.

1.3.6 Reports

Following each review visit, the RQIA project manager drafted trust specific reports detailing the findings of the review team and recommendations for improvement. This draft report was sent to the review team for comment, and then to the organisation to check for factual accuracy.

Once agreement was reached, RQIA compiled an overview report for the DHSSPS on the overall findings of the review across all HSC trusts.

The overview report is made available to the general public in print, the RQIA web site and other formats on request.

2 SERVICES WITHIN TRUSTS

At the time of the review, the new HSC trusts in Northern Ireland were in the very early stages of development following the merging of legacy trusts. These mergers created a considerable challenge for organisations in the development of trust-wide policies and procedures.

Services were to a large extent still organised along legacy trust lines and the self-assessment information returned by trusts generally reflected this approach and as a consequence, findings are at times described in terms of settings.

2.1 General Overview

Trusts' submitted proforma for each mental health and learning disability hospital within their geography. This information is presented in Table 2.

Across all trusts, reviewers were generally impressed with the caring, conscientious and open approach of staff to the vulnerable people in their care and the loyalty shown to the employing trust. Staff demonstrated commitment and dedication to providing the best and safest care possible and were co-operative and helpful in providing information to reviewers. Service users who spoke with reviewers were in the main, complimentary of staff and of the care being provided.
As the focus of this review was on the safeguards in place for children and vulnerable adults within mental health and learning disability hospitals, reviewers did not overly focus on environmental issues. It is acknowledged however, that within individual trust reports, mention has been made of specific issues relevant to reviewers' findings.

Table 2: Mental Health and Learning Disability Hospitals

Trust	Mental Health Hospital	Learning Disability Hospitals
Belfast HSC Trust	Belfast City Hospital Donard Unit (In-patient Adolescent Unit at Knockbracken) Family and Child Psychiatry Unit (located at Forster Green Hospital) Knockbracken Hospital Mater Hospital	Muckamore Abbey Hospital
Northern HSC Trust	Holywell Hospital Causeway Hospital Whiteabbey Hospital	
South Eastern HSC Trust	Ards Hospital Downshire Hospital Lagan Valley Hospital	
Southern HSC Trust	Craigavon Hospital St Luke's Hospital	Longstone Hospital
Western HSC Trust	Gransha Hospital Tyrone & Fermanagh Hospital	Lakeview Hospital

3 TRUST RESPONSES TO CORRESPONDENCE FROM THE PERMANENT SECRETARY

This section of the report focuses on the matters raised in correspondence from the permanent secretary to trust chief executives in relation to the following four issues: -

- Comprehensive risk assessment processes are in place to manage any risk of abuse presented by patients either to other patients or to members of staff,
- Appropriate child and vulnerable adult protection procedures are in place with regard to the recruitment, supervision and management of staff,
- Recording and reporting mechanisms, both within the trust and to appropriate external agencies, are in place, understood by staff and adhered to, and
- Appropriate policies and procedures to prevent and where they occur, detect and manage allegations and incidents of abuse, are in place and are being consistently and robustly applied.

3.1 Comprehensive risk assessment processes are in place to manage any risk of abuse presented by patients either to other patients or to members of staff

All HSC trusts reported that risk and vulnerability assessment processes were in place to take account of the risk of abuse presented by patients either to themselves, other patients or members of staff.

The Belfast HSC Trust reported that comprehensive risk assessment processes were in place across all mental health and learning disability hospital sites to manage the risk of abuse. A clinical risk assessment group has been established in Muckamore Abbey Hospital and the review team noted that initial risk assessment was undertaken for all children admitted to the hospital with further risk assessment and management plans put in place to safeguard children when they are admitted to adult wards. The evidence gathered through site visits satisfied the review team that staff were proactive in the prevention and management of risk.

When a child or young person was admitted to an adult ward within the Northern HSC Trust, a multi-disciplinary meeting was convened to address all risk factors associated with that admission including those risks posed by patients currently on the ward.

In the South Eastern HSC Trust the review team was satisfied that risk assessment was carried out in those inpatient settings visited although had some concerns that the risk assessment tool being used did not adequately address the particular needs of children or young people whilst inpatients on adult wards.

In the Southern HSC Trust, the review team was satisfied with the risk assessment and pre-admission planning and processes in place. However a risk assessment tool examined by the review team in the Craigavon Psychiatric Unit did not provide the necessary detail and analysis to allow for the development of a clear management plan, including the management of risk presented by patients either to other patients or to members of staff. Within Longstone Hospital, a comprehensive process of risk management is undertaken on admission, using the Salford Tool. The review team evidenced that policies and procedures had been implemented in relation to forensic clients and the risks posed to other vulnerable patients. Furthermore, the accommodation within the Interim Assessment and Treatment Unit (IATU) allowed for the separation of male and female living areas when this was deemed necessary.

Whilst the Western HSC Trust had in place risk assessment tools that took account of the risk of abuse, there was evidence that all relevant staff had not received training on their use. Training provision in this area was variable, and noticeably absent within the learning disability programme. The review team also reported variability in staff insights and levels of understanding and knowledge around the concept of risk assessment. Within Lakeview Hospital, the review team were advised that a risk assessment tool being piloted within the learning disability programme alerted hospital staff to patient's traits, behaviours and propensities, which could pose a risk to self or other patients. An untoward incident monitoring group reviewed all incidents on a monthly basis and included representation from the trust's risk management department.

3.2 Appropriate Child and Vulnerable Adult Protection Procedures are in place with regard to the recruitment, supervision and management of staff

All HSC trusts reported through their self assessment returns that a series of pre-employment checks on staff and volunteers were undertaken and which included for example, Protection of Children and Vulnerable Adults (POCVA), Occupational Health, references, (including current employer) professional registration, qualifications, proof of identity and checks in relation to continuous employment or breaks in service.

The self assessment returns and the information provided to review teams during site visits indicated that whilst arrangements for supervision and appraisal were generally in place, these were not always being applied consistently. Delays in fully assimilating staff unto 'Agenda for Change' has adversely impacted on rolling out the knowledge and skills framework. Furthermore, the review teams also noted that the regional guidance for the Clinical Supervision for Mental Health Nurses had not been consistently applied within all mental health hospitals.

RECOMMENDATION:

Trusts should establish robust individual and group supervision structures, which take into account the relevant professional guidelines and ensure that supervision is embedded throughout all professional groups.

3.3 Recording and reporting mechanisms, both within the Trust and to appropriate external agencies, are in place understood by staff and adhered to

Trust self-assessment returns indicated that recording and reporting mechanisms were in place to notify senior trust staff, Health and Social Services Boards, the DHSSPS and the Mental Health Commission of all Serious Adverse Incidents. The evidence elicited by review teams during site visits indicated that arrangements were in place within all trusts to enable the analysis of trends; learning from incidents and for feedback to front line staff through a variety of mechanisms that included ward manager meetings, staff meetings and team briefs.

Members of staff who were interviewed by review teams were familiar with incident reporting procedures, appeared open to reporting incidents and recognised the channels of accountability for incident reporting.

3.4 Appropriate policies and procedures to prevent and where they occur, detect and manage allegations and incidents of abuse, are in place and are being consistently and robustly applied

It is acknowledged that at the time of this review, HSC trusts were endeavouring to co-ordinate and harmonise all legacy trust policies and procedures, which has presented as a considerable challenge. Self-assessment returns indicated that within each HSC trust, a Child Protection Committee was in place and Area Child Protection Committees (ACPC) Policies and Procedures were available and accessible to all staff working within mental health and learning disability hospitals. However work was still required to ensure the regional adult protection guidance was fully implemented within all HSC trusts.

3.4.1 Policies and Procedures

The Belfast HSC Trust reported that a range of processes were in place to review and update policies, procedures and protocols to take account of legislative change and new/revised best practice guidance. Within the Mater Hospital, the review team was satisfied that a robust policy was in place, which ensured the delivery of safe and effective care to children. The review team was also impressed with the liaison arrangements with Child and Adolescent Mental Health (CAMH) services. A range of initiatives have been put in place in Muckamore Abbey following publication of the Social Services Inspectorate report (DHSSPS, 2003) which included; designated Child Protection Nurse specialists supporting Muckamore Abbey Hospital, hospital representation on trust child protection panel and the establishment of a hospital child protection steering group. Whilst the very significant action taken in response to child protection is acknowledged, a number staff who spoke with the review team in Fintona North and Finglass Wards, were not aware of who had lead responsibility for adult protection.

The Northern HSC Trust reported that there were policies and procedures in place regarding the admission and management of young people and vulnerable adults in hospital. The review team was informed that the senior nurse for child protection was responsible for all child protection arrangements, which included the provision of awareness training, the provision of advice/guidance to mental health staff and the induction of new staff.

The South Eastern HSC Trust had set up a trust-wide safeguarding children project to examine trust-wide processes and communications that included defining roles, responsibilities and lines of accountability. This project demonstrated a good example of

collaborative working between mental health and child care services. The trust stated members of staff had been trained to act as 'Safeguarding Children Advisors', which provided staff with a point of contact for information and advice.

Within the Southern HSC Trust, staff interviewed in Craigavon Psychiatric Unit were knowledgeable about child protection issues and were aware of their roles and responsibilities, legislative requirements, statutory functions and patient and carer rights. However, other members of staff interviewed had not received sufficient training and were unable to demonstrate good awareness of child protection issues.

Within the Western HSC Trust, the review team were complimentary of the robust policies and procedures in place governing the admission of children and young people to adult mental health and learning disability wards and of the awareness of staff in putting in place the necessary safeguards.

3.4.2 Looked After Children (LAC) review and audit activity

The information returned from HSC trusts, indicated that within the Belfast, Southern and Western HSC Trusts, reviews had been undertaken in accordance with LAC guidance although LAC reviews were not always subject to audit activity.

The Northern HSC Trust reported that LAC review associated audit activity was 'not applicable' within mental health services, although during site visits, the review team identified at least two cases, which should have been taken forward in accordance with LAC guidance.

The South Eastern HSC Trust reported that LAC reviews were undertaken within Lagan Valley Hospital but not within the psychiatric unit at Ards Hospital or the Downshire Hospital. Notwithstanding, the trust also reported that in 2004/05, one young person had been in the Ards Psychiatric Unit for 176 days. Members of staff who were questioned by the review team regarding the LAC guidance were unaware of the procedures and arrangements and there was no indication from the files examined that any LAC procedures were being followed.

3.4.3 Named Nurse & Named Doctor for Child Protection

Self-assessment returns indicated that within each HSC trust, arrangements were in place to ensure the availability of a named nurse and named doctor for child protection. Within the Southern and South Eastern HSC Trusts, it was further reported that the role of named nurse and named doctor was supported through contact arrangements with Child Protection Nurse specialists.

However, the review team noted that within those wards visited in the Belfast HSC Trust, a number of staff were unaware of the identity of the named doctor for child protection.

Within the South Eastern HSC Trust, a number of staff working in Ards Psychiatric Unit were unable to identify either the named nurse or named doctor with responsibility for child protection.

Similarly, within the Northern HSC Trust, a number of staff within the Ross Thompson Unit did not know the identity of the named doctor with responsibility for child protection.

3.4.4 Children as Visitors

At the time of this review, draft policies in relation to children as visitors were in place within the Belfast, South Eastern and Western HSC Trusts.

However, there was no policy in place within either the Northern or Southern HSC Trusts outlining the arrangements for children visiting adult wards or in relation to children whose parents had been admitted to mental health hospitals.

RECOMMENDATIONS:

Trusts should ensure that appropriate policies and procedures are in place for Looked After Children (LAC) and that all staff work in accordance with LAC guidance.

Trusts should ensure that information in relation to the named nurse and named doctor for child protection is made available to all staff.

4 SERVICE USER INVOLVEMENT AND ADVOCACY ARRANGEMENTS

Through this review, review team members met service users, carers and advocates in a number of ways that included individual and group interviews, incidental discussion during site visits and formal meetings. Whilst reviewers were able to evidence that service users and carers were engaged in a variety of ways within all trusts, their participation in the delivery and evaluation of mental health services was very limited. However, reviewers noted that the involvement of service users and carers in learning disability services was much better established. There was also in the main, an absence of corporate policies in relation to service user and carer involvement.

Trust self assessment returns and the evidence obtained by reviewers through on-site visits indicated that partnership working with a range of different groups and advocacy services was in place across all trusts; however in a number of settings these arrangements required further development.

Reviewers were complimentary of the arrangements in place within learning disability hospitals to engage patients and carers and provide independent advocacy services. Opportunities therefore exist within trusts for shared learning between learning disability and metal health services and settings to further develop this important area.

4.1 Involvement of Service Users and Carers

Public and service user involvement is one of the fundamental principles which underpins the Quality Standards for Health and Social Care and the views and experiences of service users, carers, staff and local communities should be taken into account in the planning, delivery, evaluation and review of services.

Belfast Health & Social Care Trust
Across all mental health services within the trust there was good evidence of service user and carer involvement. At the time of the review, a service user consultant post was being advertised which represented a unique initiative in Northern Ireland.

Within Muckamore Abbey Hospital, the review team commented on the open and transparent culture and the involvement of non-statutory organisations in the planning, delivery and evaluation of care. A number of wards within the hospital had patient/carer forums as well as a larger day care forum which in the main acted to safeguard patients' rights but has in the past provided a service user perspective on significant capital and policy developments.

Northern Health & Social Care Trust
The trust did not have a policy in place in relation to service user and carer involvement although senior managers were able to demonstrate to the review team how service users had been enabled to become involved in policy development. On the Holywell Hospital site, a public advisory group had been involved with the hospital management team in strategy planning and the development of new services and examples were provided to the review team of how service users helped shape services such as "*The Oasis*". On the Whiteabbey Hospital site, the review team found there was no mechanism in place to obtain feedback from service users on their experiences of the care provided.

South Eastern Health & Social Care Trust
Whilst it is acknowledged that a 'Mental Health Alliance' of service users and carers was in place within the trust, no service users or carer representatives were available to meet with

the review team on the Downshire site and the review team were of the opinion that service user and carer involvement in the planning, delivery and evaluation of services was limited. However, within the Ards Psychiatric Unit, the review team were satisfied with the examples of good practice that were shared with them in relation to the operational involvement of service users and carers.

Southern Health & Social Care Trust

The Assistant Director for Health and Wellbeing has been tasked with the development of service user involvement strategies, including monitoring, feedback and action planning to encourage public involvement. Service user and carer forums were operational within some areas of the trust although the actual involvement of service users and their carers was variable. Within St Luke's Hospital, service users and carers were involved in the 'Mind the Gap Project' and the ongoing evaluation of home treatment. The review team noted that whilst patients were given opportunity to voice concerns during impromptu meetings in the Craigavon Psychiatric Unit, this appeared to be driven by the needs of the service rather than service users. Within Longstone Hospital, the review team witnessed good rapport and interaction between patients and staff during site visits.

Western Health & Social Care Trust

At the time of the review the trust had yet to formalise the involvement of service users/carers at a strategic level to ensure a more patient centred approach was taken in relation to the planning and implementation of mental health services. A mental health 'Acute Care' forum was in place and the review team were able to evidence service user and carer involvement in the development and improvement of practice. However, those carers who met with the review team expressed a desire for greater inclusion in relation to admission and discharge processes.

4.2 Advocacy Arrangements & Voluntary Sector Involvement

In 2003, a review was undertaken at the behest of The Northern Ireland Human Rights Commission examining the human rights issues associated with mental health law and practice. In 'Connecting Mental Health and Human Rights[2]', the authors noted that "there is no right to representation or advocacy under The Mental Health (Northern Ireland) Order 1986, and people are not automatically offered or allocated a lawyer or advocate". The report concluded that the need for advocacy and voluntary sector involvement in mental health services is critical to ensure that the human rights of service users are fully upheld through all aspects of the care pathway, which for some service users may be life-long. These conclusions are equally applicable to learning disability services.

Belfast Health & Social Care Trust

The trust highlighted their commitment to using advocacy services and the review team evidenced this during site visits. Advocacy services were provided by a range of organisations, for example, the NI Association for Mental Health (NIAMH), (CAUSE), Bryson House, Voice of Young People in Care (VOYPIC), and the Chinese Welfare Association.

Within Forster Green Hospital whilst there was no independent advocacy arrangements in place, the review team was informed of discussions with NIAMH and CAUSE to develop this

[2] 'Connecting Mental Health and Human Rights' (Northern Ireland Human Rights Commission, 2003)

initiative. Notwithstanding, at the time of this review, a patient advocate service was involved in obtaining children's views in relation to the plans for a new build and associated service developments although this involvement was not on an ongoing basis.

Within Muckamore Abbey Hospital, the review team noted the strong drive to enhance advocacy and service user involvement through the use of independent organisations such as Bryson House and Mencap.

Northern Health & Social Care Trust

Independent advocacy services were available throughout the trust and a service level agreement was in place with NIAMH although this service was not available out of hours. During site visits, the review team observed posters for the mental health charity "Rethink" and the Citizens Advice Bureau.

South Eastern Health & Social Care Trust

The trust indicated that independent advocacy arrangements were in place for all mental health service users. The review team observed that posters and leaflets advising service users about advocacy services were readily available and staff reported that service users are informed about advocacy services on admission and throughout their treatment. On the Ards Hospital site, the review team evidenced good partnership working between advocates and staff, however due to the variety of advocacy services available, staff were not always clear about which service was best for particular service users. On the Lagan Valley site, a number of staff interviewed were unable to provide information in relation to the advocacy services available.

Southern Health & Social Care Trust

A number of voluntary sector organisations were involved in partnership working with the trust, for example, Praxis and NIAMH, Mencap, Downs Syndrome Association but the trust itself did not use volunteers. The review team noted that trust involvement was through service user advocates and carer representatives. At the time of this review, Mencap was providing an independent advocacy service within Longstone Hospital and although the service was only provided 8 hours per week, it covered a caseload of approximately 170 patients.

Western Health & Social Care Trust

Advocacy services were provided to relatives and carers of people with mental health problems by the peer led mental health charity, CAUSE. A service user group '*Heads Together*' represented the general views of service users and representatives from that group were key members on the Acute Care Forum and other relevant committees. The review team also evidenced the involvement of a number of self-help organisations, for example, "*Foyle Advocates*" and "*Mind Yourself*".

Within the learning disability programme, the trust commissioned advocacy services from a group known as the Western Area Learning Disability Action Group (WALDAG), an umbrella organisation, made up of parents and friends of patients with a learning disability. In addition to providing independent advocacy for a named group of patients, WALDAG have also contributed to the planning and development of Lakeview Hospital and at the time of the review were involved in the development of a replacement facility for Mourne House. Arrangements were also in place that enabled WALDAG to advocate for patients within a local nursing home.

RECOMMENDATIONS:

In addressing the HPSS Quality Standards for Health and Social Care, HSC trusts should continue to develop policies and procedures that actively engage service users and their carers in the planning, delivery and evaluation of mental health and learning disability services.

Trusts should develop clear service user and carer involvement strategies that set out how service users, carers, volunteers, staff and local communities can be actively involved in the planning, delivery, evaluation and review of mental health and learning disability services.

5 KEY TRAINING FOR STAFF AND VOLUNTEERS

Training is a key requirement for safeguarding children and vulnerable adults in mental health and learning disability hospitals. Analysis of a number of Serious Adverse Incident reviews indicated that specific training should be provided to all staff and volunteers in the areas of child protection, adult protection and the management of aggression and challenging behaviour.

Information returned from all HSC trusts in relation to key training was of poor quality, therefore it was not possible to make direct comparisons across trusts in respect of the numbers and percentages of staff trained.

5.1 Child Protection Training

The Area Child Protection Committees' (ACPC) Regional Policy and Procedures[3] state, "*Effective child protection depends on the knowledge and judgment of all staff working directly with children and those who provide guidance, supervision and direction. It is important; therefore that staff in direct contact with children and those in supervisory and management positions receive relevant training. Training should be tailored to meet the needs of different staff*". In 'Co-operating to Safeguard Children[4]' three levels of training are detailed to meet the needs of staff based on their roles and responsibilities. These are described in Table 3.

Table 3: Stages of Child Protection Training

Stages of Child Protection Training	
Stage One	Introduction to the safeguarding of children, having regular contact with children and/or parents
Stage Two	Foundation training for staff working with children and families where there may be a high risk of significant harm, but the staff are not involved directly in child protection services
Stage Three	Specialist training for staff directly involved in investigation, assessment and intervention to protect children considered to be at risk of significant harm

In applying this guidance, there is an expectation that at a minimum, all staff working in mental health and learning disability services should be trained to stage one. Training at stages 2 and 3 should be provided to staff working in more specialist areas. The provision of dedicated child protection training is essential for the provision of safe and effective services. Within this review, trusts were asked to provide information on the numbers of staff who received formal child protection training over a 3-year period (2004/05–2006/07). This information is presented in Table 4.

The information returned from trusts indicated that there had been limited provision of child protection training for staff working within mental health and learning disability hospitals and the figures presented in Table 4 indicated that not all staff had received stage 1 training. This was supported by review teams findings in a number of areas, for example, at the time of this review, no formal training had been provided to staff working in the Ross Thompson Unit (Northern HSC Trust) and the Ards Psychiatric Unit (South Eastern HSC Trust).

The review team also noted that in the main, child protection training was almost exclusively taken up by nursing staff with little involvement of medical and other clinical and non-clinical grades of staff.

The review team evidenced that all staff in Donard Regional Adolescent Unit had been trained to stage 2.

[3] Area Child Protection Committees' Regional Policy and Procedures (DHSSPS, 2005)
[4] Co-operating to Safeguard Children (DHSSPS, 2003)

Table 4 - Child Protection Training in Mental Health and Learning Disability Hospitals

Child Protection Training	2004 - 2005 Number of staff trained	2005 – 2006 Number of staff trained	2006 – 2007 Number of staff trained
Stage 1			
Belfast HSC Trust	10	86	142
Northern HSC Trust	0	63	12
South Eastern HSC Trust	15	35	25
Southern HSC Trust	56	70	70
Western HSC Trust	0	0	181
Stage 2			
Belfast HSC Trust	0	21	4
Northern HSC Trust	0	0	0
South Eastern HSC Trust	0	0	15
Southern HSC Trust	0	0	0
Western HSC Trust	0	0	0
Stage 3			
Belfast HSC Trust	0	3	0
Northern HSC Trust	0	0	0
South Eastern HSC Trust	0	0	14
Southern HSC Trust	0	0	0
Western HSC Trust	0	0	0

Within the Southern HSC Trust, staff within the two identified adult wards which admit children (Interim Assessment and Treatment Unit at Longstone and Cloughmore Ward at St Luke's) had been prioritised for child protection training although no evidence was found indicating staff had been trained to stage 2.

Ward staff at Lagan Valley Hospital told the review team that child protection training was not provided, as children were not admitted to the ward. However, this fails to take into account the number of service users who had children as dependents or visitors.

5.2 Adult Protection Training

The Regional Guidance states that the *"procedures detail the processes that must be followed in the event of a suspicion or allegation that a vulnerable adult is at risk of abuse, exploitation or neglect".* It is important therefore that all staff receive dedicated training in relation to adult protection, are familiar with the regional guidance document and work in accordance with it.

The self-assessment returns from all trusts for the 3-year period (2004/05–2006/07) indicated that only very small numbers of staff had been provided with formal training on adult protection, for example, the information returned from the Northern, Western and South Eastern HSC Trusts indicated that a total of only 85 staff received training on adult protection

(over the three year period 2004-2007) within both mental health and learning disability hospitals.

Staff informed the review teams that local adult protection policies and procedures were still in use within the Belfast and Northern HSC Trusts despite those organisations having endorsed the regional guidance.

5.3 Management of Challenging Behaviour and Aggression Training

Within all trusts, the review teams were advised that training on the management of challenging behaviour and aggression was mandatory for all staff. However the information submitted by trusts in relation to the numbers of staff who had accessed this training over the three-year period (2004-2007) did not support this contention. The relatively low numbers suggest that not all staff had received training.

Analysis of trust self assessment returns and information obtained by review teams during site visits indicated that dedicated training on the management of aggression and challenging behaviour was principally uni-disciplinary and in the main provided to nursing staff by nursing staff. Other clinical and non-clinical staff did not always have access to this important training.

Within legacy trusts, training had been commissioned from a range of different providers, e.g. Management of Aggression and Potential Aggression (MAPA), Honestas, Educare and Social Services Training Units. Therefore, within new trust structures, the potential exists for conflict between the various methodologies in use and within the Southern HSC Trust staff voiced this concern to the review team.

5.4 Volunteer Training

In the main, there was very limited use of volunteers in mental health hospital services within all trusts. Where volunteers were used, this was by way of service level agreements with a number of voluntary organisations that were responsible for providing training to their staff. There was no indication from the information submitted by trusts or through review visits that the training provided had been quality assured by the commissioning trust. Furthermore, mandatory training provided to staff e.g. child and adult protection and the management of aggression was not always made available to volunteers.

Within learning disability hospitals, there was a higher reported level of engagement with volunteers; in particular, the Western HSC Trust self-assessment returns indicated that for Lakeview Hospital, 100 volunteers had been trained in 2004/05; 130 in 2005/06 and 168 in 2006/07. Volunteer input was specific to a four-week summer scheme activity programme for children with a learning disability based within Lakeview Hospital. All volunteers were POVCA checked and were issued with an honorary contract.

In Muckamore Abbey Hospital, there was limited volunteer provision in the wards visited, however volunteers were utilised within the hospital in a range of settings and at the time of this review, the trust was in the process of identifying the training needs of volunteers.

RECOMMENDATIONS:

Trusts should develop information systems, which ensure that details of attendance at training events is captured and provides assurance that all staff receive relevant training on a regular basis.

Trusts should ensure that child protection training is provided (in accordance with regional guidance) to all staff and volunteers working in mental health and learning disability services.

Trusts should ensure that adult protection training is provided to all staff and volunteers working in mental health and learning disability services.

Trusts should ensure that all staff (clinical and non-clinical) and volunteers working in mental health and learning disability services are formally trained in the management of aggression / challenging behaviour.

Trusts should adopt a consistent approach to the management of aggression.

Trusts should ensure that the training provided by those organisations from which it commissions services is of a satisfactory standard.

6 CHILDREN & YOUNG PEOPLE IN MENTAL HEALTH AND LEARNING DISABILITY HOSPITALS AS PATIENTS

Within the self-assessment pro-forma, trusts were asked to report the number of children and young people inappropriately admitted to adult wards within mental health and learning disability hospitals. Within all trusts, review teams were informed that the admission of a child or young person to an adult ward was considered a Serious Adverse Incident and the DHSSPS, the Mental Health Commission and commissioning HSS Board were formally notified.

Trusts also reported that constant supervision was generally put in place for such children, individual rooms were allocated as far as possible and a strong emphasis placed on risk assessment throughout their stay, both in regard to the child and for other patients on the ward. The admission of children and young people to adult mental health and learning disability wards is an issue that requires urgent action on a regional basis.

6.1 Children & Young People in Mental Health Hospitals as Patients

In the Belfast, South Eastern and Southern HSC Trusts, the review team evidenced that policies and protocols were in place to manage the placement of children and young people on adult wards and for those staff providing their care.

At the time of this review, the Belfast HSC Trust was in discussion with CAMH services to enhance the interface with adult services to more effectively address the needs of children and young people being cared for on adult wards The review team was informed that additional dedicated teams were to be established to deal with crisis response and out of hours services for adolescents.

Within the Northern HSC Trust, two nurses in Holywell Hospital had completed additional training through Queens University Belfast in relation to adolescent mental health and when children or young people required admission to an adult ward, the trust endeavoured to provide such placements in Holywell Hospital. Similar arrangements were reported in the Belfast and Southern HSC Trusts.

Within the Western HSC Trust, the review team was complimentary of a forum that had been established in conjunction with the Western Health and Social Services Board which monitored and audited the issue of children being placed on adult wards.

The number of children and young people admitted to mental health hospitals and the total length of stay reported by HSC trusts is illustrated in Table 5.

Analysis of the information returned from trusts indicated that there were a total of 273 admissions of children and young people to adult wards in mental health hospitals over the period 2004 – 2007. Whilst it was difficult to undertake further analysis of this information in the absence of a greater understanding of the drivers for admission, the data returned indicated that 94 admissions (34%) occurred within the Western HSC Trust.

Table 5 - Children & Young People in Mental Health Hospitals as Patients

Total Number of Children & Young People (< 18 yrs) who spend time as patients in adult wards (average length of stay in brackets)		2004-2005	2005-2006	2006-2007
Belfast HSC Trust	Knockbracken*	10 (14.6 days)	5 (39.2 days)	2 (7 days)
	Mater	0	9 (56 days)	8 (29 days)
	Windsor	5 (10.6days)	5 (23 days)	4 (14.7 days)
Northern HSC Trust	Holywell	14 (46 days)	11 (38 days)	7 (57 days)
	Ross Thompson	3 (21 days)	11 (21 days)	2 (71 days)
	Whiteabbey	0	0	0
South Eastern HSC Trust	Downshire	7 (23 days)	2 (26 days)	1 (25 days)
	Lagan Valley	11 (5 days)	6 (58 days)	4 (33 days)
	Ards	1 (176 days)	5 (104 days)	5 (46 days)
Southern HSC Trust	Craigavon**	17 (24 days)	15 (46 days)	6 (60 days)
	St Luke's	2 (3 days)	0	1 (6 days)
Western HSC Trust	Gransha	21 (15 days)	16 (31 days)	15 (25 days)
	Tyrone & Fermanagh	16 (21.4 days)	14 (17.3 days)	12 (16.3 days)

Notes:

* *Donard Ward (Knockbracken) and the Child and Family Unit at Forster Green Hospital are specialist services for children and young people and therefore admissions to these units are not included in the figures.*

** *These figures also include those children and young people admitted to Cloughmore Ward on the St. Luke's Hospital site.*

6.2 Children & Young People in Learning Disability Hospitals as Patients

Muckamore Abbey Hospital

A policy was in place, which set out very specific responsibilities when a child required placement on an adult ward. The review team were informed that such children were placed at the highest level of supervision; risk assessments were completed and additional safeguards put in place as necessary.

Lakeview Hospital
Staff, working both in the children's unit in Lakeview Hospital and throughout the trust were knowledgeable with regard to the ACPC child protection guidance and were clear about safeguards that should be put in place when children spend time on adult wards.

During the site visit to Lakeview Hospital, the review team became aware that there were significant periods of time when a registered nurse was not always present on Crannog Lodge particularly during the evening and at night. This issue was brought to the attention of the Director and the trust subsequently made provision for trained night cover within Crannog Lodge.

Longstone Hospital
At the time of the review, Longstone Hospital had a draft protocol for the admissions of under 18's to the Interim Assessment and Treatment Unit, which was out for consultation. This protocol included the requirement that each admission of an under 18 must be reported but did not state the mechanisms for reporting or who would take responsibility at each stage of the process. The review team felt the draft policy should include timeframes, including immediate allocation of one to one supervision prior to placement of a child on the ward. Following the review, the trust has taken action to ratify this policy.

The number of children and young people admitted to learning disability hospitals and the total length of stay reported by trusts is illustrated in Table 6.

Table 6 - Children & Young People in Learning Disability Hospitals as Patients

Total Number of Children & Young People (< 18 yrs) who spend time as patients in adult wards (average length of stay in brackets)		2004-2005	2005-2006	2006-2007
Belfast HSC Trust	Muckamore	10 (201.6 days)	11 (140.2 days)	7 (161.4days)
Southern HSC Trust	Longstone	4 (128 days)	4 (240 days)	2 (75 days)
Western HSC Trust	Lakeview	9 (49 days)	8 (41 days)	6 (15 days)

RECOMMENDATION:

The DHSSPS should work closely with HSC organisations to minimise the number of children and young people admitted to adult wards in mental health and learning disability hospitals.

6.3 Child Protection Investigations

Within the self-assessment returns, HSC trusts were asked to report on the number of child protection investigations undertaken during the 3-year period 2004-2007. The Northern, South Eastern and Southern HSC Trusts reported that no child protection investigations had been undertaken in relation to hospital services.

Within the Belfast HSC Trust, 6 investigations had been carried out of which 1 allegation had been substantiated and 4 unsubstantiated. At the time of this review, 1 investigation was still ongoing.

Within the Western HSC Trust, whilst 2 investigations had been undertaken, the allegations were unsubstantiated.

6.4 Adult Protection Investigations

At the time of this review, the review team had an expectation that all trust staff would be working in accordance with the regional adult protection guidance. However the review team noted that local legacy trust policies and procedures continued to be in use in a number of sites visited and copies of the regional guidance was not always available within facilities. This was particularly the case within the Belfast and Northern HSC Trusts.

Within self assessment returns, HSC trusts were asked to report on the number of adult protection investigations undertaken during the 3 year period 2004-2007. However, the information returned in relation to mental health hospitals was at times incomplete or inaccurate. As a consequence, it is not possible to provide a regional overview of the number of investigations undertaken.

In relation to the number of adult protection investigations undertaken within learning disability hospitals, the information provided was of a much higher quality allowing for the following overview to be presented.

Table 7 – Number of Adult protection Investigations in Learning Disability Hospitals

Hospital	Substantiated allegations	Unsubstantiated allegations
Muckamore Abbey	3	23
Longstone	3	1
Lakeview	3	6

Whilst this review did not examine the nature of substantiated abuse, the information returned from HSC trusts indicated that in the main, substantiated incidents of abuse were of a physical nature.

RECOMMENDATION:

Trusts should fully implement the Regional Adult Protection Policy and Procedural Guidance.

7.0 CONCLUSION

This overview report which is further informed by the individual trust reports sets out the performance of trusts in relation to the safeguards in place for children and vulnerable adults within mental health hospitals and learning disability hospitals.

This review focused on policy and procedural development, the numbers of children and young people treated in adult wards and the relevant areas of training for staff in child and adult protection. In particular, the review drew on the matters raised in correspondence from the permanent secretary to legacy trust chief executives.

As part of the review process, trusts were provided with immediate feedback on the findings of the individual review teams. This feedback was based on the challenges and strengths identified within each trust. Whilst there were a significant number of examples of good practice identified throughout the review, RQIA are concerned at the work that remains outstanding within all trusts, especially in relation to the deficits in staff training and the numbers of children and young people being treated on adult wards.

Within new trust structures, the opportunity now exists for organisations to work much more collaboratively to take this work forward in a consistent and cohesive manner. Within this overview report, RQIA recommends that HSC organisations work collaboratively with the DHSSPS to address the significant issue of children and young people being admitted to adult wards.

8.0 SUMMARY OF KEY RECOMMENDATIONS

User Involvement

- In addressing The Quality Standards for Health and Social Care, HSC trusts should continue to develop policies and procedures that actively engage service users and their carers in the planning, delivery and evaluation of mental health and learning disability services.

- Trusts should develop clear service user and carer involvement strategies that set out how service users, carers, volunteers, staff and local communities can be actively involved in the planning, delivery, evaluation and review of mental health and learning disability services.

Recruitment, supervision and management of staff procedures

- Trusts should establish robust individual and group supervision structures, which take in to account the relevant professional guidelines and ensure that supervision is embedded throughout all professional groups.

Appropriate policies and procedures

- Trusts should ensure that appropriate policies and procedures are in place for Looked After Children (LAC) and that all staff work in accordance with LAC guidance.
- Trusts should ensure that information in relation to the named nurse and named doctor for child protection is made available to all staff.

Key Training for Staff and Volunteers

- Trusts should develop information systems, which ensure that details of attendance at training events is captured and provides assurance that all staff receive relevant training on a regular basis.
- Trusts should ensure that child protection training is provided (in accordance with regional guidance) to all staff and volunteers working in mental health and learning disability services.
- Trusts should ensure that adult protection training is provided to all staff and volunteers working in mental health and learning disability services.
- Trusts should ensure that all staff (clinical and non-clinical) and volunteers working in mental health and learning disability services are formally trained in the management of aggression / challenging behaviour.
- Trusts should adopt a consistent approach to the management of aggression.
- Trusts should ensure that the training provided by those organisations from which it commissions services is of a satisfactory standard.

Children and Young People in Adult Wards

- The DHSSPS should work closely with HSC organisations to minimise the number of children and young people admitted to adult wards in mental health and learning disability hospitals.

Adult Protection Guidance

- Trusts should fully implement the Regional Adult Protection Policy and Procedural Guidance.

Appendix 1 – Peer and Lay Reviewer

Paul Bell
Consultant Psychiatrist
Belfast Health and Social Care Trust

Annie Burrell
Lay Reviewer

Raymond Buckley
Lay Reviewer

Mark Campbell
Inspector
RQIA

Margaret Cassidy
Lead Nurse Psychiatrist
Belfast Health & Social Care Trust

Patrick Convery
OT Manager/Mental Health Commissioner
Western Health & Social Services Trust

Pat Cullen
Lead Commissioning Nurse
Eastern Health & Social Services Board

Suzanne Cunningham
Inspector
RQIA

Oscar Daly
Clinical Director Psychiatry
South Eastern Health & Social Care Trust

Dr Diana Day-Cody
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Western Health and Social Care Trust

Paul Davidson
Lay Reviewer

Maurice Devine
Consultant Nurse Learning Disability
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Trevor Fleming
Assistant Director Mental Health Nursing
Northern Health & Social Care Trust

Dr Peter Gallagher
Consultant Child Psychiatrist
Northern Health & Social Care Trust

Mandy Gormley
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Janet Haines-Wood
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Belfast Health & Social Care Trust

Eileen Harvey
Social Work Manager
South Eastern Health & Social Care Trust

Yvonne Kirkpatrick
Governance Manager
Belfast Health & Social Care Trust

Anne Madill
Senior Governance Manager
Southern Health & Social Services Board

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Dr Estelle McFarland
Consultant Psychiatrist
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Northern Health & Social Care Trust

Mairead Mitchell
Assistant Director Service Improvement & Governance
Belfast Health & Social Care Trust

Aisling Curran
OT Services Manager
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Janice Molloy
Lay Reviewer

Dr Anne Montgomery
Consultant Psychiatrist
Retired

Gordon Moore
Principal Nurse
Disability Services
South Eastern Health & Social Care Trust

Peter Murray
Lay Reviewer

Philip O'Hara
Children's Inspector
RQIA

Patricia Patten
Lay Reviewer

Robert Porter
Lay Reviewer

Esther Rafferty
Senior Manager
Community Mental Health
Belfast Health & Social Care Trust

John Rafferty
Head of Home
Cloughreagh House
Southern Health & Social Care Trust

Jim Simpson
Service Planner Mental Health & Learning Disability
Western Health & Social Services Board

Appendix 2 – RQIA Project Team

Project Management

Hilary Brownlee
Project Manager
RQIA

Bridget Dougan
Project Manager
RQIA

Zoe Hunter
Project Manager
RQIA

Mary McClean
Project Manager
RQIA

Jacqui Murphy
Project Manager
RQIA

Jude O'Neill
Assistant Director of Operations
RQIA

Phelim Quinn
Director of Operations & Chief Nurse Advisor
RQIA

Administrative Support

Katrina Andrews
Project Administrator
RQIA

Tony Hanna
Project Administrator
RQIA

Laura Sharples
Administrative Team Leader
RQIA

Appendix 3 - Glossary of Key Terms & Abbreviations

Glossary of Key Terms & Abbreviations

Term	Definition
Accountability	The state of being answerable for one's decisions and actions. Accountability cannot be delegated.
Adverse incident	An incident, accident or occurrence, relating to systems or procedures which results in harm, or an injury, or near miss to a patient, member of staff or the public.
Appraisal	Examination of people or the services they provide in order to judge their professional qualities, successes or needs.
Audit	The process of measuring the quality of services against explicit standards.
CAMH Services	Child and Adolescent Mental Health Services
Clinical and Social Care Governance (CSCG)	A framework within which HSC is accountable for continuously improving the quality of their services and safeguarding high standards of care and treatment.
Peer Review	Review of a service by those with expertise and experience in that service, either as a provider, user or carer, but who are not involved in its provision in the area under review.
POCVA	Acronym for the Protection of Children and Vulnerable Adults (NI) Order 2003 (POCVA). POCVA aims to improve existing safeguards for children and vulnerable adults by preventing unsuitable people working with them in paid or voluntary positions.
Risk-Assessment	The identification and analysis of risks relevant to the achievement of objectives.

LIS-10608

The **Regulation** and **Quality Improvement Authority**

27 June 2008

DSS - for action
Acknowledge

Dr Paula Kilbane
Chief Executive
EHSSB
Champion House
12-22 Linenhall Street
Belfast
BT2 8BS

Paula

Dear Dr Kilbane,

RE: RQIA REVIEW IN CHILD PROTECTION SERVICES

The Regulation and Quality Improvement Authority (RQIA) plans to undertake a review of Child Protection Services in Health and Social Care (HSC) Trusts and Health and Social Services (HSS) Boards.

Recommendations from the SSI Overview Report "*Our Children and Young People - Our Shared Responsibility*" (December 2006) will be used as the focus for this review.

With this in mind, and to help inform the planning of the review, I would be grateful to receive a copy of your organisation's Action Plan in response to the recommendations of the SSI Overview Report.

At this time it would also be helpful if you would identify the affiliate with whom we can liaise to take forward this process over the coming months.

A response *no later than* Friday 18th July 2008 would be greatly appreciated.

As our planning for this review progresses we will, of course, endeavour to ensure your nominated affiliate is kept informed. Nevertheless, if you have any queries, or require additional information or clarification please do not hesitate to contact Fiona Goodman, Acting Team Manager - Children's Services or Jude O'Neill, Team Manager - Mental Health and Learning Disability at:

The Regulation and Quality Improvement Authority
9th Floor
Riverside Tower
Lanyon Place
BELFAST
BT1 3BT

Tel: 028 90 517500

Thank you for your assistance and support in taking forward this important work.

Yours sincerely,

Alice

Alice T Casey
Interim Chief Executive

Director of Social Services: Hugh Connor
Direct line: 028 9055 3966
Fax: 028 9055 3620
Email: hconnor@ehssb.n-i.nhs.uk
Ref: G:\SHARED\MReynolds\Letters\2008\800mr.doc

By Email

8 July 2008

Ms Bernie McNally
Nore Villa
Knockbracken Healthcare Park
Saintfield Road
Belfast
BT8 8BH

Dear Bernie

HISTORIC CASE REVIEW: CHILDREN'S CASE FILES

The Board in considering the process by which it should undertake a review of existing cases in relation to allegations of past abuse at Lissue/FGH wishes as a first step to review the case records of the following children:

JH
V McC
K W
MA
TM
MD
MR

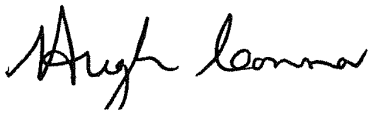
In all cases the Family and Child Care and CAMHS files are requested by the Board, although in the case of V McC it is likely that only a CAMHS file is available as her home Trust has no record of her being a client.

Following a review of these cases the Board will then be in a position to decide how best to undertake any necessary further case analysis.

I should be grateful if you would arrange for the children's files to be delivered to the Board by 19 July 2008.

Your assistance in this matter is appreciated.

Yours Sincerely



HUGH CONNOR
DIRECTOR SOCIAL SERVICES

From the Permanent Secretary
and HSC Chief Executive
Dr Andrew McCormick

Department of
Health, Social Services and Public Safety
www.dhsspsni.gov.uk

AN ROINN
Sláinte, Seirbhísí Sóisialta agus Sábháilteachta Poiblí

MÄNNYSTRIE O
Poustie, Resydènter Heisin an Fowk Siccar

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Alice Casey
Interim Chief Executive
Regulation & Quality Improvement Authority
9th Floor
Riverside Tower
5 Lanyon Place
BELFAST
BT1 3BT

Ref: SECGM/728/2008
AMCC 1947

Date: 28 November 2008

Dear Alice,

REVIEW OF SAFEGUARDS IN PLACE FOR CHILDREN AND VULNERABLE ADULTS IN MENTAL HEALTH AND LEARNING DISABILITY HOSPITALS IN HSC TRUSTS

Thank you for your letter of 8 August 2008 enclosing a copy of the above report. I am grateful to you for agreeing to delay its publication until the Department could consider its findings and recommendations in detail. I apologise that this has taken longer than anticipated.

This is an important and comprehensive report and I have drawn it to the attention of the Minister, who welcomes its recommendations.

As you know, the Minister and the Department place a very high priority on the care and protection of children and vulnerable adults, particularly those in mental health and learning disability hospitals.

I have already written to all five HSC Trusts, endorsing the recommendations of the Senior Management Group (SMG), set up by the PSNI and Health and Social Services to co-ordinate the investigation of allegations of sexual abuse by children and vulnerable adults in Muckamore Abbey Hospital. You will have received a copy of those letters. In line with recommendation 5, all Trusts will be required to produce an action plan in response to the RQIA's report and to return these action plans to the Department.

I should be grateful if you would arrange to notify the Department when you have issued your report to the service. I will then write to Trusts formally requesting a copy of their action plans and would welcome your views on the adequacy of these plans once they have been received.

Yours

Andrew

ANDREW McCORMICK

Lissue & Foster Green Retrospective Sampling (312) - DHSSPS - 04-11-13 OPT

From the Permanent Secretary
and HSC Chief Executive
Dr Andrew McCormick

Department of
Health, Social Services
and Public Safety
www.dhsspsni.gov.uk

AN ROINN
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Phelim Quinn
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Riverside Tower
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BT1 3BT

Ref: AMCC 2042

Date: 29 January 2009

Dear Phelim

Review of Safeguards in Place for Children and Vulnerable Adults in Mental Health and Learning Disability Hospitals in HSC Trusts

I am grateful for Alice Casey's letter of 11 December 2008 in response to my letter of 28 November. Our professional advisers have now had an opportunity to consider the extent and detail of the Trusts' Quality Improvement plans (while they had been shared with the Department's Mental Health Unit in August 2008, they had not at that stage been put formally to others here who had an interest).

Now that RQIA has also had the opportunity to consider the Trust Quality Improvement Plans, I would ask you to confirm, that in giving approval for the publication of the RQIA report, you are content with the appropriateness of Trust responses i.e. coverage of relevant recommendations in respect of individual Trusts.

As I have advised previously, the Minister and the Department place a very high priority on the care and protection of children and vulnerable adults, particularly those in mental health and learning disability hospitals. I am, therefore, pleased to note your comments that you are currently refining your methodology for the programme of inspection visits to hospitals and community services during 2009/10 and that this programme should provide you with an opportunity to monitor the actions taken by Trusts in response to their Quality Improvement Plans.

Within this context, I would ask that you engage with the new Regional Health and Social Care Board in order to establish regular meetings with the Trusts, which would allow them to share information regarding the implementation of the recommendations.

Yours sincerely

ANDREW McCORMICK

cc: Linda Brown
Maura Briscoe
Colin McMinn
Ian McMaster
Sean Holland
Christine Smith
Charles Bamford
Jim Livingstone
Andrew Browne
Hilary Harrison

Director of Social Services:
Hugh Connor

Fax: 028 9055 3620
Direct line: 028 9055 3964
E-mail: hconnor@ehssb.n-i.nhs.uk
Ref: Mer/PSS/F&CC/ResAcc/LissHistInQ/KT090209

9 February 2009

Strictly Private & Confidential
Ms K Thompson
Director of Social Work
South Eastern Health & Social Care Trust
Admin Building
Ulster Hospital
Newtownards Road
Dundonald BT16 1RH

Dear Kate

Re: Lissue

As you know we have been carrying out an internal historic review of the treatment and care of children in Lissue and Forster Green Hospitals. I would hope to be able to issue you with this report within the next few weeks. I am writing to remind you that your Trust will need to consider professional and employment issues arising from allegations made against previous and current staff.

As I understand it, Marion has shared information and the draft report with Rodney Morton, John Veitch and John Toner. Obviously one strand that will arise from the issuing of the report will be our need for you to indicate that you have completed a review in relation to staffing and that you are content - hence my heads up.

Regards

Hugh Connor
Director of Social Services

Director of Social Services:
Hugh Connor

Fax: 028 9055 3620
Direct line: 028 9055 3964
E-mail: hconnor@ehssb.n-i.nhs.uk
Ref: Mer/PSS/F&CC/ResAcc/LissHistInQ/BMcN090209

9 February 2009

Strictly Private & Confidential
Ms B McNally
Director of Social Work
Belfast Health & Social Care Trust
Knockbracken Healthcare Park
Saintfield Road
Belfast
BT8 8BH

Dear Bernie

Re: Lissue

As you know we have been carrying out an internal historic review of the treatment and care of children in Lissue and Forster Green Hospitals. I would hope to be able to issue you with this report within the next few weeks. I am writing to remind you that your Trust will need to consider professional and employment issues arising from allegations made against previous and current staff.

As I understand it, Marion has shared information and the draft report with Rodney Morton, John Veitch and John Toner. Obviously one strand that will arise from the issuing of the report will be our need for you to indicate that you have completed a review in relation to staffing and that you are content - hence my heads up.

Regards

Hugh Connor
Director of Social Services

To: Dr Briscoe

From: Máire Redmond

Date: 05 May 2009

RE: SAFEGUARDING VULNERABLE ADULTS – RETROSPECTIVE SAMPLING

1. Dr McMaster, Charlie Bamford and myself have met to discuss the Retrospective Sampling exercise for the Safeguarding of Vulnerable Adults in Mental Health and Learning Disability Hospitals. These responses now need to be analysed but, owing to the time period to which they refer, the sensitive nature of the content and also the issues raised this may not be straightforward. We have considered the options available and would appreciate a decision as to which option you think we should follow - these are outlined below:

OPTION 1

Pass all responses to RQIA asking them to bear these in mind when performing any future inspections - they could also assist the RQIA to identify key areas requiring further specific investigation.

OPTION 2

Perform a table top exercise limited to reviewing the information contained within the reports and identifying the overarching issues/areas which could require further investigation by/assurance from Trusts. This could take approximately 5 working days to cover all the reports.

OPTION 3

Perform a more detailed review which would include directly challenging Trusts/requesting further information and face to face meetings. It must be borne in mind that Pat Newe performed such a review over the response from the Western Trust and this took up to 8 days in total (to deal with follow up to issues arising etc.)

2. To date not all responses have been received, and Jeanette Bratty has sought an update in respect of the outstanding response from the Northern Trust. A full response is not due from the Belfast Trust until the end of May 2009.

3. Should either option 2 or option 3 be selected, agreement from the appropriate line manager would have to be obtained in view of the resource requirement and the need to be off-line to complete the reviews.

Happy to discuss

Máire J Redmond

C.C Dr Ian McMaster
Charlie Bamford
Pat Swann

Health and Social Care Board

HSC Board Headquarters
12-22 Linenhall Street
Belfast
BT2 8BS

Tel : *028 90 321313*
Fax : *028 90 553625*
Email: *marion.reynolds@hscni.net*

Date: 15 July 2009

Mr Sean Holland
Acting Chief Social Services Inspector
DHSSPS
Room C3:28 Castle Buildings
Stormont
Belfast BT4 3SQ

Our Ref: PSS/FCC/Residential/Lissue – ltr to Sean Holland ....

Dear Sean

INTERIM REPORT ON THE LISSUE & FORSTER GREEN HOSPITALS HISTORIC CASES REVIEW

Attached please find an interim report, a copy of the Consultant's report and a summary of findings from a sift of children's cases in respect of the historic review of cases at the above hospitals.

Work is continuing to acquire medical perspectives on the operation of the Units.

As you possibly are aware the new HSC Board has not yet been briefed on this matter and I would, therefore, ask that the attached information remains confidential until the Board has had an opportunity to review all aspects of the work.

Happy to discuss.

Yours sincerely,

Marion Reynolds
Deputy Director of Social Services

cc Fionnuala McAndrews

Southern Health
and Social Care Trust

Our ref: CD/fmcc/ew

27 August 2009

Linda Brown
DHSSPS
Castle Buildings
Stormont Estate
BELFAST
BT4 3SQ

Dear Linda

SAFEGUARDING CHILDREN AND VULNERABLE ADULTS IN LEARNING DISABILITY HOSPITALS AND MENTAL HEALTH HOSPITALS – RETROSPECTIVE SAMPLING

I refer to your letter of 10 August 2009 regarding the final report on the retrospective sampling exercise at St Luke's Mental Health Hospital and associated sites.

I am today forwarding you this completed report. The recommendations included within this report are currently being incorporated into an action plan and will be signed off through the Trust Governance Committee. If you require any further information please do not hesitate to contact me.

Yours sincerely

Colm Donaghy

COLM DONAGHY
CHIEF EXECUTIVE

Trust Headquarters, Craigavon Area Hospital, 68 Lurgan Road, Portadown, Craigavon BT63 5QQ
Tel: 028 3861 3950 Fax: 028 3833 5496 www.southerntrust.hscni.net

Maura
(1) See my drafting chgs.
(2) Finalise, discuss briefly on Monday Am & then we [illegible] issue forward – with the Report & [illegible] Appended.

From: Dr Maura Briscoe
Mental Health and Disability Policy

Date: December 2009

To: 1. Linda Brown
2. Dr Andrew McCormick

RQIA REVIEW OF THE SAFEGUARDS IN PLACE FOR CHILDREN AND VULNERABLE ADULTS IN MENTAL HEALTH AND LEARNING DISABILITY HOSPITALS IN HSC TRUSTS

Summary

Issue: A reply has been received from the RQIA in response to your letter of 29 January 2009 regarding their overview report of the safeguards in place for children and vulnerable adults in mental health and learning disability hospitals. RQIA asked you to agree to the publication of this Report.

Timing: Immediate

Presentational Issues: There may be significant media interest in this report.

FOI Implications: Policy under development –not disclosable

Recommendation: You are asked to issue a response to RQIA along the lines of the attached draft, inviting the Chief Executive to meet with you early in New Year.

(1) Also need to A + D

Background

1. RQIA have recently (19th November 2009) responded to your letter of January 2009 **(Tab A)** in which you ~~gave your approval to publication of the RQIA overview report subject to RQIA confirmation that they~~ RQIA were content with the appropriateness of Trust responses i.e. coverage of relevant recommendations in respect of individual Trust Quality Improvement plans. You also asked that the RQIA engage with the new Regional Health and Social Care Board in order to establish regular meetings with the Trusts, which would allow them to share information regarding the implementation of the recommendations.

2. In their response **(Tab B)** RQIA have apologised for the oversight in not responding earlier and provided an assurance that the issues addressed in you 29 January letter have been addressed. RQIA have also confirmed that a number of RQIA initiatives are now in place in respect of follow-up on issues pertaining to statutory mental health and learning disability services for both adults and children across Northern Ireland. These include:
   - the development of a program of service and thematic reviews (to commence with a review of Child and Adolescent Mental Health Services which will be completed in 2010;
   - The development of an inspection program of regulated and statutory sector services; and
   - Quarterly liaison meetings with the five Health and Social Care Trusts on issues pertaining to regulated and statutory sector general and mental health services.

3. The RQIA Overview Report makes a number of key recommendations covering the following 6 areas:
   - User Involvement
   - Recruitment, supervision and management of staff procedures

- Appropriate policies and procedures
- Key training for Staff and Volunteers
- Children and Young People in Adult Wards
- Adult Protection Guidance

More detailed background on this report is provided in a previous submission (SUB/1105/2008). Note also that the within the body of the RQIA report, it specifically refers to your letter to HSC Chief Executives, dated 2006.

4. Trusts have responded to this Report by way of actions plans to address these recommendations and, as outlined above, RQIA have advised that they are content with the appropriateness of Trust responses.

5. The RQIA has advised that it has met with the Regional Health and Social Care Board although the issues raised in the review have not been discussed as a specific agenda item, RQIA plan to raise these at the next meeting the HSC Board.

6. RQIA have advised that they would welcome the opportunity to place the overview report **(attached at appendix 1)** on the RQIA website although as this is a commissioned review, RQIA understanding is that the decision on timing of publication rests with the Department. In addition, RQIA have advised that they would also welcome the opportunity to place the individual Trust reports on the RQIA website. (This would be an unusual ~~step~~ Stop? - Individual Trust reports would normally be published)

Options for Handling of the RQIA Review Report and associated Trust Reports

7. There are strengths and weaknesses in the placement of the RQIA Review Report on the RQIA website. On the one hand, RQIA have requested publication, as per the letter to you, and in the interests of transparency it may be considered appropriate to do so, ~~especially as a previous letter from you in~~

January 2009 indicated that there was a willingness to publish. However, circumstances have now moved on, caused in some part by RQIA delay in replying to you; on balance, we now believe that there are more appropriate mechanisms for the handling of this Report.

8. Options for the handling of this Report include:-
   a) Postponement of publication, pending completion of more "up to date" work by RQIA (justification below); and
   b) asking the HSC Board to ensure that Trust improvement plans have been completed.

9. The justification for non publication of the RQIA Review Report would be as follows:

   - The Review took place in 2007 (ie over 2 years ago) with the report being completed in June 2008 (1.5 years ago). As such, whilst it will help identify what has happened in the past, it will not help to identify what the current practices are;

   - Trust should have had sufficient time to improve practice and implement change;

   - Since the Review was conducted new Risk assessment and Management Guidance (September 2009) and Child Protection and Safeguarding Vulnerable Adults Guidance have been issued; therefore, the RQIA Report will not shed any light on whether or not such guidance is being adhered to;

   - The RQIA has advised that they intend to commence a programme of thematic reviews starting with CAMHS in 2010; and

- The Department has already requested a review of implementation of Risk Assessment and Management Guidance which will be undertaken by RQIA within the next two years.

All of the above would suggest that there is ample opportunity to determine how HSC systems have moved on, especially since publication of new guidance, as identified above. In addition, it may be a more coherent approach to commission an integrated piece of work from RQIA.

10. To complement this approach, it should be agreed that RQIA liase with the HSC Board and, should you wish it, further discussion could be had with the HSC Board regarding their responsibilities to ensure effective monitoring of the Trust Improvement Plans.

Related Matters

11. A separate, but related issue, is the Retrospective Sampling Exercise(1986-2005) on sexual behaviour in long-stay Mental Health and Learning Disability Hospitals which you instigated in your letter of September 2006 to the Chief Executives of the legacy Boards and Trusts and Linda Brown's subsequent letter of May 2007. Not all of the Trust reports have been received; we expect the final report from the Belfast Trust within the next two weeks. A separate submission on this topic will be sent to you when our final analysis of this work is complete. However, what is proposed above regarding the commissioning of RQIA to do further work on current practice regarding the safeguarding of children and vulnerable adults in mental health and learning disability hospital is likely to form part of the conclusion of this retrospective sampling exercise.

Summary

12. This submission relates to the handling of the RQIA overview report *"RQIA Review of The Safeguards in Place for Children and Vulnerable Adults in*

RQIA already have approved Trust Improvement Plan - release 15 Report findings

Mental Health and Learning Disability Hospitals in HSC Trusts". There has been considerable delay in the formal submission of this Report to the Department. Circumstances have changed since completion of this work in June 2008. The relative strengths and weaknesses regarding publication are identified, together with a number of handling options. Given the nature and timing of this Report, you may consider it prudent to invite Glenn Houston, Chief Executive of RQIA, to a meeting with you to discuss future direction

Recommendation

13. You are asked to consider;-

a) the content of this submission and indicate your preference for moving forward;

b) should you agree with the handling options, as identified in para eight above, you may wish to send a letter **(Tab C)** to the Chief Executive of RQIA, inviting him to a meeting with you to discuss the content of the Report and future arrangements.

Signed:

Dr Maura Briscoe
Director of Mental Health and Disability Policy
Ext: 20724

cc: Dr Ian McMaster
Charlie Bamford
Maurice Devine
Peter Deazley

Dr Jim Livingstone
Andrew Browne
Colin McMinn
Sean Holland
Christine Smith
Fergal Bradley
Hilary Harrison

NEW Sub

From: Dr Maura Briscoe
Mental Health and Disability Policy

Date: 31 December 2009

To: 1. Linda Brown
2. Dr Andrew McCormick

RQIA REVIEW OF THE SAFEGUARDS IN PLACE FOR CHILDREN AND VULNERABLE ADULTS IN MENTAL HEALTH AND LEARNING DISABILITY HOSPITALS IN HSC TRUSTS

Summary

Issue:	A reply has been received from the RQIA in response to your letter of 29 January 2009 regarding their overview report of the safeguards in place for children and vulnerable adults in mental health and learning disability hospitals. RQIA asked you to agree to the publication of this Report.
Timing:	Immediate
Presentational Issues:	There may be significant media interest in this report. Copied to Special Advisers.
FOI Implications:	Policy under development –not disclosable
Recommendation:	You are asked to issue a response to RQIA along the lines of the attached draft, inviting the Chief Executive to meet with you early in New Year.

Issue
Special Advisers

Background

1. The genesis and timeline of the RQIA report *on "Safeguards in Place for Children and Vulnerable Adults in Mental Health and Learning Disability Hospitals"* (June 2008 unpublished) is contained in **Tab A**.

2. RQIA have recently (19th November 2009) responded to your letter of January 2009 **(Tab B)** in which you asked for assurances (before agreeing to publish the Report) that RQIA were content with the appropriateness of Trust responses i.e. coverage of relevant recommendations in respect of individual Trust Quality Improvement plans. You also asked that the RQIA engage with the new Regional Health and Social Care Board in order to establish regular meetings with the Trusts, which would allow them to share information regarding the implementation of the recommendations.

3. In their response **(Tab C)** RQIA have apologised for the oversight in not responding earlier and provided an assurance that the issues addressed in you 29 January letter have been addressed. RQIA have also confirmed that a number of RQIA initiatives are now in place in respect of follow-up on issues pertaining to statutory mental health and learning disability services for both adults and children across Northern Ireland. These include:
   - the development of a program of service and thematic reviews (to commence with a review of Child and Adolescent Mental Health Services which will be completed in 2010;
   - The development of an inspection program of regulated and statutory sector services; and
   - Quarterly liaison meetings with the five Health and Social Care Trusts on issues pertaining to regulated and statutory sector general and mental health services.

4. The RQIA Overview Report makes a number of key recommendations covering the following 6 areas:
    - User Involvement
    - Recruitment, supervision and management of staff procedures
    - Appropriate policies and procedures
    - Key training for Staff and Volunteers
    - Children and Young People in Adult Wards
    - Adult Protection Guidance

    More detailed background on this report is provided in a previous submission (SUB/1105/2008). Note also that the within the body of the RQIA report, it specifically refers to your letter to HSC Chief Executives, dated September 2006.

5. Trusts have responded to this Report by way of actions plans to address these recommendations and, as outlined above, RQIA have advised that they are content with the appropriateness of Trust responses.

6. The RQIA has advised that it has met with the Regional Health and Social Care Board although the issues raised in the review have not been discussed as a specific agenda item, RQIA plan to raise these at the next meeting the HSC Board.

7. RQIA have advised that they would welcome the opportunity to place the overview report **(attached at appendix 1)** on the RQIA website although as this is a commissioned review, RQIA understanding is that the decision on timing of publication rests with the Department. In addition, RQIA have advised that they would also welcome the opportunity to place the individual Trust reports on the RQIA website.

Options for Handling of the RQIA Review Report and associated Trust Reports

8. There are strengths and weaknesses in the placement of the RQIA Review Report on the RQIA website. On the one hand, RQIA have requested publication, as per the letter to you, and in the interests of transparency it may be considered appropriate to do so ~~especially as your letter to Alice Casey~~, ~~dated 28th November 2008, supported publication of the RQIA Report~~. However, circumstances have now moved on, caused in some part by RQIA delay in replying to you and the fact that the Report is now somewhat out of date. On balance, we now believe that there are more appropriate mechanisms for the handling of this Report.

9. Options for the handling of this Report include:-
   a) non publication, pending completion of more "up to date" work by RQIA (justification below); and
   b) asking the HSC Board to ensure that individual Trust Improvement Plans have been completed.

10. The justification for non publication of the RQIA Review Report would be as follows:

- The Review took place in 2007 (ie over 2 years ago) with the report being completed in June 2008 (1.5 years ago). As such, whilst it will help identify what has happened in the past, it will not help to identify what the current practices are;

- Trust should have had sufficient time to improve practice and implement change;

- Since the Review was conducted new Risk assessment and Management Guidance (September 2009) has issued. A new assessment framework has also been issued to improve the quality of the risk assessment for children referred to Social Services (UNOCINI) and work is also ongoing in relation to the Safeguarding of Vulnerable Adults. The RQIA Report will therefore not shed any light on whether or not such guidance is being adhered to;

- The RQIA has advised that they intend to commence a programme of thematic reviews starting with CAMHS in 2010; and

- The Department has already requested a review of implementation of Risk Assessment and Management Guidance which will be undertaken by RQIA within the next two years.

All of the above would suggest that there is ample opportunity to determine how HSC systems have moved on, especially since publication of new guidance, as identified above. In addition, it may be a more coherent approach to commission an integrated piece of work from RQIA.

11. To complement this approach, it should be agreed that RQIA liase with the HSC Board and, should you wish it, further discussion could be had with the HSC Board regarding their responsibilities to ensure effective monitoring of the Trust Improvement Plans.

Related Matters

12. A separate, but related issue, is the Retrospective Sampling Exercise(1986-2005) on sexual behaviour in long-stay Mental Health and Learning Disability Hospitals which you instigated in your letter of September 2006 to the Chief Executives of the legacy Boards and Trusts and Linda Brown's subsequent letter of May 2007. Not all of the Trust reports have been received; we expect

the final report from the Belfast Trust within the next two weeks. A separate submission on this topic will be sent to you when our final analysis of this work is complete. However, what is proposed above regarding the commissioning of RQIA to do further work on current practice regarding the safeguarding of children and vulnerable adults in mental health and learning disability hospital is likely to form part of the conclusion of this retrospective sampling exercise.

Summary

13. This submission relates to the handling of the RQIA overview report *"RQIA Review of The Safeguards in Place for Children and Vulnerable Adults in Mental Health and Learning Disability Hospitals in HSC Trusts"*. A timeline on the genesis of this report is provided at **Tab A**.

14. There has been considerable delay in the formal submission of this Report to the Department. Circumstances have changed since completion of this work in June 2008. RQIA have already approved Trust improvement plans in relation to report findings. The relative strengths and weaknesses regarding publication are identified, together with a number of handling options. Given the nature and timing of this Report, you may consider it prudent to invite Glenn Houston, Chief Executive of RQIA, to a meeting with you to discuss future direction

Recommendation

15. You are asked to consider;-

a) the content of this submission and indicate your preference for moving forward;

b) should you agree with the handling options, as identified in para nine above, you may wish to send a letter **(Tab E)** to the Chief Executive of

RQIA, inviting him to a meeting with you to discuss the content of the Report and future arrangements.

Signed:

Dr Maura Briscoe
Director of Mental Health and Disability Policy
Ext: 20724

cc: Dr Ian McMaster
Charlie Bamford
Maurice Devine
Peter Deazley
Dr Jim Livingstone
Andrew Browne
Colin McMinn
Sean Holland
Christine Smith
Fergal Bradley
Hilary Harrison

DHI/08/150963

TAB A

GENESIS OF RQIA REPORT "*SAFEGUARDS IN PLACE FOR CHILDREN AND VULNERABLE ADULTS IN MENTAL HEALTH AND LEARNING DISABILITY HOSPITALS*"

Sequence of events

2005	Complaint by former patient in Muckamore Hospital alleging sexual abuse some 30 years earlier.
2005/06	EHSSB – North and West Trust conducted a small review of case files from 1960s, 70s and 80s.
May 2006	Senior Management Group(SMG) formed to coordinate HPSS/PSNIaction, chaired by Dr Kilbane. 296 case files reviewed.
22 Sept 2006	Letter from Dr McCormick to HSC Service requesting assurance regarding in-patient facilities. Request to RQIA to provide independent assurance on safeguards in place.
June 2008	RQIA report on safeguards completed.
Aug 2008	RQIA sent draft report to Dr McCormick advising of intention to publish in September 2008.
7 Oct 2008 SUB from SQS	Submission to Andrew McCormick highlighting RQIA findings and recommendations of SMG – note that 5th recommendation of SMG was for Trust Action Plans in response to RQIA findings.
8 Oct 2008 SUB/927/2008 from SQS	Submission to Minister on the content of the draft RQIA report and explaining links to the wider Muckamore investigation conducted by SMG outlining their 5 recommendations. Lines to take provided for Minister, only if required.

8 Oct 2008	Letter from Andrew McCormick to HSC Trusts endorsing SMG findings and asking Action Plans in response to individual RQIA Trust reports.
28 Nov 2008	Letter from Andrew McCormick to Alice Casey (RQIA) **(TAB D)** supporting publication of RQIA report and the need for Trusts to produce individual action plans.
29 Jan 2009	Letter from Andrew McCormick to RQIA (**TAB B**) seeking assurance that RQIA are content with individual Trust improvement plans before giving approval to formally publish RQIA report.
19 Nov 2009	Letter from Glenn Houston confirming Trust improvement plans are appropriate and seeking permission to publish the Overview Report and individual Trust reports.

TAB B

ecym/706/04

The **Regulation** and **Quality Improvement** Authority

19 November 2009

Dr Andrew McCormick
Permanent Secretary
DHSSPS
Castle Buildings
Belfast
BT4 3SQ

23 NOV 2009

Dear Dr McCormick

Re: **Review of Safeguards for Children and Vulnerable Adults in Mental Health and Learning Disability Hospitals in HSC Trusts**

I write further to your letter dated 29 January 2009 to Phelim Quinn, which was brought to my attention recently via telephone contact from Christine McKee. I can confirm that the issues raised in your letter in respect of Trust improvement plans had been addressed by RQIA, but this appears not to have been communicated to your office. I apologise for this oversight.

I can confirm that the content of the Trust improvement plans were deemed appropriate. I understand, however, that the individual Trust reports and the overview report of this commissioned review remain unpublished. I attach, for ease of reference, a copy of the Overview Report dated June 2008. I note from our records that Mrs Casey wrote to Jim Livingstone following his correspondence dated 9 September 2008 advising of RQIA's intention to reschedule publication in October 2008. However, as this is a commissioned review, it is my understanding that the decision on timing of publication rests with the Department.

Since completion of the review, a number of RQIA initiatives are now in place in respect of follow-up on issues pertaining to statutory mental health and learning disability services for both adults and children, across Northern Ireland.

These include:

- Effective discharge of the functions of the former Mental Health Commission, as outlined under the Mental Health Order 1986;

  Specific initiatives include:
  - development of a programme of service and thematic reviews (to commence with a review of Child and Adolescent Mental Health services) which will be completed in 2010.
  - development of an inspection programme of regulated and statutory sector services

[redacted]

- piloting and implementation of a programme of mental health patient experiences review, to assess the experiences of patients subject to detention under the Mental Health Order.

- Quarterly liaison meetings with the five health and social care trusts on issues pertaining to regulated and statutory sector general and mental health services;

- Six monthly meetings with the relevant policy branch in DHSSPS;

- Specific development of a "Rights Based Approach" to all review, regulation and monitoring activity of RQIA. This work will concentrate on mental health services in the first instance.

RQIA has met with the Regional Health and Social Care Board. However, the specific issues raised in this review have not been discussed as a specific agenda item. We plan to raise this at the next meeting with the Board.

I hope this clarifies the current position in respect of this review. If you require any further clarification or information on any of the points raised, please do not hesitate to contact me.

The RQIA believes that the reports have merit, and the individual reports have already been shared with the Trust. We would welcome, even at this stage, an opportunity of placing the reports onto the RQIA website.

Yours sincerely

Glenn Houston
Chief Executive

cc Phelim Quinn
Linda Brown
Dr Maura Briscoe
Dr Jim Livingstone

TAB C

Glenn Houston
Regulation & Quality Improvement Authority
9th Floor, Riverside Tower
5 Lanyon Place
BELFAST
BT1 3BT

December 2009

Dear Glenn

REVIEW OF SAFEGUARDS IN PLACE FOR CHILDREN AND VULNERABLE ADULTS IN MENTAL HEALTH AND LEARNING DISABILITY HOSPITALS IN HSC TRUSTS

Many thanks for your recent response to my January 2009 letter. It is encouraging to see the number of initiatives that RQIA have put in place to facilitate follow-up on issues pertaining to statutory mental health and learning disability services for both adults and children and the regular meetings with the HSC Regional Board. In addition, I was particularly pleased to note that RQIA considered that individual Trust Improvement Plans were deemed appropriate.

I would like to have the opportunity to discuss with you the issues raised in this Report and how these might be linked to other departmental guidance and future RQIA thematic reviews. To this end, it would be most helpful if we could meet early in the New Year. Accordingly, I will ask my secretary to arrange a mutually convenient time.

Yours sincerely

Andrew McCormick

TAB E

Glenn Houston
Regulation & Quality Improvement Authority
9th Floor, Riverside Tower
5 Lanyon Place
BELFAST
BT1 3BT

December 2009

Dear Glenn

REVIEW OF SAFEGUARDS IN PLACE FOR CHILDREN AND VULNERABLE ADULTS IN MENTAL HEALTH AND LEARNING DISABILITY HOSPITALS IN HSC TRUSTS

Many thanks for your recent response to my January 2009 letter. It is encouraging to see the number of initiatives that RQIA have put in place to facilitate follow-up on issues pertaining to statutory mental health and learning disability services for both adults and children and the regular meetings with the HSC Regional Board. In addition, I was particularly pleased to note that RQIA considered that individual Trust Improvement Plans were deemed appropriate.

I would like to have the opportunity to discuss with you the issues raised in this Report and how these might be linked to other departmental guidance and future RQIA thematic reviews. To this end, it would be most helpful if we could meet early in the New Year. Accordingly, I will ask my secretary to arrange a mutually convenient time.

Yours sincerely

Andrew McCormick

Cc:
Linda Brown
Maura Briscoe
Ian McMaster
Charlie Bamford
Maurice Devine
Peter Deazley
Dr Jim Livingstone
Andrew Brown
Colin McMinn
Sean Holland
Christine Smith
Hilary Harrison

Tel: (028) 90360047
Fax: (028) 90360053

23rd December 2009

Ms L Brown
Deputy Secretary
Department of Health, Social Services & Public Safety
Castle Buildings,Stormont Estate
BELFAST BT4 3SQ

Dear Linda

Re: Safeguarding Children and Vulnerable Adults in Learning Disability Hospitals and Mental Health Hospitals – Retrospective Sampling

I refer to your previous correspondence regarding the above matter and wish to apologise for the delay in providing the attached audit report in relation to the provision of Inpatient Child & Adolescent Services. This report was approved by Belfast Trust Executive Team at a meeting on 23rd December 2009.

As you are aware the earlier report provided by the Trust included reference to young people accommodated in Adult Mental Health wards and therefore this report relates specifically to services provided at Lissue and Foster Green Hospitals and at the Adolescent Inpatient Unit previously located at 10 College Gardens. As the Eastern Health & Social Services Board previously commissioned an audit in relation to practice at Lissue Hospital during 1980s we are awaiting the availability of this report. We therefore excluded this time period at Lissue Hospital from our sample. Both audits do however raise similar issues of concern in relation to children/young people and we are currently liaising with the Health & Social Care Board to ensure a consistent and co-ordinated approach is adopted to such concerns. The Trust is also making arrangements to address other recommendations included in the attached report as quickly as possible.

I trust the attached report is helpful. You may wish to give consideration to a meeting of all Stakeholders in this process to map out an agreed way forward.

Yours sincerely

Miss B McNally
Director of Mental Health & Learning Disability

enc

Maura
(i) See my drafting changes.
(ii) Finalise, discuss briefly on Monday Am & then [illegible]
Issue is [illegible] –
with the Report & ~~[illegible]~~
~~[illegible]~~ Appended.
[illegible]

From: Dr Maura Briscoe
Mental Health and Disability Policy

Date: December 2009

To: 1. Linda Brown
2. Dr Andrew McCormick

RQIA REVIEW OF THE SAFEGUARDS IN PLACE FOR CHILDREN AND VULNERABLE ADULTS IN MENTAL HEALTH AND LEARNING DISABILITY HOSPITALS IN HSC TRUSTS

Summary

Issue: A reply has been received from the RQIA in response to your letter of 29 January 2009 regarding their overview report of the safeguards in place for children and vulnerable adults in mental health and learning disability hospitals. RQIA asked you to agree to the publication of this Report.

Timing: Immediate

Presentational Issues: There may be significant media interest in this report.

FOI Implications: Policy under development –not disclosable

Recommendation: You are asked to issue a response to RQIA along the lines of the attached draft, inviting the Chief Executive to meet with you early in New Year.

(1) Also need to [illegible] A + D
[illegible] amendments.

Background

1. RQIA have recently (19th November 2009) responded to your letter of January 2009 **(Tab A)** in which you ~~gave your approval to publication of the RQIA overview report subject to RQIA confirmation that they~~ RQIA were content with the appropriateness of Trust responses i.e. coverage of relevant recommendations in respect of individual Trust Quality Improvement plans. You also asked that the RQIA engage with the new Regional Health and Social Care Board in order to establish regular meetings with the Trusts, which would allow them to share information regarding the implementation of the recommendations.

2. In their response **(Tab B)** RQIA have apologised for the oversight in not responding earlier and provided an assurance that the issues addressed in you 29 January letter have been addressed. RQIA have also confirmed that a number of RQIA initiatives are now in place in respect of follow-up on issues pertaining to statutory mental health and learning disability services for both adults and children across Northern Ireland. These include:
   - the development of a program of service and thematic reviews (to commence with a review of Child and Adolescent Mental Health Services which will be completed in 2010;
   - The development of an inspection program of regulated and statutory sector services; and
   - Quarterly liaison meetings with the five Health and Social Care Trusts on issues pertaining to regulated and statutory sector general and mental health services.

3. The RQIA Overview Report makes a number of key recommendations covering the following 6 areas:
   - User Involvement
   - Recruitment, supervision and management of staff procedures

- Appropriate policies and procedures
- Key training for Staff and Volunteers
- Children and Young People in Adult Wards
- Adult Protection Guidance

More detailed background on this report is provided in a previous submission (SUB/1105/2008). Note also that the within the body of the RQIA report, it specifically refers to your letter to HSC Chief Executives, dated 2006.

4. Trusts have responded to this Report by way of actions plans to address these recommendations and, as outlined above, RQIA have advised that they are content with the appropriateness of Trust responses.

5. The RQIA has advised that it has met with the Regional Health and Social Care Board although the issues raised in the review have not been discussed as a specific agenda item, RQIA plan to raise these at the next meeting the HSC Board.

6. RQIA have advised that they would welcome the opportunity to place the overview report **(attached at appendix 1)** on the RQIA website although as this is a commissioned review, RQIA understanding is that the decision on timing of publication rests with the Department. In addition, RQIA have advised that they would also welcome the opportunity to place the individual Trust reports on the RQIA website. (This would be an unusual ~~step~~ Stop? ~~Individual~~ Trust reports would normally be published)

Options for Handling of the RQIA Review Report and associated Trust Reports

7. There are strengths and weaknesses in the placement of the RQIA Review Report on the RQIA website. On the one hand, RQIA have requested publication, as per the letter to you, and in the interests of transparency it may be considered appropriate to do so, ~~especially as a previous letter from you in~~

January 2009 indicated that there was a willingness to publish. However, circumstances have now moved on, caused in some part by RQIA delay in replying to you; on balance, we now believe that there are more appropriate mechanisms for the handling of this Report.

8. Options for the handling of this Report include:-
   a) Postponement of publication, pending completion of more "up to date" work by RQIA (justification below); and
   b) asking the HSC Board to ensure that Trust improvement plans have been completed.

9. The justification for non publication of the RQIA Review Report would be as follows:

   - The Review took place in 2007 (ie over 2 years ago) with the report being completed in June 2008 (1.5 years ago). As such, whilst it will help identify what has happened in the past, it will not help to identify what the current practices are;

   - Trust should have had sufficient time to improve practice and implement change;

   - Since the Review was conducted new Risk assessment and Management Guidance (September 2009) and Child Protection and Safeguarding Vulnerable Adults Guidance have been issued; therefore, the RQIA Report will not shed any light on whether or not such guidance is being adhered to;

   - The RQIA has advised that they intend to commence a programme of thematic reviews starting with CAMHS in 2010; and

- The Department has already requested a review of implementation of Risk Assessment and Management Guidance which will be undertaken by RQIA within the next two years.

All of the above would suggest that there is ample opportunity to determine how HSC systems have moved on, especially since publication of new guidance, as identified above. In addition, it may be a more coherent approach to commission an integrated piece of work from RQIA.

10. To complement this approach, it should be agreed that RQIA liase with the HSC Board and, should you wish it, further discussion could be had with the HSC Board regarding their responsibilities to ensure effective monitoring of the Trust Improvement Plans.

Related Matters

11. A separate, but related issue, is the Retrospective Sampling Exercise(1986-2005) on sexual behaviour in long-stay Mental Health and Learning Disability Hospitals which you instigated in your letter of September 2006 to the Chief Executives of the legacy Boards and Trusts and Linda Brown's subsequent letter of May 2007. Not all of the Trust reports have been received; we expect the final report from the Belfast Trust within the next two weeks. A separate submission on this topic will be sent to you when our final analysis of this work is complete. However, what is proposed above regarding the commissioning of RQIA to do further work on current practice regarding the safeguarding of children and vulnerable adults in mental health and learning disability hospital is likely to form part of the conclusion of this retrospective sampling exercise.

Summary

12. This submission relates to the handling of the RQIA overview report *"RQIA Review of The Safeguards in Place for Children and Vulnerable Adults in*

RQIA already have approved Trust Improvement Plan - release 15 Report findings

Mental Health and Learning Disability Hospitals in HSC Trusts". There has been considerable delay in the formal submission of this Report to the Department. Circumstances have changed since completion of this work in June 2008. The relative strengths and weaknesses regarding publication are identified, together with a number of handling options. Given the nature and timing of this Report, you may consider it prudent to invite Glenn Houston, Chief Executive of RQIA, to a meeting with you to discuss future direction

Recommendation

13. You are asked to consider;-

a) the content of this submission and indicate your preference for moving forward;

b) should you agree with the handling options, as identified in para eight above, you may wish to send a letter **(Tab C)** to the Chief Executive of RQIA, inviting him to a meeting with you to discuss the content of the Report and future arrangements.

Signed:

Dr Maura Briscoe
Director of Mental Health and Disability Policy
Ext: 20724

cc: Dr Ian McMaster
Charlie Bamford
Maurice Devine
Peter Deazley

Dr Jim Livingstone
Andrew Browne
Colin McMinn
Sean Holland
Christine Smith
Fergal Bradley
Hilary Harrison

HSC Public Health Agency

Public Health Directorate
12-22 Linenhall Street
BELFAST
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Email: Carol.Beattie@hscni.net
Web Site : www.hscni.net

Ms Fionnuala McAndrew,
Director of Social Care and Children,
Health and Social Care Board,
12-22 Linenhall St,
Belfast, BT2 8BS

Date: 25 March 2010

Our Ref: CB/mmcg

Dear Ms McAndrew

LISSUE AND FORSTER GREEN HOSPITALS - SA1 117- 08

Thank you for your correspondence of 18 March 2010 and the opportunity to comment on the process and the following reports:

1. Interim report, July 2009, Marion Reynolds.
2. Report of RS Stinson, January 2009.
3. Report of Maura Devlin, May 2009.
4. Report of Dr BW Jacobs, February 2010.
5. Retrospective audit within CAHMS Inpatient Service, Belfast Trust , received February 2010.

Comments on reports.

1. Patient names should not appear in any of these reports. The reports should now be anonymised before any further dissemination and copies with the names of individuals should be shredded.

2. It is not clear whether patient consent to access records was sought in those cases where no complaint had been made.

3. It would be important to have a clearer description of the facilities, age profile and case mix of patients, type and level of staffing both onsite and visiting, training and

experience of staff both on-site and visiting, and services provided in Lissue during the period that the alleged events took place. From the information provided, it would appear that the group of children cared for in Lissue had a wide range of service needs and may have included children with mental illness, significant behaviour problems and learning disability . This should be clarified.

4. It is not documented what action was taken in relation to each member of staff against whom allegations were made ie whether in each case regulatory bodies were advised of the complaints, whether professional registration status was established, whether current employment status was established within the public sector in N Ireland and beyond, and whether all appropriate information was shared with appropriate bodies, including where the location/employment status of individuals was not established .

Comments on future action.

1. It would be important to take stock of the work undertaken to date, particularly in relation to ;

- Completing the process of investigation, reporting and follow up / actioning of each complaint;

- Review of HSC actions in relation to reporting, investigating and responding to allegations, at the time complaints were originally made and determining whether any further action is required.

- Quality assurance of the process of this inquiry at Trust and Board level to date , to ensure that all appropriate actions have been taken.

- Review of service and practice issues identified and assessment of whether any of these are ongoing areas of concern eg case – mix and age profile in inpatient CAMHS services.

- Review of terms of reference, who needs to be involved, their roles and responsibilities and the reporting arrangements.

- New action plan to be developed.

- Mechanism for disseminating the learning and implementing the changes required, across the system to be agreed.

2. The HSC Board designated doctor for child protection is the lead medical adviser to the Board in relation to child protection. Their expertise in the field of child protection is an essential resource to this inquiry. They should be made aware of the findings to date and involved in the process going forward.

3. Consideration should be given to involving the CAMHS leads in HSC Board and PHA, particularly in relation to the lessons learned, action required and implementation of service changes.

Yours sincerely

Dr Carol Beattie
Consultant in Public Health Medicine

Copy to Dr C Harper, PHA
Mrs M Hinds, PHA
Dr J Little, PHA
Dr F Kennedy, PHA

UPDATE

The review of medical practice has now been completed and the independent Consultant, Dr Bacon has submitted his report. This is being considered by professional staff within HSCB.

The Trust has responded to the concerns about staff member HR and has confirmed that this person has left the service and the file submitted to NHC for consideration of registration.

A meeting is being arranged with Belfast Trust to consider the findings and to agree a response.

Fionnuala McAndrew
March 2010

RETROSPECTIVE SAMPLING OF CASES IN BELFAST TRUST/ SAI 117-08

INTERIM REPORT TO DHSSPS

Introduction

The legacy EHSSB received a Serious Adverse Incident Report from Belfast Trust in May 2008. This related to an internal review being conducted by the Trust in respect of allegations of abuse at Lissue and Forster Green between 1985 and 1991. As the EHSSB was directly accountable for service provision on both sites during this period, it led on an investigation of the historic aspects of the alleged abuse.

Independent reports

The legacy EHSSB commissioned a series of reviews in respect of professional practice at Lissue and Forster Green which are outlined below.

RS Stinson, Social Services Manager, SET (retired), File review, January 2009.

M Devlin, Director of Nursing and Midwifery Education, Beeches Management Centre, Review of the Standard of Nursing Care, May 2009.

Dr B Jacobs, Consultant Child and Adolescent Psychiatrist, South London and Maudsley NHS Foundation Trust, 'Independent Child, Psychiatry Comment on report by RS Stinson', February 2010.

In addition the Board is in receipt of the report of the Belfast Trust 'Retrospective Child Protection and Safeguarding Audit within Regional Child and Adolescent Inpatient Service' and their action plan.

It is understood that a number of allegations have been considered by PSNI. Further information was passed to PSNI following receipt of Dr Jacobs report and a strategy group meeting in April 2010.

On 17th September 2010 the Board received confirmation from PSNI that no further action is anticipated and that they consider the case closed.

Staffing Issues

The children admitted to these facilities had complex and challenging needs and the layout of the institutions added to the staffs challenges in caring for them. It is important to ensure that the practice at the time is judged by the standards of the day.

However, there were three staff members named in the Stinson report and require consideration.

Staff 1: no allegations were made against this staff member. No concerns have been expressed by previous employers or staff members. The person remains in employment and there have been no reasons for concern.

Staff 2: disciplinary procedures were initiated against this staff member who denied all allegations. The person was made redundant from their employment with the Belfast Trust who refuses to act as a referee. A vetting and barring referral was made by the Trust. It has been confirmed that nursing registration has lapsed.

Staff 3: this person retired from the service in 1996. It is understood that he/she was interviewed by PSNI but that no prosecution has ensued.

Next steps

The Board considers that it is now in a position to make recommendations on this matter to DHSSPS. These will be considered by the Board at their meeting on 25th November 2010. A report will be issued to DHSSPS thereafter. This will include an action plan to supplement that prepared by the Belfast Trust.

Fionnuala McAndrew
October 2010

Fionnuala McAndrew
Director of Social Care and Children

Email: Fionnuala.mcandrew@hscni.net

9th March 2011

Dr Maura Briscoe
Director of Mental Health and Disbility
DHSSPS
Room D4.14
Castle Buildings
Stormont Estate
Belfast BT4 3SQ

Personal Social Services
Health and Social Care Board
12 – 22 Linenhall Street
Belfast
BT2 8BS
Tel : 028 9055 3964
Fax : 028 9055 3620
Web Site :
www.hscboard.hscni.net

Dear Maura,

RE: RETROSPECTIVE SAMPLING

Please find attached a report into the review of a sample of cases of children who were admitted to Lissue and Foster Green Hospitals. You are aware from previous communications that the HSCB has liaised with the Belfast Trust and PSNI on these matters and PSNI has confirmed that no further action will be taken in relation to the allegations they have investigated.

The review reports have been shared with the Belfast Trust. there were 16 recommendations and 12 conclusions contained within the three professional review reports commissioned by the HSCB and there was some overlap in their findings. I have written to the Belfast Trust to require further reassurance in respect of three of these as follows:

Process for Monitoring Abscondings

The Trust should confirm that it has robust policies for monitoring and assessing abscondings from its current in patient facility and for independent de-briefing of young people on their return.

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.

I would also like to confirm that the Health and Social Care Board was made aware of the findings of this exercise at the confidential Board meeting held on 25 November 2010.

Finally, I would like to apologise for the delay in finalising this report to you. As you are aware the work was commenced by the legacy EHSSB. The final review report relating to medical practice was commissioned by the new HSCB. On receipt this identified new concerns which were shared with PSNI, and there was an administrative delay in receiving their confirmation of no further action.

However, I hope that you will find that the EHSSB instituted a robust sampling exercise but if you have any further queries then please contact me.

Yours sincerely

Fionnuala McAndrew
Director of Social Care and Children

Enc

TAB A

Retrospective Sampling
Meeting 18/3/2011
Room C5.11

Present
Dr Andrew McCormick
Dr Michael McBride
Mr Martin Bradley
Mr Sean Holland
Dr Maura Briscoe

1. The objective of the meeting was to determine how best to move forward with the retrospective sampling taking account of :-

   a) Departmental receipt of reports from each of the 5 Trusts, which were commissioned following a meeting held in the Department on 28 June 2007. This meeting advised Trusts to do a 10% retrospective sampling exercise to ascertain abuse in mental health and learning disability establishments, building on the work that had already been undertaken as a consequence of the review of alleged abuse in Muckamore Abbey Hospital.

   b) Departmental professional opinion, as identified in a report dated 21 May 2010 and the subsequent exchange of memos between Dr McBride(CMO) and Linda Brown(Grade 3) of October/ November 2010;

   c) Final report – from Fionnuala McAndrew – *Director of Social Care and Children* in HSC Board, dated 9 March 2011 which, it was noted, only covered the Lissue/Forster Green sample of cases. This Report indicated that whilst further assurance was being sought by the HSC Board in respect of three particular Actions, the Board was satisfied that specific concerns in relation to individual staff members and potential abuse had been appropriately addressed.

   d) OFMDFM - led work on Institutional Abuse – It was noted that the draft terms of reference being proposed by the interdepartmental taskforce, which is chaired by OFMDFM, would probably encompass facilities such as mental health and learning disability institutions. However, a final determination of this and all other aspects on any inquiry will be for the Executive to determine.

experience might be met - **MB to draft and share for comment;**

iii) Write to RQIA to conduct a further review within the next 12 months building on the baseline Safeguarding Report in each Trust in 2007 – **MB to draft and share for comments;**

iv) Write to PSNI – inviting them to a meeting. **MB to draft and share for comment; and**

Intermediate Steps

vi) Reconvene the Group following discussion with PSNI and receipt of replies from HSC organisations - **Christine McKee to arrange follow up meeting in liaison with MB;** and

vii) Confirm whether another sampling exercise is required in light of the option selected in the Professional Paper (dated May 2010) and following the outcome of discussion with PSNI; also following consideration of the assurances received from each Trust Chief Executive and HSCB Chief Executive, as commissioner of HSC services – **Dr McCormick in collaboration with group.**

Longer-term Steps

viii) Depending on decision on intermediate steps, consider methodology and develop a short Terms of Reference for a further review of Lissue/Forster Green -**for clearance by Group-MB to liase with chief professionals on the drafting;** and

ix) Agree the outcome of such a review and the closure of the retrospective sampling exercise - **Dr McCormick and Group.**

18/5/11

Retrospective Sampling in HSC Institutions – Allegations of Abuse

Briefing Note for John Compton

The attached letter was received by HSCB and requests assurances in relation to a number of matters related to the above exercise.

A meeting was held with Trusts to prepare the response and this reinforced the complexities of doing so.

1. The Eastern Board was adjoined in the investigations into Muckamore Abbey and Forster Green Hospitals. These took the form of significant reviews and inquiries. The scope of these exercises and the manner in which they were conducted would, I believe, lend themselves to the provision of the assurances requested.

2. The retrospective sampling exercise undertaken in all Trusts was initiated by DHSSPS and monitored and managed by them. Trusts have reported that they submitted their reports to DHSSPS and meetings were held to discuss and, presumably, sign them off.

3. It would appear that the exercise lacked a standardised approach and the actions taken by Trusts in response to their sampling exercise appear varied.

4. In particular it would appear that not all cases were referred to PSNI, nor was the individual contacted vis a vis making a complaint.

5. It follows that not all individuals have been offered trauma counselling.

6. Personnel involved in the exercise have now left post, in some Trusts, so staff are currently "reviewing the review".

7. Some other matters are more straightforward;

    7.1 Belfast Trust has been asked to give an update on their action plan. There was one

outstanding recommendation from their review of inpatient CAMHS services; there were 3 matters they had to take forward from the Lissue/Forster Green review.

7.2 It should also be noted that the following reviews have been undertaken subsequently;

- Child Protection Services (RQIA)
- CAMHS Services (RQIA).

RQIA has also been asked to undertake a further review of existing arrangements.

Meeting between PSNI, HSC Board and DHSSPS re: Retrospective Sampling

Room E4 Conference Room, Castle Buildings 22 June 2011

Attendees:

Sean Holland	DHSSPS
Christine Jendoubi	DHSSPS
Christine Smyth	DHSSPS
Ian McMaster	DHSSPS
Pat Newe	DHSSPS
Maurice Devine	DHSSPS
Angela McLernon	DHSSPS
Colin Mc Minn	DHSSPS
Detective Inspector Anne Marks	PSNI
Inspector Alison Conroy	PSNI
Fionnuala McAndrew	HSCB
Deirdre Webb	PHA
Ann Mooney	DHSSPS

1. Introductions

Sean welcomed all present and there followed a brief round of introductions.

2. Retrospective Sampling

Sean provided a brief overview of action to date and it was agreed that the Department would share all relevant reports with PSNI.

It was agreed that PSNI and DHSSPS/HSCB professional reps would meet to develop recommendations for way forward

Action Points

- Department to share all relevant reports with PSNI
- Maurice to circulate Scottish Report to group
- Ian to set up meeting between PSNI and DHSSPS/HSCB professional reps

3. Date of Next Meeting

It was agreed that the group would meet again late August/early September

Note of Retrospective Sampling Subgroup Meeting
Room C2.2, Castle Buildings
22nd August 2011

In Attendance

Ian McMaster	Chair, Medical Adviser, DHSSPS
Colin McMinn	Head Mental Health Policy Unit, DHSSPS
Maurice Device	Nurse Adviser, DHSSPS
Pat Newe	Office of Social Services, DHSSPS
Fionnuala McAndrew	Director of Social Care and Children, HSCB
Anne Marks	Inspector Criminal Justice Unit, PSNI
Alison Conroy	Inspector Criminal Justice Unit, PSNI
Alister Wallace	Superintendent Criminal Justice Unit, PSNI
Stephen Wilson	Detective Inspector Serious Crime Branch, PSNI
Deirdre Webb	PHA
Máire Redmond	Mental Health Policy Unit, DHSSPS

Welcome and Apologies

1. Dr McMaster welcomed everyone to the meeting and there were no apologies.

Purpose of Meeting

2. Dr McMaster outlined the overall aim for the meeting, following consideration by the agencies represented of the information already available in the Trust/HSSB reports, as providing advice to the larger group chaired by Sean Holland/Christine Jendoubi on way forward. This larger group was due to meet again in the autumn and DHSSPS agreed to confirm date.

Perspectives on Trust and Board Commissioned Reports

DHSSPS:

3. Dr McMaster advised that following discussion with DHSSPS colleagues present, their view remains the same as outlined in the previous professional analysis i.e. there were methodological flaws in the way that the whole retrospective exercise was undertaken (e.g. independence of reviewers, timeframes used and that some Trusts had not included both children and vulnerable adults in their samples), but they still had significant concerns over the nature and frequency of incidents recorded, particularly in the reports submitted from CAMHS in-patient services.

PSNI:

4. Supt. Wallace outlined the legal obligation of the PSNI to protect vulnerable people through investigation and follow-up and advised that if credible evidence was available then the PSNI had a duty to investigate. Supt. Wallace advised that the PSNI had reviewed the information received and whilst they appreciated the time lapse and other limitations they considered that some potential for prosecutions could still exist. He then outlined some of the information that would be required i.e. the names of identifiable staff involved, are they still working/volunteering in HSCS/Independent sector today, and if not where are they now? It was also proposed by PSNI that there is also a requirement to consider the patient perpetrators of abuse and to determine the risks they currently pose.

5. DI Wilson pointed out that a cold paper exercise was often quite fruitless and interviews where appropriate may be needed. In considering the possibility of prosecutions and resource implications, Insp. Marks advised that prosecutions were not by themselves the primary objective, and that an investigation by itself could be conducive to ensuring the protection and safety of vulnerable adults and children.

6. All agreed that a key concern was to ensure that any identified perpetrators had been appropriately followed up. This was of particular concern in respect of the CAMHS reports which had a high prevalence of recorded incidents. PSNI considered that as a matter of urgency those named as perpetrators and victims should be followed up to ensure both that the perpetrators were no longer in the system, or those that are are appropriately managed, and that the victims, where appropriate and using a 'victim approach', were aware of services and/or offered support.

HSCB:

7. Ms McAndrew advised that due to a lack of detail in the reports there could be a variation in terms of what the Trusts did / did not report to the police at the time and variability in police response. Further clarity is also required in terms of what exactly the Trusts did in response to their own findings. She considered that a better understanding of how Trusts carried out and responded to findings was needed before a decision could be taken on the way forward. She recognised however some inevitability that a further more robust exercise would be required.

Way Forward

8. Attendees discussed the way forward and considered various possible options along a continuum from no further retrospective case file examination, but ensuring all currently known individuals were followed up, to the conducting of a further more rigorous and extensive retrospective exercise across all Trusts to gain full closure.

9. It was agreed that a suitable starting point would be to examine, in co-operation with the HSCTs, all the current reports to establish exactly how they were completed and what actions were taken. Such a process should be initiated by the SH/CJ group. For the Lissue report, initially instigated and led by the EHSSB, this would now fall to the HSCB. Another possible immediate action would be to request from Trusts the known names of both perpetrators and victims, which could be passed to PSNI to check

against their current databases -this action could be progressed both separately and as a matter of urgency.

10. A second stage, following receipt of information from the Trusts and HSCB, could be a further retrospective sample exercise by an independent group(s) working to agreed TOR drawn up by the DHSSPS/HSCB/PSNI. It was also felt some priority should be given to CAMHS. Following this further sample a decision could be taken as to whether or not a more extensive review would be required.

11. It was felt by those present that a joint structured approach involving PSNI & HSC would be best placed to take forward such reviews and comparisons were made to the CMR (Case Management Review) process. Before more detailed work on process/resource implications would be carried out agreement to the approach above should be sought from the larger group at their autumn meeting.

AOB

12. None

20

From: Christine Jendoubi

Date: 6 December 2011

To: 1. Andrew McCormick

2. Edwin Poots

RETROSPECTIVE SAMPLING EXERCISE

Issue:	Taking forward the retrospective sampling of patient records in mental health and learning disability hospitals
Timescale:	Routine
FOI:	Not Disclosable – Policy in Development
Legislative/financial issues:	None arising from this submission.
Presentational Issues:	Recent events indicate a close interest on the part of the Irish News; other media outlets may note (cleared by Press Office).
Special Adviser:	
Recommendation:	That you note developments and agree our proposed way forward, as set out in paras 13-17 below, ie: • complete the examination of the sample of patient files already identified, by forwarding to the PSNI all patient and related files which they wish to examine in more detail; • reconstitute the Strategic Management Group to oversee this next stage; and • liaise with the Historical Institutional Child Abuse Inquiry team on how our exercise can best fit in with their work.

As you are aware from Andrew McCormick's submission of 2 November (SUB/1589/2011), the retrospective sampling exercise was commissioned by the Department on foot of the investigation in 2005/06 prompted by a complaint by a former patient at Muckamore Abbey Hospital (MAH), which had revealed extensive evidence of possible sexual abuse dating back to the 1960s, 70s and

80s. Although this exercise did not lead to any convictions (as announced by the PPS in April of this year), as soon as the extent of the evidence at MAH came to light, it had been our concern that this type of activity was unlikely to have been confined to one institution. So when the Department wrote to all Chief Executives of the Trusts responsible for mental health and learning disability inpatient facilities in September 2006, seeking assurances about current practices and procedures for preventing abuse of children and vulnerable adults and handling any incidents that do arise, we also asked Chief Executives to consider the need for a retrospective review of patients' notes.

2. The format for the retrospective sampling exercise was agreed at a meeting in the Department in June 2007. At that meeting it was agreed that **a 10% sampling exercise would be performed in each Mental Health and Learning Disability Hospital throughout Northern Ireland for the period 1985 - 2005.** Unfortunately no notes were taken of that meeting, and no subsequent correspondence with the Trusts confirmed the parameters of the exercise.

3. The Trust reports of the sampling exercise were received into the Department between September 2008 and December 2009 and were considered by the Department's medical, nursing and social services professional advisors. The conclusion was that the exercise had not been executed in a uniformly robust manner and options on a way forward were provided. It was soon apparent that there were, not only inconsistencies among Trusts in how they approached the exercise (see below), but also indications coming out of the patients' files that there may have been other instances of abuse in other locations.

4. During that period, in response to another allegation about Lissue in the 1980s (JH), the then Eastern Health and Social Services Board had also instigated an audit of patient records in Lissue/Forster Green Hospitals (the Stinson Report): the retrospective sampling exercise conducted by the Belfast Trust therefore excluded that decade for those hospitals.

Retrospective Sampling Exercise – methodologies and discrepancies

5. The retrospective sampling exercise covered the following adult mental health and learning disability hospitals:

   - WHSCT – Stradreagh (LD), Tyrone & Fermanagh and Gransha Hospitals
   - BHSCT – Knockbracken Hospital site
   - SHSCT – St Luke's (Armagh), Craigavon Psychiatric Unit and Longstone (LD) Hospitals
   - NHSCT – Holywell Hospital
   - SEHSCT – Downshire Hospital

   As noted above, it also covered the Regional Child and Adolescent Inpatient Service, audited by BHSCT, and the EHSSB/HSCB commissioned reports on Lissue and Forster Green Hospitals.

6. The intended time period for the sampling exercise was 1985 – 2005, with a 10% sample of files on those most at risk especially children/minors, and the expectation was that Trusts would use the rigorous methodology agreed with the Police for use in the Muckamore review, which covered different classes of both sexual and physical abuse (8 categories in total).

7. However, the Department's professional advisers found that both scale and scope had been interpreted by Trusts in different ways, and there were significant inconsistencies and variation in both methodology and sampling among the Trusts and within the reports. Southern Trust included no adults' files and had not adopted the Muckamore methodology, focusing only on sexual abuse. The Northern Trust, on the contrary, included no children in its sample of 25, and it was unclear how these 25 files were chosen. WHSCT surveyed 300 files from Stradreagh alone, with a further 111 from T&F and 24 from Gransha. Belfast Trust confined its survey of Knockbracken files to children only and to 1970-

1986 only, and did not include Windsor House or the Mater Hospital mental health wards; SEHSCT, again, focused only on adults.

8. Nonetheless, the exercise did produce a considerable quantity of material on incidents of varying descriptions during the periods surveyed, some of which, in our view, were suggestive of physical or sexual abuse – in the main, by far, patient-on-patient abuse – and in many cases it was not clear what action had been taken at the time, whether that action was sufficient/appropriate by the standards of the day, or what the outcome was.

9. Once all the reports were accumulated (the most recent being the Stinson, Jacobs and Devlin reports under cover of a letter from the HSC Board confirming action taken on foot of them, received in March 2011), and after two meetings with PSNI, a total of 13 reports – all the Department had – were sent to PSNI in July 2011 for their views on whether the information in them should be investigated further with an eye to possible prosecutions. The 13 reports are listed at appendix A.

10. PSNI had already seen and commented on the Stinson Report, which dealt only with Lissue/Forster Green hospitals during the period 1975-1995, in 2009. Their view at that time was that, unless further evidence came to light, no further investigations would be taken forward in respect of Lissue Hospital. The Board had also forwarded to PSNI the Jacobs report, as it raised one new piece of evidence from the files, and the Police confirmed that no prosecutions would be taken forward.

11. In relation to the other reports, particularly the retrospective sampling reports, which they had not previously seen, PSNI confirmed in August 2011 after a preliminary consideration that in their view there were indeed instances which would merit further investigation, but repeated their view that prosecutions were unlikely, not only because of the passage of time (which would render many potential assault cases statute barred, for example) but also because of the age and characteristics of the potential

victims. They indicated that they would consider the files further and we arranged to meet them again on 14 November.

12. That meeting has now taken place. The Police remain of the view that further investigations should be undertaken (although we have not been told in which of the reports their concerns lie), and Detective Superintendent Brian Hanna has confirmed that he has been appointed to the role of Senior Investigating Officer to the allegations of historical abuse arising from the Lissue/Forster Green Hospitals review. Although further allegations surrounding Lissue have come to light on foot of the Irish News coverage, we understand this to be 'shorthand' for the retrospective sampling investigations in the round.

The Way Ahead

13. The meeting on 14 November, which involved the Board, PHA, PSNI and the Department, discussed what the next steps should be in taking forward the retrospective sampling exercise, also bearing in mind the establishment shortly of the Inquiry into Historical Institutional Child Abuse. At that meeting the PSNI reiterated their concern to control the extent of the retrospective sampling exercise in the light of the priority they need to accord to present-day protection issues within the resources available to them – and indeed which they would also need to apply to evidence coming to light through the HICA Inquiry. They continued to hold the view, however, that where it appeared that a crime may have been committed, they were bound to investigate.

14. As a first step, the PSNI and the HSC Board agreed to reconstitute the Strategic Management Group between the HSC and the PSNI which had been in operation during the early parts of this exercise in 2006-2008. The Board also reported that it will appoint 1-2 individuals at Board level to maintain an overview of the whole exercise in order to ensure co-ordination and consistency of approach among the Trusts.

15. Our intention is that the next phase of the exercise will concentrate on the information already to hand from the exercise to date. The PSNI will liaise directly with the Board and Trusts in identifying the patients' files that they want to see and investigate further, and these will be provided to them. Where those patient files indicate a need to see staff files or Family and Child Care files (social services files) these will also be provided.

16. Since we already have reports that cover both children and adults, we propose that the exercise in this next phase will also cover both. When the Historical Institutional Child Abuse Inquiry is established, we will meet with the Inquiry Team to discuss how our work and theirs can best be taken forward to avoid duplication but allow full scope for new evidence to come forward to the Inquiry from new victims.

17. When this next phase of the exercise is completed, we will meet again with the HSC and the Police to consider and take a view on what has been learnt, and whether the exercise needs to be widened, its relationship with the Historical Institutional Child Abuse Inquiry, and what the next phase should cover, and we will offer you advice in a further submission at that point.

18. The Police also reiterated their concern (which we would share) about the welfare of the patients – now all adults, some of them elderly – should they be approached about events which happened 20 or more years ago. Bearing in mind that these were, at the time, either children or vulnerable adults with learning disabilities and/or mental health problems, contact with them would need to be very carefully managed and professional advice sought as necessary (as was the case in the MAH Inquiry). The Police also repeated their view that prosecutions were unlikely.

Recommendation

19. You are asked to note and agree our proposed way forward as set out in paragraphs 13-17 above, ie:

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- complete the examination of the sample of patient files already identified, by forwarding to the PSNI all patient and related files which they wish to examine in more detail;
- reconstitute the Strategic Management Group to oversee this next stage; and
- liaise with the Historical Institutional Child Abuse Inquiry team on how our exercise can best fit in with their work.

20. We would be happy to discuss.

Christine Jendoubi
x 22388

Cc Michael McBride
Angela McLernon
Sean Holland
Christine Smyth
Ian McMaster
Eilis McDaniel
Colin McMinn
Pat Newe
Maurice Devine
Ronan Henry

Appendix A

Schedule of Documents

TAB	TITLE	TRIM REF
1	Interim Report in respect of Historic Review of Children Admitted to Lissue and Forster Green Hospitals associated with SAI 117-08	DH1/11/49325
2	Independent Report Lissue and Forster Green Hospitals Historic Case Review – RS Stinson	DH1/11/49325
3	EHSSB Review of the Standard of Nursing Care Provided to Children and Adolescents as part of the Lissue Hospital Historic Case Review	DH1/11/127614
4	Commentary Report on Independent Report Lissue and Forster Green Hospitals Historic Case Review by RS Stinson – Brian Jacobs	DH1/11/121080
5	Belfast Trust CAMHS Report	DH1/11/49326
6	Belfast Trust (Knockbracken - Adults) Report	DH1/09/135889
7	South Eastern Trust (Downshire Hospital) Report	DH1/09/150034
8	Northern Trust (Holywell Hospital) Report	DH1/09/122741
9	Southern Trust (Longstone Hospital) Report	DH1/09/150028
10	Southern Trust (St Luke's Hospital) Report	DH1/09/150208
11	Western Trust (Tyrone & Fermanagh and Gransha Hospitals) Report	DH1/09/148686
12	Western Trust (Stradreagh Hospital) Report	DH1/09/150034
13	Professional Comments on Retrospective Sampling Exercise (May 2010)	DH1/10/58986

Kerr, John (DHSSPS)

From: Jendoubi, Christine
Sent: 04 December 2012 12:10
To: Fionnuala McAndrew; martin.quinn@hscni.net; joyce.mckee@hscni.net
Cc: McDaniel, Eilis; Holland, Sean; Brown, Lorraine; McMinn, Colin
Subject: FW: Retrospective sampling update 22/11/12

Follow Up Flag: Follow up
Flag Status: Flagged

Fionnuala/Joyce/Martin

A draft note of our recent meeting for any comments/amendments please – comments by Friday would be welcome: see final para: Andrew would like a brief update note to go now to the Minister, based on what's below, if you are content; and then followed by a more substantive note in January after you come back to us. After the next SMG meeting.

Joyce

I think I should say that we are still quite surprised at the figure of 79 adult case files. By the reports we got at the time, the Western Trust alone claimed to have reviewed 128 files from Gransha and T&F.

Cj

FILE NOTE

A meeting took place on 22/11/12) on the Retrospective Sampling exercise, at the Board's request, prior to the next Strategic Management Group meeting the following day. Present were Fionnuala McAndrew, Martin Quinn (Children's Services) and Joyce McKee (Adult Services) from the Board, Seán Holland, Eilís McDaniel and Christine Jendoubi.

Fionnuala reported good buy-in by the Police to the SMG, which they co-chair. She explained what action had been undertaken thus far: essentially that Trusts had been given a template for completion and tasked with going back over the action that had been taken at the point of the retrospective sampling exercise, how any issues had been handled and what gaps there were.

Adult Services:

There had been 79 case files in the original retrospective sampling exercise over the 5 Trusts (we had thought, considerably more). Templates had been completed for all of them. The original exercise had only tasked the Trusts with commenting on abuse in categories 1-3; this time they were asked to comment on all 8 categories as they went over each file. Some things remain unclear (eg what was meant when "sexualised behaviour" was reported, whether there was consent etc). It was pointed out that the patients were in mixed wards at the time and behaviours (eg male patient putting hand on female patient's leg), and ways of dealing with them, were tolerated and regarded as normal and acceptable practice then which would not be now.

5 instances of possible staff abuse had been identified: one of these (for physical abuse) had led to a police prosecution and dismissal.

In brief, the Board feels it can say that issues identified, which in the main were practice issues rather than criminal issues, were dealt with appropriately in accordance with the protocols and procedures of the time. All papers had been referred to the Police.

The discussion then turned to next steps in relation to adult services. Fionnuala pointed to the difficulties around investigating adult files from so long ago when the retention requirements were only 5 years and much documentation may no longer be available. She felt it would be more effective simply to ask affected adults to come forward, rather than embark on a difficult (perhaps impossible) and lengthy exercise which could represent a disproportionate response with limited benefits.

More broadly, she reported that the Board was very much alive to the range of serious issues that were coming up in learning disability care homes, involvement of police etc, and were in discussion with RQIA about what more was needed to be done to secure people's rights to adequate standards of care.

Seán proposed a submission to the Minister which would list the challenges and set out options for achieving our objectives (and our objectives are: to acknowledge the past, identify potential contemporary threats, bring perpetrators to justice where possible and ensure that we have learnt enough from the past to make things as safe as possible today).

He suggested that one option (short of a wholesale exercise) of achieving at least the first objective might be to commission a book (as a research project, to be done by a social/medical historian) on the journey that social care has taken in the last century, from institutional care (workhouses etc) to today's care in the community. In addition to providing a demonstration of the State's acknowledgment and recognition of the issues in the past, such a book would add to the canon of knowledge and understanding on the subject and could be valuable at undergraduate level.

Alongside this it would be necessary to establish, at Board level, a point of contact for people who want to raise concerns – possibly same contact point as the Board is establishing for children.

As regards assurances for the present, these will include issues that are planned to be taken forward anyway, but will include:

- Review and development of appropriate legislation and policy to protect vulnerable adults;
- Review of training of staff in institutional establishments (cf Theresa Nixon's report)
- Review of standards by RQIA/Dept
- Role of advocates, confidence of families to raise concerns about care, esp overnight arrangements

It was agreed that the HSC Board would complete any outstanding work and come back in early January with a report on what action has been taken, outcomes and a recommendation. The Department will then put a submission to the Minister to reflect this and look for a decision on the way forward for adult services.

Children's Services:

Again, the Trusts had been asked to look at their reports in detail and report back on how incidents had been handled, gaps etc (NHSCT still to respond).

BHSCT had re-examined the 10 files each from Lissue, FGH and the YPC. These have not yet been further investigated by cross-reference to the fieldwork files, but are being connected to the 15 complaints logged by the Police over the past year. These had thrown up two new names, a blond Dr Alastair [?] at FGH and a Dr Gupta, now thought to be in India. The Police are following these up. NB in relation to the 15

complaints (mostly Lissue), no statements have been taken and nothing is known beyond "I was abused...". In relation to the one complaint about YPC, the victim was too ill to be interviewed. The complaints relate to both physical and sexual abuse.

Re timeframe for these 15 complaints, one dates back to the 1950s but most are in the 1979-1985 period. Some of these individuals have engaged Solicitors and may be preparing to sue.

It was considered that the frequency of the complaints around Lissue and YPC appears to be high and we have not yet been able to get assurance that things we handled appropriately at the time: this work is incomplete. And given the timeframe, it is likely that victims and perpetrators are still alive and possibly still working in the sector.

HAI:

Consideration was given to how the HSC's work dovetailed/overlapped with the work of the Historical Abuse Inquiry. The HAI will manage the process for dealing with other complaints, which may throw up other concerns in other institutions, and connect as necessary with the Police. It was agreed that a meeting with Judge Hart would be necessary to establish an agreed position on how complaints are going to be handled and who will do what, so that there is no overlap/duplication/confusion between the HAI and HSCB work. The HAI had been in touch with the Board to say that in their first month they had already been contacted by some 120 individuals covering 30 institutions; they will follow this up with a letter asking for assistance with evidence.

Once the Board has reported back in early January, Seán/Eilís will seek Minister's agreement to write to Judge Hart about the retrospective sampling exercise and the HSCB/PSNI joint working, which has now reached a stage where we can articulate concerns with greater clarity and while the HSC has its own duties to carry out it would wish to co-ordinate this work with that of the HAI; we would appreciate an early meeting to discuss handling.

At this point it was estimated that the support work for the HAI would need additional staffing; depending on the fruits of the discussion with Judge Hart it may be that we would want to progress a further, more in-depth review of Lissue/YPC which could take a dedicated team of some 2-5 individuals and up to 6 months' work.

Meeting with Andrew McCormick:

These matters were reported to Andrew by way of update at Seán's Business Review Meeting this afternoon. Andrew felt that a short update submission should go to the Minister now, paving the way for a more detailed submission mid-January once the Board has reported (after 4 Jan meeting of the SMG).

cj

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The Regulation and Quality Improvement Authority

The Regulation and Quality Improvement Authority

Safeguarding of Children and Vulnerable Adults in Mental Health and Learning Disability Hospitals in Northern Ireland

Overview Report

September 2012

informing and improving health and social care
www.rqia.org.uk

The Regulation and Quality Improvement Authority

The Regulation and Quality Improvement Authority (RQIA) is the independent body responsible for regulating and inspecting the quality and availability of health and social care (HSC) services in Northern Ireland. RQIA's reviews are designed to identify best practice, to highlight gaps or shortfalls in services requiring improvement and to protect the public interest. Our reviews are carried out by teams of independent assessors, who are either experienced practitioners or experts by experience. Our reports are submitted to the Minister for Health Social Services and Public Safety and are available on the RQIA website at www.rqia.org.uk.

Membership of the Review Team

Theresa Nixon	Director of Mental Health and Learning Disability and Social Work
Patrick Convery	Head of Mental Health and Learning Disability
Margaret Cullen	Mental Health Officer/ Inspector
Rosaline Kelly	Mental Health Officer/ Inspector
Carolyn Maxwell	Mental Health Officer/ Inspector
Janet McCusker	Mental Health Officer/ Inspector
Audrey Murphy	Mental Health Officer/ Inspector
Patricia Corrigan	Project Administrator, RQIA

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Executive Summary

The Regulation and Quality Improvement Authority (RQIA) believes that the safeguarding of children and vulnerable adults is about the individuals rights and choices, and keeping them safe from abuse or potentially abusive situations.

In April 2011 the Department for Health and Social Services and Public Safety (DHSSPS) commissioned RQIA to carry out a review of the effectiveness of safeguarding arrangements within mental health and learning disability (MHLD) hospitals across the five health and social care (HSC) trusts in Northern Ireland.

RQIA's Mental Health and Learning Disability Team incorporated the theme of safeguarding into a planned programme of inspections for 2011-2012. This report summarises the findings from 33 inspections carried out between December 2011 and July 2012. It contains 28 recommendations to ensure the continued safeguarding and protection of children and vulnerable adults.

Inspectors found that all trusts had policies and procedures in place to keep people safe from the risk of harm and abuse. Trusts had established safeguarding partnerships to promote the awareness of safeguarding and much effort has been made to ensure staff were appropriately trained. At the time of the review, responsibility for safeguarding adults was vested in the Northern Ireland Adult Safeguarding Partnership (NIASP). The Regional Child Protection Committee (RCPC) had responsibility for child protection but was in the process of transferring this duty to the new independent Safeguarding Board for Northern Ireland (SBNI). These new arrangements had not been fully reflected within the trust's safeguarding policies and procedures. Further work is required to ensure this occurs within an appropriate timeframe.

Although there was evidence that safeguarding was being promoted, a common theme across all trusts was that there were instances where procedures were not always being appropriately and consistently applied. Trusts need to continue their efforts to ensure staff are made aware of the indicators of abuse and monitor closely the evidence of the effectiveness of the implementation of safeguarding policies, procedures and practices.

To ensure that patients' rights are fully protected, there are areas that require improvement by trusts. These include: variation in thresholds for referring safeguarding concerns; the inappropriate use of restraint by untrained staff; and the lack of application of the correct procedures to protect patients' money and possessions.

Inspectors noted efforts by all trusts to increase advocacy services for patients, but this was variable in some places. Discrepancies were noted in record keeping and many records were not appropriately signed. Assessments were not always updated and at times the types of interventions made were not appropriately recorded.

Recommendations for improvement are made within this report, which have been raised with the trusts, through the inspection process.

In order that children and vulnerable adults are protected and kept safe from harm, the focus on safeguarding needs to continue to be a priority for all trusts

The findings of all mental health and learning disability inspections are reported on the RQIA website. The MHLD team also continues to follow up the progress in respect of the implementation of the recommendations contained in the inspection reports.

Section 1 – Introduction

1.1 Context for the Review

In April 2011 DHSSPS commissioned RQIA to carry out a review of safeguarding in the mental health and learning disability (MHLD) hospitals. The term of reference was to review the effectiveness of the safeguarding arrangements in place within the MHLD hospitals across the five HSC trusts in Northern Ireland.

This review focused primarily on the arrangements in place that can prevent abuse and assist staff to protect patients and themselves. The individual inspections also examined a number of aspects of patient care and these findings are detailed in the inspection reports.

Safeguarding is a generic term which is used to describe the multi-disciplinary measures put in place to minimise and manage risks to children and vulnerable adults. The safeguarding of children and vulnerable adults is a shared responsibility. Safeguarding arrangements require to be effective across a number of dimensions including awareness, prevention, identification and response.

In 2009 DHSSPS put in place specific standards and guidance for safeguarding children and vulnerable adults.

For the purpose of this report the term safeguarding refers to the HSC organisations' responsibilities to protect people whose circumstances make them particularly vulnerable to abuse. For adults the definition of vulnerability is defined as:

> 'a person aged 18 years or over who is, or may be, in need of community care services or is resident in a continuing care facility by reason of mental or other disability, age or illness or who is, or may be, unable to take care of him or herself or unable to protect him or herself against significant harm or exploitation'.[1]

It is accepted that a person's need to be safe from harm is determined not only by their individual circumstances but also by the care setting they are in. Abuse may be committed as the result of negligence, ignorance or deliberate intent and targeting of vulnerable people, either in a single act or on a continuing basis.

The definition of abuse for both children and vulnerable adults is set out in the Safeguarding Vulnerable Adults Guidance (September 2006) as:

> 'The physical, psychological, emotional, financial or sexual maltreatment, or neglect by another person. The abuse may be a

[1] Safeguarding Vulnerable Adults – Regional Adult Protection Policy and Procedural Guidance. (September 2006)

single act or repeated over a period of time. It may take one form or a multiple of forms. The lack of appropriate action can also be a form of abuse. Abuse can occur in a relationship where there is an expectation of trust and can be perpetrated by a person/persons, in breach of that trust, who have influence over the life of a dependant, whether they be formal or informal carers, staff or family members or others. It can also occur outside such a relationship'.[2]

In meeting the objectives of the term of reference, the review focused on:

- policies and procedures associated with safeguarding
- management, supervision and training of staff
- arrangements for the recruitment of staff
- awareness and response to safeguarding concerns
- identification and prevention of abuse
- concerns and complaints from patients and relatives
- records management arrangements

Inspectors examined the safeguarding arrangements in place across the MHLD hospital wards in all five HSC trusts, including:

- children's learning disability wards
- children's mental health wards
- adolescent mental health wards
- acute learning disability wards
- acute mental health wards
- brain injuries units
- continuing care learning disability wards
- continuing care and rehabilitation units
- dementia wards and
- psychiatric intensive care units

Relevant legislation, policies, procedures, guidance and best practice documents were considered by the inspector's in their assessment of the effectiveness of each trusts' safeguarding arrangements.

Services or facilities excluded from this review included: those attended by children and vulnerable adults which are not either mental health or learning disability facilities; any MHLD services provided by private, independent and voluntary agencies; and the agencies and establishments currently regulated by RQIA.

This report summarises the findings from these inspections and makes the recommendations necessary to ensure the continued safeguarding and protection of vulnerable adults and children.

[2] Safeguarding Vulnerable Adults – Regional Adult Protection Policy and Procedural Guidance. (September 2006)

1.2 Review Methodology

Seventy two MHLD wards fell within the scope of this review. It was necessary to adopt a suitable methodology that would maximise the ability to validate the quality of safeguarding arrangements across the trusts. The review team agreed that validation of the safeguarding arrangements would be undertaken through a programme of announced inspections, carried out by RQIA MHLD team. The rationale for this approach was to maximise the number of facilities inspected.

The review process used by inspectors:

1. Prior to the inspections a programme of 113 patient experience interviews was undertaken by RQIA from July to September 2011. Patients' views were used to inform the assessment of the effectiveness of the safeguarding arrangements in place.

2. Prior to inspection each ward completed a self-assessment questionnaire detailing its safeguarding arrangements. Each HSC trust was also asked to complete a questionnaire regarding its corporate responsibility in all areas of safeguarding.

3. RQIA MHLD team analysed the available information on each ward and used the following risk based criteria to select the wards to be inspected:

   - intelligence and recommendations made from previous inspections
   - information gathered from patient experience reviews
   - information received from complaints and serious adverse incidents
   - the analysis of self-assessment questionnaires returned by the trusts
   - type of ward or service provided

   From this analysis, 33 wards rated as high priority and were selected for inclusion in this programme of inspection (see Appendix 1). RQIA agreed with DHSSPS that this sample would provide an overview of the quality of safeguarding and safety arrangements across the five trust areas.

4. Each inspection examined all aspects of safeguarding arrangements. Evidence to support their findings was drawn from:

   - meetings held with patients, staff and other professionals
   - an examination of patient case files, complaints and serious adverse incidents
   - an analysis of the findings from recent RQIA inspections and reviews.

5. In line with the methodology, two stages of reporting of the findings were agreed:

   - individual inspection reports would be produced for each ward and presented to the trusts in line with the normal inspection process.
   - a single overview report containing a summary of the regional findings would be produced for the DHSSPS.

Section 2 – Findings from the Review

2.1 Background to the Findings

The findings of this review are presented under the following themes:

- governance arrangements both in the trust and in specific hospital wards
- the level of awareness of safeguarding arrangements and issues
- the ability of trust staff to recognise signs of abuse
- the mechanisms in place to prevent people experiencing abuse in the first place
- the procedures in place for staff to act appropriately if made aware of allegations or cases of abuse

In measuring effectiveness, it was important to recognise the broader context of practice and the internal and external challenges that impact on performance. It was not appropriate to judge safeguarding arrangements using a single effectiveness measure, as there are many components that need to be considered. Rather, different evidence was used to inform the development of indicators to assess effectiveness (conditions to support effective safeguarding arrangements).

The indicators in themselves are not absolute criteria for effectiveness; however, inspectors considered these would offer an appropriate basis for determining whether the safeguarding arrangements were sufficient to enable staff to effectively promote the welfare of children and vulnerable adults.

During the course of the inspections of the wards issues were identified such as: a lack of consultation regarding human rights; environmental issues; and other areas not associated with safeguarding. Any issues identified during the inspection were brought to the immediate attention of relevant trust personnel for action, or raised under RQIA's escalation process. The required action was detailed in the relevant quality improvement plan, for response by the trust.

The Belfast Health and Social Care Trust (Belfast Trust) and the Western Health and Social Care Trust (Western Trust) have children's mental health and learning disability wards and these were included in the inspection programme. The admission of young people under 18 to adult wards was noted in all trusts, even those which had specific children's wards.

2.2 Governance Arrangements in Respect of Safeguarding

A successful safeguarding agenda requires the support of a wide network of agencies, organisations and communities of interest from across the statutory, voluntary, community, private and faith sectors.

Unlike child protection, prior to 2010 the co-ordination of arrangements for the safeguarding of vulnerable adults was limited. However, the recent work undertaken by DHSSPS and the Department of Justice (DoJ), led to the establishment of safeguarding partnerships and to the development of working groups to standardise regional policies and procedures.

Adult Safeguarding Partnerships

At the time of the review, the adult safeguarding partnerships had been in place for approximately 18 months. While HSC organisations were able to clearly demonstrate their structures, governance and working arrangements, inspectors considered that safeguarding arrangements were in the early stages of development, as many policies and procedures were not updated. Inspectors considered that the publication of new regional adult safeguarding policy and procedures, completion of further safeguarding training for all staff, and the compilation of information on safeguarding are key factors requiring progression, to bring these partnerships to a more established stage of development.

Overall regional responsibility for adult safeguarding partnerships rests with the Northern Ireland Adult Safeguarding Partnership (NIASP), chaired by the HSC Board. The NIASP is made up of representatives from the statutory, voluntary, community and faith sectors. It has responsibility for the strategic direction and development of adult safeguarding throughout health and social care.

Within each trust area, a Local Adult Safeguarding Partnership (LASP) has been established, with responsibility for implementing the NIASP's guidance and operational policies and procedures at local level. Each LASP is chaired by an assistant director from the trust and includes representation from the trust and statutory, voluntary, community and faith sectors. The chairs of the LASPs are also integral members of the NIASP, which provides direct links for communication and reporting between the partnership groups.

Inspectors considered there is an effective infrastructure in each trust to support the operation of partnership groups. This includes sub-groups of NIASP who lead in the areas of policies and procedures; performance management and information; training; and communication and service user experience. During the review, some representatives of the partnerships suggested that the effectiveness of the sub-groups could be further improved by restructuring into trust led sub-groups, with a regional focus to improve practice.

Communication and reporting arrangements between the LASPs and NIASP were considered to be effective. LASPs regularly report on standards and outcomes such as training, trends, serious incidents related to adult safeguarding and vulnerable adult reviews. This information is used in the compilation of NIASP progress reports and a delegated statutory functions report is delivered annually by each trust to the HSC Board.

The only vacancy reported in the NIASP or LASPs, was one position within the Northern Health and Social Care Trust's (Northern Trust) LASP. This was in the process of being filled and was not impacting on the activities of the group. Good attendance at NIASP and LASP meetings was reported. However, a number had fallen, particularly their attendance at the sub-group meetings.

Child Safeguarding Partnerships

Well established child protection arrangements have been in place in HSC organisations for many years, in response to the events surrounding child abuse and historical child abuse inquiries. These focused more on child protection, than on wider aspects of safeguarding. However, this focus has changed with the introduction of new child safeguarding legislation by DHSSPS, leading to the establishment of new safeguarding structures. These new structures include a regional independent Safeguarding Board for Northern Ireland (SBNI) and five safeguarding panels located within each trust area. These will mirror existing child protection arrangements, but with increased independence and direct accountability to the Minister for Health, Social Services and Public Safety.

As child protection partnerships have been in place for many years, HSC organisations were able to demonstrate the structures, governance and joint working arrangements. At the time of the review, the Regional Child Protection Committee (RCPC) held overall responsibility for child safeguarding partnerships, which was chaired by the HSC Board. The RCPC is made up of representatives from the statutory, voluntary and community sectors and has responsibility for the strategic direction and development of child protection throughout Northern Ireland.

Considerable progress has been made in establishing new child safeguarding arrangements and during the transition period, the chair of the SBNI sat on the RCPC partnership, and the RCPC continued responsibility for child protection on an interim basis. During the review, it was established that the delay in transition of responsibility was impacting on the development of some aspects of child safeguarding arrangement, in particular, the development of up-to-date policies and procedures.

Within each trust area, a child protection panel (CPP) was established, with responsibility for implementing RCPC guidance and operational policies and procedures at local level. Each CPP was chaired by a trust assistant director and included representatives from the trust and the statutory, voluntary and community sectors. The chairs of the CPPs are also integral members of the

RCPC, which provides direct links for communication and reporting between the partnership groups.

Inspectors considered that there is an effective infrastructure to support the operation of the partnership groups. Established RCPC sub-groups have taken a lead in the areas of policies and procedures; case management reviews; education, training and audit; and communication and media management.

Communication and reporting arrangements between the CPPs and the RCPC is considered to be effective as there is a set of requirements for regular reporting and direct links for communication. CPPs regularly reported on standards and outcomes, which included statistical reporting, training, serious incidents related to child safeguarding and case management reviews. This information is used to compile RCPC quarterly reports and each trust's delegated statutory functions report to the HSC Board.

No vacancies were reported on the RCPC or CPPs and attendances at their meetings was generally good. Inspectors noted that the position of the designated paediatrician for child protection within the HSC Board was vacant; however, another paediatrician was currently fulfilling the responsibilities of the post.

Policies, Procedures and Protocols

While partnership groups were able to demonstrate a strategic plan for adult safeguarding, inspectors were concerned about the lack of an up-to-date regional policy and procedure for safeguarding vulnerable adults. Some trusts had developed their own policy and procedures and others had embraced the best practice elements from the - Safeguarding Vulnerable Adults - A Shared Responsibility: Standards and Guidance for Good Practice in Safeguarding Vulnerable Adults (Volunteer Now, 2010). However, the most recent regional guidance used by most MHLD hospital settings was the 2006 document - Safeguarding Vulnerable Adults - Regional Adult Protection Policy and Procedural Guidance. Inspectors considered the 2006 document to be out-dated as it does not reflect current best practice for safeguarding vulnerable adults.

A NIASP sub-group has developed new draft operational policy and procedures to be regionally adopted, which are currently under review. However, given the direct relationship between these procedures and the development of an Adult Safeguarding Policy Framework, being undertaken between DHSSPS and DoJ, the policy and procedures will not be released in advance of the Adult Safeguarding Policy Framework being published. Inspectors considered that until this is published, NIASP will be unable to fully deliver an effective safeguarding plan using up-to-date policies and procedures.

While children's partnership groups were able to demonstrate a strategic plan for child protection based on regional policy and procedures, few trusts had

taken steps to further develop trust specific child safeguarding policy and procedures. With the developments in child safeguarding and the transfer of responsibility to SBNI, both the regional policy and procedures any trust specific child safeguarding policy and procedures will need to be updated.

Patient Experiences

An area that was not fully evident in the reporting process was that of adult patient experience. The inspectors considered that work on patient experience with adults, undertaken within the trusts, should be reported on and the information used to inform the commissioning of services by the HSC Board.

While work on patient experience of children has been initiated, it was not yet evident in the reporting process. The RCPC had already identified this gap and was planning to incorporate this in its work in the period before transfer to the SBNI. The promotion of communication between the SBNI and children and young people had already been established as a key priority of the new SBNI.

Inspectors considered that the newly established partnerships within children and vulnerable adult services provide effective arrangements in terms of leadership, governance, infrastructure, communication and reporting. This constitutes a sound foundation for safeguarding in Northern Ireland. The findings from inspections also indicated a number of on-going challenges, including the need for more direct patient experience and feedback; the release of regional policy and procedures; and the establishment of new safeguarding structures.

Recommendations

1. The DHSSPS should prioritise the publication of the Adult Safeguarding Policy Framework to facilitate the release of the new Adult Safeguarding Policy and Procedures.

2. Trusts should ensure that work capturing patient experience is included in their quarterly and annual reports to the HSC Board.

3. The DHSSPS and HSC Board should expedite the transfer of responsibilities to the Safeguarding Board for Northern Ireland.

2.3 Awareness of Safeguarding Practice

The abuse of children or vulnerable adults can occur when a person is neglected, harmed or not provided with proper care. Raising awareness of abuse is one of the building blocks of effective safeguarding and not only enables staff within services to recognise and prevent it, but assists those at risk to maybe recognise it and protect themselves.

For systems to be fully effective, safeguarding arrangements must be promoted and not limited to the awareness of abuse. Staff must be familiar with the safeguarding structures within their organisation; understand their role and the roles of others; be aware of the policies and procedures; and know what action should be taken in relation to safeguarding issues. Similarly, patients and relatives should be made aware of the procedures and support arrangements associated with safeguarding.

Responsibility for safeguarding children and vulnerable adults is not specific to MHLD and applies equally across all services provided by the trusts. Information obtained during this review and also from the previous RQIA review of the Joint Protocol[3], demonstrated that trusts had clear lines of management accountability and corporate responsibility in relation to safeguarding children and vulnerable adults.

Whilst structures associated with the safeguarding of children and vulnerable adults are in place in each trust, they differ from trust to trust. Each structure facilitated representation at board and director level; designated officers and investigating officers for vulnerable adults; and designated paediatricians and named nurses for child protection. The effectiveness of the structures was confirmed by evidence of clear channels of accountability and communication. All trusts were able to demonstrate how they reported information from service level to trust board, and externally to the HSC Board. This included general information, performance returns, case management, risk management, governance oversight arrangements and information on the discharge of statutory functions.

On adult wards, inspectors considered that staff awareness of the designated officer role was generally well understood. However, the awareness was still not fully developed, as some staff were unsure of, or unable to identify who their designated officer was. A similar view was identified from visiting professionals, such as consultant psychiatrists, social workers and therapists. Staff perceptions of their roles in relation to safeguarding vulnerable adults varied and was clearly linked to awareness and understanding received through training. Staff who had received training considered that it was mostly effective in terms of raising awareness of their roles in safeguarding vulnerable adults.

[3] RQIA Review of the Protocol for Joint Investigation of Alleged and Suspected Cases of Abuse of Vulnerable Adults

Each trust was developing the role of the designated officer and also the role of the investigating officer within MHLD services, either in individual wards or in covering a hospital site. Inspectors considered this development to be beneficial in terms of improved communication, reporting and providing advice on adult safeguarding issues. The Northern Trust had the lowest number of designated officers, compared to other trusts. Its approach is to establish the number of designated officers proportionate to the level of safeguarding activity. The trust confirmed that the number of designated officers would increase if the level of safeguarding activity increased.

In relation to child safeguarding, the roles of designated paediatricians and named nurses were clear in all trusts and staff awareness was also very good.

All wards were noted to be proactive in promoting the awareness of child and adult safeguarding and had information regarding safeguarding displayed appropriately on notice boards. Posters and information leaflets were displayed at the entrance to wards to alert relatives and visitors, while procedural and other information was displayed for staff in ward offices.

Training in Safeguarding Children and Vulnerable Adults

Awareness of adult safeguarding and knowing what to do in a safeguarding situation can be improved through experience. If staff are to be equipped to deal effectively with an adult safeguarding situation, they must be appropriately trained. While most staff across the trusts were trained, inspectors noted that approximately one third of the total number of staff working in MHLD wards had not received training in safeguarding vulnerable adults. At the time of the review only 16 wards were found to have had all staff trained in safeguarding vulnerable adults, although training schedules were noted to be in place for most of those who had not been trained.

On children's wards, child protection training was considered to be an integral element in maintaining appropriate child safeguarding arrangements. However, not all staff working on the wards had received child protection training or training in Understanding the Needs of Children in Northern Ireland (UNOCINI). Inspectors expressed concern about this and recommended that all staff working on children's wards are appropriately trained.

Knowledge and Awareness of Policy and Procedures

Effective adult safeguarding is unsustainable without appropriate guidance or policy and procedures. Each trust's strategy for adult safeguarding has been determined in accordance with the DHSSPS regional guidance - Safeguarding Vulnerable Adults - Regional Adult Protection Policy and Procedural Guidance (2006) and the Protocol for the Joint Investigation of Alleged and Suspected Cases of Abuse of Vulnerable Adults (2009). Most trusts had also embraced the best practice elements from the 2010 standards - Safeguarding Vulnerable Adults - A Shared Responsibility and trusts have commenced developing their own safeguarding guidance, policy and procedures to complement the regional guidance

Arrangements for ward staff to access their trust's adult safeguarding guidance, policy and procedures were effective, with up-to-date information being maintained and accessible either in hard copy or electronically via the trust's intranet. Inspectors identified that some supporting procedures, such as the joint protocols[4] for investigations for both children and vulnerable adults and procedures for reporting and responding to allegations made against staff were missing from a limited number of wards across the Belfast, Western and South Eastern Health and Social Care Trusts (South Eastern Trust).

Staff awareness of each trust's policy and procedures for safeguarding vulnerable adults is an indicator how alert an organisation is to the possibility of abuse occurring. It is concerning that some staff in each trust claimed not to be aware of these. Even though it had been identified that not all staff across the trusts had completed safeguarding vulnerable adults training, inspectors considered that this was unlikely to be the primary contributing factor for the lack of awareness.

While trusts are taking positive steps in this area, inspectors considered that current regional guidance for adult safeguarding is not fully effective. Inspectors considered that the guidance was not up-to-date and did not reflect current best practice for safeguarding vulnerable adults. The NIASP is in the process of developing new operational policy and procedures. However, the delay in release of the revised guidance is having an impact on trusts' ability to fully progress the adult safeguarding agenda at a local and regional level.

Guidance, policy and procedures for safeguarding children, the ACPC Regional Policy and Procedures (2005), was well established within all trusts and staff within children's wards were aware of them. Inspectors also observed appropriate policies and procedures specific to looked after children on the children's wards. The arrangements for staff on children's wards to access each trust's guidance, policy and procedures were considered to be effective, with information both available and accessible either in hard copy or electronically via trusts' intranets.

It was identified that some of the current documentation on children's wards was out-dated. Although most wards were aware of this, some highlighted they had refrained from instigating any changes to documentation until the completion of the transfer of responsibilities and updated regional policies and procedures were available. With responsibility for child safeguarding transferring to the SBNI, the current ACPC Regional Policy and Procedures (2005) and associated trust policy and procedures will require to be updated to reflect the new structures.

Policies and procedures to support adult safeguarding and child protection, such as policies for management of violence and aggression, restrictive practices and the use of restraint and physical interventions were in place

[4] The Protocol for Joint Investigation of Alleged and Suspected Cases of Abuse of Vulnerable Adults and the Protocol for Joint Investigation by Social Workers and Police Officers, of Alleged and Suspected Cases of Child Abuse.

across all trusts. However, on a limited number of wards some of these policies were not up-to-date. The majority of staff across all trusts demonstrated an awareness of the supporting policies and procedures and how and where to access them, if required.

Effective awareness of safeguarding should not be limited to trust staff, but should include both patients and relatives. While many wards were actively promoting safeguarding and raising the awareness through posters and information leaflets, many patients and relatives had little understanding or awareness of their respective trusts' safeguarding arrangements. On average, 42% of patients and 43% of relatives who responded during the review, claimed to be unaware that the ward had a safeguarding sulnerable adults policy. Inspectors considered patients and relatives should have been made aware of trust procedures in order to be able to reflect any safeguarding concerns.

Recommendations

4. Trusts should ensure that all staff working within mental health and learning disability wards are appropriately trained in safeguarding vulnerable adults.

5. Trusts should ensure that all staff working on children's wards within mental health and learning disability services are appropriately trained in child protection and Understanding the Needs of Children in Northern Ireland (UNOCINI).

6. Trusts should ensure that the awareness of their safeguarding structures and roles is fully promoted in all wards, to ensure that this information is readily accessible to staff, patients, relatives and visitors.

7. Trusts should ensure that all supporting policies and procedures are up-to-date, available and accessible in all wards.

2.4 Identification of Safeguarding Concerns

Determining whether abuse has occurred or not, can be a difficult task. To help to ensure effective safeguarding arrangements are in place, staff must be suitably skilled and competent in identifying any signs of abuse and managing potential risks to vulnerable adults or children.

Inspectors were advised that some staff had not received updated training in safeguarding vulnerable adults. While many staff were able to demonstrate good working knowledge and understanding of adult safeguarding and the types of abuse, others were less able to demonstrate the same levels of knowledge or understanding. This was evidenced across all trusts during the inspection of wards.

The lack of ability to identify safeguarding issues was an area of particular concern to inspectors. Inspectors identified numerous safeguarding cases in both adult and children's wards that were not being classified by staff as a safeguarding concern. This meant that appropriate follow up and prevention mechanisms were not initiated. Such cases included patient on patient assaults or unexplained bruising. Lack of consideration of these incidents as possible abuse was associated with what staff determined to be the threshold at which an incident should be designated as a safeguarding issue. In cases where a staff member is faced with doubt about a threshold decision, the appropriate course of action should be a referral to the designated officer for advice, but, on some occasions, this did not occur.

A lack of training was cited by some to be a contributing factor, however, not the only factor. Inspectors also found that some staff were unable to provide assurances that they fully understood safeguarding procedures and requirements, while others stated they did not feel confident in dealing with safeguarding issues, even after receiving training.

In light of this, inspectors considered that some aspects of safeguarding vulnerable adults training were not effective in providing staff with the understanding and confidence necessary to discharge their roles. A similar view was shared by a ward manager in one trust, who stated that clarification on the content of adult safeguarding training was required. Inspectors considered that the understanding of staff of the threshold level for reporting issues requires further review by NIASP.

Risk Assessment and Management

Identifying potential risks and putting measures in place to deal with them are crucial in the prevention of abuse. All trusts have systems in place to identify and manage risks to patients, which included the use of the DHSSPS 2010 guidance on Promoting Quality Care (PQC).

Patient files were reviewed in all trusts and it was noted that risk assessments and care plans were completed for all patients. There was also clear evidence of these documents being reviewed and discussed at multi-

disciplinary team meetings, with many instances of the patients being involved. Information provided by relatives indicated that some considered they were not being informed or kept up-to-date with what was happening on the ward. Although this was not the case in all wards, many relatives expressed dissatisfaction with the feedback they had received from staff.

While patients in all trusts had received a risk assessment following admission to the ward, inspectors identified that the comprehensiveness of the documentation varied considerably between trusts. Concerns included:

- risks had been identified and recorded, but sometimes subsequent management plans had not been recorded in the notes, or notes were not being correctly updated
- records were not updated to reflect patients' changing circumstances
- occurrences of risks that were considered to be serious had not been reviewed in detail
- some risks were not being recorded within the risk assessment
- patient assaults on staff that were not reported as a risk

Staff indicated that assaults from patients formed part of the job; however, inspectors considered this may also be an indicator of potential risk to others and should be reported. A strategy should also be put in place to review, manage and minimise the risk.

Although each trust was able to demonstrate they had risk management systems in place, inspectors considered that some staff were not adhering or fully using the policy and procedures. A risk management plan is considered to be a live document and should be regularly updated to reflect any changes in patients' assessed needs and risks. Inspectors concluded that while the initial stages of the risk management process were being adhered to in all trusts, follow-up actions to update these documents were not always occurring. In the absence of updated and accurate patient documentation arrangements to safeguard patients could be compromised.

All staff reported being aware of the risk assessment procedure, but not all staff had received training in how to carry out a patient risk assessment. While it is possible that some staff may not carry out a patient risk assessment, inspectors considered this training would enhance their skills in the identification of risks.

Key indicators used in identifying child or adult safeguarding issues are accidents, incidents and near misses, where recurrences can highlight potential risks. It is important therefore, that trusts have in place procedures for reporting and recording accidents, incidents and near misses. Lessons can be learned from the analysis of these events which should be disseminated to staff and used to inform changes in practice, policy and procedures.

Serious Adverse Incidents and Complaints

All trusts had policies and procedures in place for recording and reporting accidents and incidents, supported by accident and incident log books on the wards. Staff demonstrated high levels of awareness of the accident and incident reporting process.

Each trust had their own individual reporting process and demonstrated how accidents and incidents were regularly reported and discussed at their respective governance meetings. Mechanisms to bring risks and concerns to the attention of the trust board/ senior management were also in place. Evidence of the analysis and learning being fed back to the wards was presented and staff also confirmed that learning was discussed at staff meetings.

Inspectors considered that there were effective accident and incident reporting processes in place across all trusts to complement their safeguarding arrangements. However, the effectiveness of these processes was on occasions comprised by the lack of application of the procedures by some staff. In particular, the previously identified problem associated with the threshold level for reporting an incident of abuse resulted in cases not being entered into the process. Thus these cases were not being investigated and learning from them could not be identified and shared appropriately with staff.

Other indicators applied to the identification of safeguarding issues are the concerns and complaints received from patients, relatives and staff. They can highlight issues or cases of abuse never previously identified or reported. When patients, relatives or staff have a concern or complaint they should have access to the organisation's complaints procedure.

The arrangements for complaints were well established in all trusts, with policy and procedures in place in all wards, supported by robust recording and reporting mechanisms. All staff demonstrated a high awareness of the complaints procedures. However, fewer than 50% of staff indicated that they had received complaints training. The high levels of awareness in this area were attributed to staff experience of managing complaints over the years.

Inspectors considered that effective arrangements were in place for the handling of complaints in order to provide patients, relatives or staff the opportunity to have their issues addressed. However, awareness and access to the process needs to be addressed. It was identified on the majority of wards visited, that information regarding the complaints policy was displayed and was available either on a poster, in leaflets or both. Information regarding complaints was also included in the information packs provided for patients and relatives on admission. Even though this information was readily available, patients and relatives still reported having low awareness. A limited number of wards across all trusts demonstrated evidence of being proactive in the promotion of the complaints procedure. Inspectors were unable to determine a reason for low levels of awareness of the complaints procedure

among patients and relatives and considered this as an area the trusts should investigate further.

The awareness of whistleblowing and cases arising from it is becoming more prevalent and offers a further opportunity for the identification of safeguarding issues. All trusts have a whistleblowing policy which was observed on all wards visited and all staff indicated a high awareness of the policy. While inspectors considered that effective arrangements are in place in relation to whistleblowing, they considered that trusts needed to update their whistleblowing policies to indicate that RQIA is a designated body which staff can contact if they are concerned about abuse.

Recommendations

8. Trusts should develop in consultation with ward managers a mechanism to review the effectiveness of safeguarding vulnerable adults training.

9. Trusts should undertake an audit of practice to determine if all staff are robustly adhering to safeguarding policies and procedures.

10. Trusts should ensure that comprehensive investigations and risk assessments are carried out as required.

11. Trusts should ensure that risk assessment training is provided for all staff.

12. Trusts should ensure that all staff receive training in relation to their complaints policy and procedure.

13. Trusts should ensure that complaints policy and procedures are clearly communicated and promoted to patients and relatives in a user-friendly format.

2.5 Safeguarding Practice in Preventing Abuse

It is often difficult to prove that an abusive event has occurred and equally difficult to demonstrate that an abusive event has been prevented. Identifying what constitutes a successful prevention intervention is very difficult to determine. It is for this reason that appropriate safeguarding prevention arrangements need to be in place. The prevention of abuse is preferable to supporting children or vulnerable adults after an abusive event has taken place.

Prevention is most likely to be effective where proper arrangements are in place such as: legislation and regulation; policies and procedures; training; awareness raising; information, advice and advocacy; interagency collaboration; and promoting involvement of patients and relatives. However, the success of these arrangements will be determined by how well staff operate and adhere to them.

Appropriate recruitment and selection procedures are required to minimise the opportunity for unsuitable people to work with children or vulnerable adults. All trusts confirmed they had arrangements in place for vetting applicants including carrying out pre-employment checks, requesting evidence of qualifications and registration with professional bodies, the provision of written references and Access NI checks. Inspectors found these arrangements to be effective in preventing an unsuitable applicant from being employed by the trusts.

Good organisational practice requires a thorough induction process. In all trusts, new staff were required to undertake both a corporate induction and a local ward induction. Three trusts advised that the induction process included information on the trust's safeguarding arrangements. However, in the South Eastern and the Northern trusts inspectors noted that safeguarding was not included in the corporate induction process. This absence of safeguarding from corporate induction is concerning. Inspectors considered this should be addressed and safeguarding included as an integral part of all trusts' induction programmes.

Ward inductions were more comprehensive in terms of outlining safeguarding arrangements. Evidence of the use of an induction checklist was observed on the wards. The only notable issue in relation to ward induction was in one ward in each of the Belfast and Western trusts, where adult safeguarding was not observed to be part of the process. From observation of induction processes on other wards, inspectors considered the arrangements to be effective, as they provided an appropriate introduction to safeguarding for all new staff.

Good management of staff will ensure that everyone on the wards is clear about their roles and responsibilities in relation to safeguarding. Alongside daily management responsibilities, supervision and appraisal should be available to assure the trusts that staff are carrying out their work to the

required standard. Supervision is also essential to ensure that staff feel supported.

All trusts were noted to have policies and procedures in place for supervision and appraisal, and in the majority of wards visited, both occurred in line with the trusts' policies and procedures. Feedback from staff confirmed that frequent supervision is offered and staff stated they felt supported by the ward manager. In some wards it was observed that no regular supervision was offered and no supervision was taking place. Appraisals had taken place in most wards, with the exception of several wards in the Western Trust, where the absence of appraisals had been confirmed by staff. The Western Trust advised that in one instance this was due to no permanent ward manager being in place.

Inspectors considered that, in general, there were effective arrangements in place to facilitate appropriate supervision and appraisal; however, these were not being applied consistently in all wards. Inspectors also considered that by not adhering to supervision and appraisal procedures there is a risk that safeguarding arrangements may be compromised by the failure to identify potential safeguarding issues and staff training needs.

For those staff receiving supervision and appraisal, the tools used to identify training needs included personal development plans and the Knowledge and Skills Framework. While most staff were satisfied that their training needs were being met, there were some instances where staff indicated this not to be the case, with a number of staff stating they had found it difficult accessing appropriate training.

Safeguarding practices were assessed in several areas on the wards to determine what arrangements were in place and whether staff were adhering to best practice guidance, policies and procedures. The areas covered included aspects of care considered under the following headings:

- deprivation of liberty
- protecting patients' money and possessions
- visitation of children to the wards
- admission of young people under 18 to adult wards
- management of records and record keeping

If arrangements in these areas are not properly managed and controlled a potential for abuse can occur.

Deprivation of Liberty

Inspectors examined the circumstances in which patients may be subject of seclusion, and/or restraint and the practice of close observation of both adult and children on wards. This highlighted that all trusts had policies and procedures for the management of interventions. Some policies needed to be updated and on one ward, within the South Eastern Trust, no policy on restraint was available.

Staff demonstrated a good awareness of the need for documentation of close observation and restraint. Staff in some wards seemed less aware of the need to monitor seclusion. The Southern and Northern trusts advised of using seclusion as an intervention on a limited number of wards. The numbers of staff trained in close observation and restraint was high, but not all staff had completed this training. The number of staff trained in seclusion was considerably lower; however, this may be a consequence of seclusion no longer being practiced within three of the five trusts.

The appropriate management of challenging behaviour could reduce the need for further interventions and limit the number of potential safeguarding cases. In the Western Trust it was noted that the use of de-escalation techniques had resulted in a reduction in the number of incidents of physical aggression. From the information provided by the five trusts, not all staff were trained in this area. The majority of staff were trained in the management of challenging behaviour, the exception being the South Eastern Trust who reported having less than 50% of staff trained.

Throughout the trusts, it was observed that the application of policies and procedures for seclusion, restraint and close observation varied between wards. It was noted that the use of such interventions was only employed after discussion and agreement during multi-disciplinary team meetings or after a risk assessment had been completed. A review of a number of patient records confirmed this to be the case and inspectors noted that staff were following the recommendations contained within patients' care plans. While there were areas of good practice, there were many cases where the interventions had not been recorded or updated in patients' notes. A concern was raised in relation to a limited number of staff who were not adequately trained but were applying behaviour intervention techniques on patients. From a review of staff training records it was observed that not all staff had attended initial training, or had received updated training in a suitable method of control or restraint. To prevent unintentional abuse to patients and to ensure staff are protected from inadvertently causing harm to a patient, inspectors considered that further training in this area is required. As some staff were not fully adhering to the procedures and others were not fully trained, inspectors considered the arrangements for managing interventions to be partially effective.

Protection of Patients' Money and Property

While children and vulnerable adults are in hospital, protection arrangements should be in place to safeguard their property and possessions. During the review it was recognised that this was a difficult area to administer and manage, a view reiterated by staff across all trusts.

Where children and vulnerable adults are incapable of managing their affairs, suitable protection arrangements must be in place to protect them from financial abuse. Each trust has arrangements in place which govern the management of patients' money, which include policies and procedures and

mechanisms for receipt and storage of patients' property, including personal finance. The majority of staff in all trusts were familiar with the arrangements for handling patients' money. Many staff expressed concern that documentation applied trust wide and was not specific to MHLD wards and suggested further clarification was necessary.

Each trust had its own policy and procedure to govern patients' property, which actively discouraged patients from bringing valuable items onto the wards. This was considered a sensible approach, because to safeguard patients' property effectively, would require trusts to redirect staff resources away from patient care.

For those patients who deposited money, it was noted that it was recorded in an inventory book and either stored in the ward safe, a locked cabinet or lodged in the trust's cash office. Each ward had arrangements to allow patients access to their money. Even though patients and relatives did not raise any major concerns about the arrangements in relation to patients' money, inspectors identified issues in relation to how patients' money was used. Records of expenditure were not always maintained. In particular, inspectors identified that on some wards in the Southern Trust, patient finances were used to purchase furnishings for the ward, such as curtains and bed linen. Trusts advised that such items could not be given to the patients upon discharge. RQIA considers this to be an inappropriate use of patients' personal monies, as items such as furnishings and bed linen should be provided by the HSC trust. This matter was raised with the trust following the inspection and has since been resolved.

In the management of patients' property, wards provided guidance and information to patients and relatives upon admission, used an inventory book to record patients' property brought onto the ward and provided patients with locked storage facilities. Relatives were also requested to label patient's property and clothing. Even with these arrangements in place, staff found this a difficult area to manage and patients regularly advised of items going missing. A contributing factor to this issue was that clothes and possessions were brought to and from the wards by relatives, which were not recorded in the inventory books. In these circumstances staff had no way of maintaining an accurate inventory of patients' possessions. Inspectors considered that trusts had put basic arrangements in place to safeguard patients' property but considered that unless patients and relatives fully adhered to the arrangements, it was difficult to see how the wards could be expected to achieve effective oversight in this area.

Although there were policies and procedures in place, as well as mechanisms to record the receipt of patients' money, inspectors considered the current arrangements were not sufficiently robust to provide effective safeguarding of patients finances. Inspectors also considered that guidelines on the use of patients' money need to be further developed and communicated to all relevant staff.

Visits of Children to the Wards

Children visiting parents is central to maintaining normal family relationships. However, the best interests of the child must be paramount and taken into consideration when considering a visit. All trusts have incorporated this into their safeguarding prevention arrangements and it has been outlined in their policies and procedures for children visiting MHLD wards. This was not fully reflected in the practice observed on some wards.

While many staff on adult wards demonstrated awareness of the procedures associated with child protection, there were instances where the procedures were not available on the ward and staff did not know what the arrangements were. There was a perception from some staff that they did not require extensive knowledge of child protection as they worked in predominantly adult services. Inspectors considered that these staff had failed to understand the potential child protection issues of children visiting adult wards.

The number of staff on adult wards trained in child protection varied considerably across trusts, with an overall average of only 50% recorded as having received child protection training.

Information provided in relation to children visiting adult wards included posters, leaflets and a patient information booklet. This information was only observed on some wards throughout the trusts. In the Southern Trust it was observed that risk assessments were carried out prior to the child visiting, to allow for suitable monitoring arrangements to be put in place. In the Northern Trust, there was a protocol that dictated that all child visits were to be pre-arranged with the ward manager. However, staff advised that this was difficult to manage as relatives did not adhere to this protocol and often arrived at the ward unannounced.

The physical arrangements in place on the wards to facilitate a child visiting varied considerably. While many wards had separate rooms to accommodate such a visit, many had no visiting area and some visits took place in the manager's office or the patient's bedroom.

Inspectors considered that the arrangements for children visiting adult wards are only partially effective, due to the lack child protection training, staff understanding of the procedures and the lack of suitable visiting arrangements on the wards.

Admission of Young People Under 18 to Adult Wards

In accordance with best practice, all children and adolescents should be accommodated within age appropriate services, rather than admitted onto adult wards. During the period from November 2010 to November 2011, a total of 71 admissions of young people under 18 to adult wards were reported by the five trusts.

All trusts had policies and procedures in place for the admission of young people under 18 to adult wards and staff demonstrated high levels of awareness in relation to this. Evidence was observed of wards adhering to the relevant guidance from DHSSPS and of the arrangements put in place by the trusts for such occurrences. These included: one-to-one nursing care; admission to single bedded rooms; and close observation. Admission of young people under 18 to adult wards is categorised as a serious adverse incident and requires notification to external organisations. Evidence of notification of these incidents was presented to inspectors.

Inspectors were concerned about the level of adequate child protection training in respect of arrangements for the admission of young people under 18 to adult wards. Of the wards which admitted young people under 18, only one ward in the Western Trust was recorded as having all staff trained in child protection. The lack of staff with appropriate child protection training in the other wards was considered a potential risk to the safeguarding of children admitted to these wards. Inspectors recommended that immediate action is required in relation to child protection training.

Management of Records and Record Keeping

As well as a requirement to implement best practice, the mechanisms that support robust safeguarding prevention arrangements, such as good records management, contribute in their own right to better safeguarding arrangements. Accurate recording of clinical outcomes, interventions, training and supervision help to ensure appropriate information is available for the purposes of patient care and also assists managers to identify gaps in staff capability that might impact on patient care.

Records management policies and procedures have been established in all trusts and schedules for auditing of records were identified by each trust. Staff demonstrated a high awareness of the procedures. However, information provided by staff indicated that on average, only 41% of staff had received records management training. In the majority of patient records reviewed, the notes reflected good record keeping, but there were still some instances where information had not been recorded in line with trust procedures or best practice. In particular, discrepancies included: notes that had not been signed; risk assessments not being updated or completed; and interventions not having been recorded.

Records management procedures were also applicable to recording information about training, supervision and appraisal. Recording in this area was generally acceptable with up-to-date information being maintained about staff training and the dates for supervision and appraisal. However, the review of records highlighted some gaps in mandatory training, out-of-date training and also that supervision and appraisal were not taking place. With such information readily available, the inspectors raised concerns in respect of the lack of application of training, supervision and appraisal.

While inspectors determined there were effective arrangements in place to facilitate best practice in records management, this area was only considered to be partially effective as there were too many instances where the procedures were not being adhered to.

Recommendations

14. Trusts should ensure that appropriate safeguarding awareness should be included in staff induction training.

15. Trusts should ensure that all staff receive regular supervision and appraisal.

16. Trusts should ensure that all policies and procedures associated with safeguarding are kept up-to-date and made available to staff on all wards.

17. Trusts should ensure that staff are appropriately trained in the area of management of challenging behaviour.

18. Trusts should ensure that staff are appropriately trained in the areas of seclusion, restraint and close observation.

19. Trusts should ensure that only staff who are appropriately trained should employ restrictive intervention techniques.

20. Trusts should ensure that policies and procedures that govern patients' money and property should be reviewed and updated.

21. Trusts should ensure that all staff have received the appropriate level of training in child protection.

22. Trusts should ensure that all arrangements in place for children visiting or those admitted to adult wards should comply with child protection requirements.

23. Trusts should ensure that all staff receive training in records management.

24. Trusts should ensure that all staff adhere to the records management policy and procedures.

2.6 Response to Safeguarding Concerns

Even when organisations have arrangements in place to safeguard people from abuse, there can still be instances where abuse occurs. In such cases, it is the safeguarding response employed by the organisation that will determine whether appropriate action and support has been provided to individuals who may have been abused.

The response arrangements do not operate in isolation, or only when abuse occurs. These are intertwined throughout the policies, procedures and training, which are the mechanisms that enable staff to know how to respond following an incident of alleged abuse. The effectiveness of many aspects in these areas have been discussed throughout the report.

This section focuses on the arrangements for communication and the involvement of and support for patients.

For people who experience abuse, the need to involve and work with other organisations is key in protecting them from further abuse. Promoting the welfare of patients is a joint responsibility that should be shared by a range of organisations. Engagement with other organisations was observed to be working well in all trusts. In particular, representatives from external organisations were represented on the RCPC, CPPs, NIASP and LASPs and were involved in serious case reviews. This was similar to the findings obtained during RQIA's Review of the Protocol for Joint Investigation of Alleged and Suspected Cases of Abuse of Vulnerable Adults (February 2012). Inspectors considered that the arrangements in place for liaison with other organisations were effective due to the multi-agency approach, established lines of communication and regular meetings.

Each ward advised of promoting and communicating an ethos of inclusion and transparency to patients and relatives. While most wards displayed their philosophy or mission statement either on the ward or in their information booklets, there were still a considerable number of wards where such information was not evident. It is therefore important to communicate a commitment to the principles of openness and transparency to patients, relatives, advocates and staff.

Although there was good communication throughout each trust and externally to other organisations, the inspectors identified that communication with patients and relatives was not always of an appropriate standard. Communication and involvement were also areas highlighted by both patients and relatives. While many felt they had received adequate communication, others were concerned about the lack of information regarding their relatives care and about incidents that happened on the ward. Across all trusts, patients' notes identified that many relatives were being informed about incidents, but other patients' notes and reports from relatives identified this practice was not happening routinely on all wards.

The inclusion of patients and relatives was referenced in many patients' notes; however, there were many cases in each trust where these two groups were not represented during discussions about patient care. The instances of weekly meetings with patients and relatives were limited to a few wards in each trust.

In terms of openness and transparency, a concern raised by many relatives was their access to the wards to see where their relatives were staying. Many visits were facilitated in side rooms or outside the ward. There were only a limited number of wards where relatives were permitted access to the ward. While this practice was to facilitate ward routine and reduce disruption, relatives viewed it as a lack of transparency. In some cases the ward manager facilitated relatives' access to the ward, but this was limited. RQIA believes that an appropriate balance needs to be struck between assuring relatives of the comfort of the ward, including sleeping arrangements, without comprising the privacy and dignity of the patients.

Patients' access to information held about them was considered an area that was not well promoted in most trusts and was further reflected in the comments from patients and relatives. While the trusts advised of having policies and procedures in place to govern this, it was determined these were freedom of information procedures. The South Eastern Trust had additional information about accessing personal information made available to patients on the wards. Inspectors considered the current arrangements were only fulfilling the minimum requirements in respect of access to information and considered that trusts should be more proactive in informing patients of their rights.

Where patients, relatives or their advocates have concerns or complaints about any aspect of treatment or care, they should have access to the trust's complaints procedure. There was evidence of relatives being encouraged to make a complaint in some patients' records, but many patients and relatives claimed not to be aware of the complaints procedures. On several wards, throughout each trust, there was no evidence of informing or promoting the procedures to patients or relatives.

While the trusts strived to have a culture of openness and transparency in safeguarding practice, this was not evident on all wards. Inspectors considered the arrangements to promote inclusion were not sufficiently effective. Although many mechanisms were in place to facilitate best practice, they were not being fully applied.

Advocacy services can make a significant contribution to the prevention of abuse, by enabling patients to become more aware of their rights and facilitating them to express their concerns. The availability of advocacy services varied considerably across trusts and between wards. However, most wards were promoting advocacy services to patients and relatives, through leaflets and posters. In a few wards, where advocacy services were available, the ward was not seen to be promoting this service to patients or relatives.

Advocates spoken to during the review confirmed the benefits of promoting the services and reported an increase in the number of consultations. While most patients had access to advocacy services there were still a number of patients who were unable to avail of this service. The most proactive wards had resident advocates based on their wards.

Inspectors considered the trusts were making good progress in providing advocacy services, but this should be available to patients in all wards.

Recommendations

25. Trusts should ensure that a culture of inclusion and transparency is promoted across all wards.

26. Trusts should ensure that patients and relatives are, where possible, fully included in discussions about their care.

27. Trusts should ensure that patients and relatives are fully communicated with in relation to their care, and about incidents and accidents on the wards.

28. Trusts should ensure that patients and relatives on all wards have access to advocacy services.

Section 3 - Conclusion and Recommendations

3.1 Conclusion

This report presents an overview of the safeguarding arrangements in place to protect children and vulnerable adults in mental health and learning disability hospitals across Northern Ireland. These recommendations apply to all trusts even though some may already compliant. All five trusts have made good progress in establishing effective safeguarding arrangements for both children and vulnerable adults, although inspectors found that the levels of progress varied both across trusts and between wards.

Wards, where a designated officer or safeguarding lead was based or spent a considerable amount of time, demonstrated higher levels of safeguarding awareness, more up-to-date training, and the application of policies and procedures was more evident. The role of the designated officer is invaluable in establishing and delivering more effective safeguarding arrangements. Local and regional groups were established to facilitate multi-agency working and clear communication protocols were in place for staff to report any concerns about the safeguarding of vulnerable people. Through these groups, trusts are able to share information, and to work on regional initiatives to drive further improvements in safeguarding practice.

The overall governance arrangements in place to support effective safeguarding were considered to be robust, with clear management and accountability structures evident in both children and adult wards.

Generally, the trusts have successfully determined the main priorities for safeguarding and maintained a focus on meeting these. However, the areas requiring progression were the development of the new adult safeguarding policy framework and the transfer of responsibilities for children to the new SBNI. Once these are put in place, this should help to bring a clear focus on further improvement in safeguarding practices.

Most staff were able to demonstrate an awareness of safeguarding issues, of policies and procedures and of the required reporting arrangements if they have any concerns. Improvement is required in ensuring that all staff are trained appropriately in vulnerable adults and child protection procedures; that all relevant policies and procedures are updated and implemented; and that staff are more proactive in the promotion of safeguarding to patients and relatives.

Inspectors found that different thresholds and mechanisms are being employed by trusts to identify potential safeguarding issues, such as patient risk assessments, reporting accidents and incidents and evaluation of complaints. Although good written procedures are in place to support best practice, their effectiveness is being hindered by the lack of implementation by some staff.

There was evidence of risk management of patients and of risks being discussed at multi-disciplinary meetings; however, there were instances where further follow-up was required. The reporting and analysis of accidents and incidents is being carried out, but inspectors noted that many incidents had not been considered as a safeguarding concern and subsequently were not appropriately reported. Further training is required to drive improvement in this area. Although there are complaints procedures in place, many patients and relatives indicated they were not familiar with or aware of them. It was considered this needs to be promoted further with patients and relatives.

All trusts had effective arrangements in place to prevent unsuitable people working with children or vulnerable adults. To support staff, policies and procedures for supervision and appraisal were noted to be in place in all trusts. Many staff reported they were supported by management but, there were still many cases where regular supervision or appraisals are not being carried out.

All trusts had policies and procedures in place to prevent abuse, particularly in the areas of deprivation of liberty and financial abuse. In some instances arrangements for managing patients' money and property were not wholly effective in providing adequate protection of patient money and belongings. Although staff demonstrated an awareness of the guidance of depriving patients of their liberty, a number of concerns were evident. Inspectors found that physical interventions for restraint were also being applied by some staff who were not appropriately trained.

Procedures were in place for children to visit wards and in most cases the arrangements were adequate. However, inspectors considered that the current arrangements on each ward should be reviewed to ensure that child protection procedures are being consistently adhered to. Further staff training in child protection in both adult and children's wards is required and this was recognised by the trusts.

The arrangements for responding to safeguarding issues varied across trusts. While arrangements for working with other organisations were noted to be in place, the internal arrangements to involve patients and relatives were not as good and needed to be improved. In particular, an improvement is required in communication with patients and relatives in terms of the types and levels of information provided to them. Both patients and relatives should be consulted and involved in decisions about safeguarding and patient care.

Advocacy services were available to most patients and relatives, however, inspectors noted many wards did not actively promote the services to patients or relatives.

RQIA wishes to thank the management and staff from the Health and Social Care Board, the health and social care trusts, and all the patients and relatives who agreed to be interviewed for their co-operation and contribution to this review.

3.2 Summary of Recommendations

1. The DHSSPS should prioritise the publication of the Adult Safeguarding Policy Framework to facilitate the release of the new Adult Safeguarding Policy and Procedures.

2. Trusts should ensure that work capturing patient experience is included in their quarterly and annual reports.

3. The DHSSPS and HSC Board should expedite the transfer of responsibilities to the Safeguarding Board for Northern Ireland.

4. Trusts should ensure that all staff working within mental health and learning disability wards are appropriately trained in safeguarding vulnerable adults.

5. Trusts should ensure that all staff working on children's wards within mental health and learning disability services are appropriately trained in child protection and Understanding the Needs of Children in Northern Ireland (UNOCINI).

6. Trusts should ensure that the awareness of their safeguarding structures and roles is fully promoted in all wards, to ensure that this information is readily accessible to staff, patients, relatives and visitors.

7. Trusts should ensure that all supporting policies and procedures are up-to-date, available and accessible in all wards.

8. Trusts should develop in consultation with ward managers a mechanism to review the effectiveness of safeguarding vulnerable adults training.

9. Trusts should undertake a review to determine if all staff robustly adhere to safeguarding policies and procedures.

10. Trusts should ensure that comprehensive investigations and risk assessments are carried out when required.

11. Trusts should ensure that risk assessment training is provided for all staff.

12. Trusts should ensure that all staff receive training in relation to their complaints policy and procedure.

13. Trusts should ensure that complaints policy and procedures are clearly communicated and promoted to patients and relatives in a user-friendly format.

14. Trusts should ensure that appropriate safeguarding awareness should be included in staff induction training.

15. Trusts should ensure that all staff receive regular supervision and appraisal.

16. Trusts should ensure that all policies and procedures associated with safeguarding are kept up-to-date and made available to staff on all wards.

17. Trusts should ensure that staff are appropriately trained in the area of management of challenging behaviour.

18. Trusts should ensure that staff are appropriately trained in the areas of seclusion, restraint and close observation.

19. Trusts should ensure that only staff who are appropriately trained should employ intervention techniques.

20. Trusts should ensure that policies and procedures that govern patients' money and property should be reviewed and updated.

21. Trusts should ensure that all staff have received the appropriate level of training in child protection.

22. Trusts should ensure that all arrangements in place for children visiting or those admitted to adult wards should comply with child protection requirements.

23. Trusts should ensure that all staff receive training in records management.

24. Trusts should ensure that all staff adhere to the records management policy and procedures.

25. Trusts should ensure that a culture of inclusion and transparency is promoted across all wards.

26. Trusts should ensure that patients and relatives are, where possible, fully included in discussions about their care.

27. Trusts should ensure that patients and relatives are fully communicated with, in relation to their care and incidents and accidents on the wards.

28. Trusts should ensure that patients and relatives on all wards have access to advocacy services.

Glossary of Terms

Belfast Health and Social Care Trust (Belfast Trust)

Child Protection Panel (CPP)

Department for Health and Social Services and Public Safety (DHSSPS)

Department of Justice (DoJ),

Health and Social Care (HSC)

Local Adult Safeguarding Partnership (LASP)

Mental Health and Learning Disability (MHLD)

Northern Ireland Adult Safeguarding Partnership (NIASP)

Northern Health and Social Care Trust's (Northern Trust)

Promoting Quality Care (PQC)

Regional Child Protection Committee (RCPC)

Regulation and Quality Improvement Authority (RQIA)

Safeguarding Board for Northern Ireland (SBNI)

South Eastern Health and Social Care Trust (South Eastern Trust)

Southern Health and Social Care Trust (Southern Trust)

Understanding the Needs of Children in Northern Ireland (UNOCINI)

Western Health and Social Care Trust (Western Trust)

APPENDIX 1 - List of Wards Inspected

Trust	Hospital	Ward
Belfast Trust	Mater Hospital	Ward L
	Foster Green Hospital	Beechcroft Adolescent Unit
	Foster Green Hospital	Beechcroft Children's Unit
	Muckamore Abbey Hospital	Iveagh Centre
	Muckamore Abbey Hospital	Greenan
	Muckamore Abbey Hospital	Cranfield ICU
	Muckamore Abbey Hospital	Moylena
	Muckamore Abbey Hospital	Finglass
	Knockbracken Healthcare Park	Avoca
	Knockbracken Healthcare Park	Valencia
Northern Trust	Causeway Hospital	Ross Thompson Unit
	Holywell Hospital	Inver 3
	Holywell Hospital	Carrick 4
	Holywell Hospital	Tardree 1
	Holywell Hospital	Inver 4
	Holywell Hospital	Lissan 1
South Eastern Trust	Lagan Valley Hospital	Ward 12
	Downe Hospital	Downe Acute
	Downshire Hospital	Ward 28
	Downshire Hospital	Ward 29
	Downe Hospital	Downe Dementia Ward
	Lagan Valley Hospital	Ward 11
Southern Trust	Longstone Hospital	Sperrin
	Longstone Hospital	Donard
	Longstone Hospital	Cherry Villa
	Longstone Hospital	Mourne
	St. Lukes Hospital	Gillis Memory Centre
Western Trust	Lakeview Hospital	Brooke Lodge
	Lakeview Hospital	Crannog
	Tyrone and Fermanagh Hospital	Ash
	Lakeview Hospital	Strule
	Waterside Hospital*	Wards 1 and 3

* While two wards were inspected only one inspection report was prepared.

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4.2 A caveat that must also be borne in mind when considering the Trust reviews of their adult mental health and the learning disability hospitals, is that there were significant weaknesses in the methodologies applied.

4.3 Nevertheless there is very clear evidence of numerous accounts of failure to implement recognised child care procedures and vulnerable adult guidance. All Trusts reference their failure and shortcomings in this area and most have stated that they have drawn up training plans to address this concern. Also, some Trusts have made recommendations which have been converted into action plans in order to ensure the current and future safety of patients and this should be considered the most reassuring outcome of this Retrospective Sampling Exercise.

4.4 In ensuring regional learning occurs it is vital to note the findings and recommendations of the Regional review undertaken by RQIA into the 'Safeguards in place for children and vulnerable adults in mental health and learning disability hospitals' in HSC Trusts. This took place during September/October 2007 and an Overview Report was available in June 2008.

4.5 The findings contained in the RQIA Overview Report identified concerns in a number of key areas including:

- the failure to implement child protection procedures;
- the failure to implement vulnerable adult policy and guidance;
- significant variance in the implementation of comprehensive risk assessment processes;
- similar variances in relation to Looked After Children (LAC);
- variance in review and audit activity;
- and concerns regarding the amount and quality of training in respect of the above key policies and procedures.

4.6 With regard to the recommendations made in the RQIA Overview Report which seeks to address the above concerns, they include:

- the establishment of robust individual and group supervision structures, which take account of relevant professional guidelines;
- the implementation of policies and procedures for Looked After Children;
- the identification of a named nurse and named doctor for child protection cases;
- the implementation of appropriate child protection procedures and training;
- the implementation of adult protection (vulnerable adult) procedures and associated training;
- a 'consistent' approach to the management of aggression;
- the full implementation of regional adult protection policy and procedural guidance.

4.7 As a mechanism for providing assurance on current and future governance arrangements being robust, it is important to note that this Overview Report does not give any clear indication of commitment for follow up of implementation of its' recommendations other than the following statement: 'the findings from this Review and **any subsequent follow-up** Review will be shared with the Minister for Health, Social Services and Public Safety and made available in the context of open reporting'. It would therefore be imperative that RQIA ensure that the recommendations of this Report are followed up, and furthermore, it would be essential to seek assurance from RQIA that such monitoring of safeguards of children and vulnerable adults is conducted on a regular basis (and including spot checks). These inspections should not only take account of the implementation of RQIA recommendations, but also examine the implementation of recommendations made by Trusts in their respective reports.

EHSSB

INDEPENDENT REPORT LISSUE & FORSTER GREEN HOSPITALS HISTORIC CASE REVIEW

Final Draft

RS STINSON

January 2009

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

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1. Background

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

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

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

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

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

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

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

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

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

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

Phase 1

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

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

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

Phase 2

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

Methodology

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

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

3. Definitions

3.1 The following definitions have been used:

Child: a person under the age of eighteen.

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

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

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

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

physical e.g. hitting, kicking

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

indirect e g. spreading rumours

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

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

4. Index

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

Child	DOB	Categories 1	2	3	4	5	6	7
A.	28.11. 77	√		√				√
B	25.06.70		√					
C	05.07 84							
D	19.01.80						√	√
E	02.05.87			√			√	
F	16.01.78							
G	28.10.78.							
H	27.10.76.							√
I	18.09.75.							√
J	12.05.75.						√	√
L	01.02 74.							
M	06.06.83.							√
N	26.07.66.							
O	07.06.80.							
P	17.01.77.		√					√
Q	20.2.75.							
R	12.02.82.	√						
S	10.01.84	√						√
T	18.11.81.	√						
U	31.07.75.	√						
V	25.11.69.							
W	13.06.76.		√					

Child	DOB	Category					
X	10.08.79						
Y	13.10.67		√				√
Z	18.09.76.						√
AA	06.06.80.						√
BB	05.07.65	√		√		√	√
CC	21.07.82.						√
DD	23.04.75.					√	√
EE	12.05.77.	√	√				√
FF	02.05.76.						√
GG	01.12.77.	√					√
HH	24.02.77						

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

Note. Individual incidents are not recorded

Children's Index

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

Child	Name	DOB	Categories 1	2	3	4	5	6	7
A.	LS 67	28.11. 77	√		√				√
B	LS 47	25.06.70		√					
C	Ashleigh Burtenshaw	05.07 84							
D	Alexander Cameron	19.01.80						√	√
E	Grainne Clawson	02.05.87			√			√	
F	Martin Doherty	16.01.78							
G	Alan Faulkner	28.10.78.							
H	Naomi Ferguson	27.10.76.							√
I	Joan Greer	18.09.75.							√
J	Jacqueline Halliday	12.05.75.						√	√
L	Marie Kidd	01.02 74.							
M	Zarina La Touche	06.06.83.							√
N	LS 126	26.07.66.							
O	Stuart Moore	07.06.80.							
P	Thomas Moran	17.01.77.		√					√
Q	Vivienne McClelland	20.2.75.							
R	Kerrie McIntyre	12.02.82.	√						
S	Natalie McNeice	10.01.84	√						√
T	Rose McNeice	18.11.81.	√						
U	Mary O'Neil	31.07.75.	√						
V	Susan Parker	25.11.69.							
W	Mark Robinson	13.06.76.		√					
Child	Name	DOB	Category						
X	Adam Rogers	10.08.79							

Y	Nigel Scott	13.10.67		√				√
Z	Alexandra Thorne	18.09.76.						√
AA	Charlene Tumelty	06.06.80.						√
BB	LS 66	05.07.65	√	√		√	√	
CC	Michael Williamson	21.07.82.						√
DD	LS 41	23.04.75.				√	√	
EE	Paul Reilly	12.05.77.	√	√				√
FF	Frances Spence	02.05.76.						√
GG	Bridget Garlick	01.12.77.	√					√
HH	Gavin Duncan	24.02.77						

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

Note. Individual incidents are not recorded

5. FINDINGS

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

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

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

5.1.1 Allegations of Sexual Abuse by Peers (Category 1)

Total number of children abuse 8

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

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

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

5.1.2 Allegations of Sexual Abuse Against Peers (Category 2)

Total number of abusing children: 6

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

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

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

5.1.3 Allegation of Sexual Abuse by Staff (Category 3)

Total number of incidents: 3

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

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

Appendix 3 provides details on these 3 incidents.

5.1.4 Allegations of Physical Abuse by Peers (Category 4)

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

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

5.1.5 Allegations of Physical Abuse against Peers (Category 5)

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

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

5.1.6 Allegations of Physical Abuse by staff (Category 6)

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

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

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

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

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

Appendix 4 provides further details.

5.1.7 Grooming (Category 7)

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

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

Child / Child

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

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

Another note referring to the same patient states:

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

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

Staff / Child

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

6. CARE MANAGEMENT REGIME

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

6.1.1 Restraint

6.1.2 Sanctions

6.1.3 Victimisation

6.1.4 Humiliation

6.1.5 Supervision / Staffing Levels

6.1.6 Staff / Child Relationships

- Child A
- Child H.

6.1.7 Child J

6.1.1 Restraint

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

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

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

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

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

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

Issues Arising from use of Restraint

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

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

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

policies and procedures to implement this guidance.

6.1.2 Sanctions

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

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

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

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

6.1.3 Victimisation

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

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

6.1.4 Humiliation

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

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

Issues arising fell within the following broad categories:

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

General Issues arising regarding Bathing and Showering

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

6.1.5 Supervision / Staffing Levels

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

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

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

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

Issues

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

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

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

6.1.6 Staff / Child Relationships.

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

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

6.1.7 Child J

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

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

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

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

General Issues Arising from Child J's case

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

7. CONCLUSION & RECOMMENDATIONS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

APPENDIX 1: DETAILS OF ALLEGATIONS OF SEXUAL ABUSE BY PEERS

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

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

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

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

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

Issue

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

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

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

Issue

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

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

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

Issue

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

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

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

Issue

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

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

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

Issue

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

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

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

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

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

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

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

Issue

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

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

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

(See also Child EE - Sexual Abuse Against Peers)

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

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

Issue

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

APPENDIX 2: DETAILS OF ALLEGATIONS OF SEXUAL ABUSE AGAINST PEERS

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

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

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

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

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

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

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

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

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

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

Issue

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

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

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

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

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

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

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

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

Issue

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

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

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

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

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

Issue

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

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

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

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

Issues

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

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

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

APPENDIX 3: DETAILS OF SEXUAL ABUSE BY STAFF

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Issues

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

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

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

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

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

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

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

Issue

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

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

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

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

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

Issue

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

She continues:

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

She recalls another occasion when she was heavily sedated:

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

Issue

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

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

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

In her statement she continues:

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

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

Issue

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

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

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

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

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

Issue

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

APPENDIX 4: DETAILS OF ALLEGATIONS OF PHYSICAL ABUSE BY STAFF

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

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

Issue

No staff member was named by the complainant.

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

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

Issue

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

Child J - 12 year old girl

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

Child BB 13 year old Female

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

APPENDIX 5: RESTRAINT

Child D - 12 year boy admitted 19.01.80 to 06.03.92

Restraint was used on 2 occasions as follows:

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

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

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

Restraint was used on 2 occasions as follows:

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

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

Child S - 11 year old girl admitted 06.01.95 to 26.09.95

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

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

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

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

22/23.02.95 - disruptive defiant behaviour continued so brought downstairs

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

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

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

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

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

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

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

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

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

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

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

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

Restraint was used on 2 occasions as follows:

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

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

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

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

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

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

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

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

FROM FAMILY AND CHILD CARE NOTES:

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

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

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

Issues

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

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

Restraint was used on 4 occasions as follows:

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

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

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

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

APPENDIX 6: SANCTIONS

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

This child had a history of Eating Disorder

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

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

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

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

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

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

This child had a history of encopresis and nocturnal enuresis.

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

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

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

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

APPENDIX 8: HUMILIATION

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

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

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

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

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

His school report for week commencing 04.01.88 states:

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

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

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

The report for week commencing X states:

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

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

Issue

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

Child J - 12 year old girl

See separate Section at (vii) below

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

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

Issues

The following questions arise:

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

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

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

Issue

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

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

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

Issue

A possible interpretation of this comment could constitute an assault.

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

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

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

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

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

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

Issue

Practices in relation to this child raises he following questions:

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

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

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

Issue

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

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

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

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

Issue

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

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

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

Issue

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

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

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

Issue

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

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

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

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Issue

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

APPENDIX 9: DETAILS OF SUPERVISION/

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

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

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

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

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

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

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

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

APPENDIX 10: DETAILS OF STAFF/CHILD RELATIONSHIPS

Child A - 8 year old girl

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

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

Issue

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

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

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

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

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

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

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

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

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

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

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

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

Issue

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

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

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

APPENDIX 11: Child J

Transcription 1- Page 8

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

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

Control of Patients

Page10

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

Page12

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

Page16

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

Issue

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

Child / Child Relationships

Page 13

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

Staff / Child Relationships

Page 14

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

Page 14

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

Page 15

She named the member of staff as a CC.

Page 18

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

Issue

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

Page 18

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

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

Page 22

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

Issue

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

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

Page 23

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

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

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

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

Issue

This alleged action clearly constitutes an assault.

Page 24

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

Issue

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

Page 24

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

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

Issue

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

Transcription 2

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

Page 7

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

Issue

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

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

Page 17

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

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

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

Page 19

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

Page 20

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

Page 23

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

Issues

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

Page 26

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

Issue

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

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

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- Page 1 of Stinson's report notes a time span for this review of 1975 to 1995. However the previous BHSCT report on Regional Inpatient CAMHS had intimated that the time span for this review of Lissue and Forster Green would be for the period 1980-89.

(b) Key findings and circumstances of abuse/suspected abuse

- The frequency, range and serious nature of incidents/ practice reported and apparent prevalence of abuse is very high. From the initial 34 children identified, 23 encountered abuse/alleged abuse, with the files specifying 38 specific incidents of concern.

- The severity and frequency of findings documented, and the lack of follow-up or robustness of any action taken, raises very serious concerns, including the failings in staff leadership, accountability and governance.

- There is a lack of comments on the actions taken subsequent to such incidents.

- There is a lack of comment on the disparity between the then extant guidance/procedures/professional standards compared to events/practice described. This is a serious flaw within this exercise.

- There have been very serious allegations made against a range of staff members. Although it is apparent from the reports that follow up action has been taken to address allegations made against a number of staff, we could not be assured that this has taken place for all staff mentioned. A considerable number of nursing staff have

information be useful in current therapeutic analysis/care or clinical processes supporting such individuals?

- The methodology used in this review of Lissue and Forster Green hospitals would appear to have been disjointed and as a result there does not appear to have been appropriate communication across the system. Given the sensitivites, nature and complexity of this work this is understandable, however lessons must be learnt from this in relation to how this can be avoided in the future so there is a joined up and seamless approach at all levels including DHSSPS, HSCB, and Trusts.

- In terms of overall governance/accountability, the responsibilities of key individuals in positions of management/leadership throughout the HSC needs to be considered.

- Do we need a written record of actions taken to ensure coverage of all staff mentioned in this report?

- The Stinson report was completed in January 2009, yet DHSSPS have received it over one year later.

4. SUMMARY

4.1 It is important not to underestimate the internal difficulties which Trusts had in carrying out these retrospective exercises. Allocation of adequate resources and poor record keeping over the 20 year period have impacted on the gathering of necessary evidence. Furthermore, the history of caring culture within psychiatric institutions over this period of time needs to be kept in mind – what was acceptable 20 years ago is no longer acceptable and many policies and procedures which we have now, were then not in place.

Draft

Lissue Historic Cases Review Phase Two.

EHSSB

INDEPENDENT REPORT LISSUE & FORSTER GREEN HOSPITALS HISTORIC CASE REVIEW

Final Draft

RS STINSON

January 2009

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

view was that there was evidence of multi-disciplinary working, and it was wrong for the Board to say there was little multi-disciplinary working.

A. Certainly my experience of working with Lissue and former patients there was that there was very much a multi-disciplinary ethos.

Q. We will ask the Board's representative maybe why they came to that conclusion.

A. Uh-huh.

Q. But certainly the Department then, when they received this report, they accepted the views of the Board?

A. Yes. Well, we certainly didn't challenge those findings, but were obviously very concerned about them and with Lissue in particular having closed, but with other institutions still being up and running the Department established -- its concern was such that we established the Strategic Management Group to advise on the way forward and assure us that things were very different today.

I should also say that I had actually forgotten when we were speaking earlier, but as far as I recall the Department also commissioned the Regulation, Quality and Improvement Authority to do a comprehensive review of learning disability and mental health hospitals and the report of that review also made several recommendations.

undertaken --

A. Uh-huh.

Q. -- into Lissue and Forster Green Hospitals. If we can look, please, at page 13716. Just if we go to 13714 just to show the start of the report, you will see that the report sets out the findings of a review of the care and treatment of children admitted to Lissue and Forster Green Hospitals in the late 1980s. It goes on then at that page 13716, where she says that:

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

A. I totally deny that as being present in Lissue. It was not my impression that that was the regime.

Q. And I think you said you would totally disagree with that assessment.

A. Oh, I would indeed.

Q. Even the next line:

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

Again you would say the whole ethos was of multi-disciplinary working.

A. Undoubtedly.

Q. We have heard that older staff maybe were stricter with

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

Belfast Health and Social Care Trust

Retrospective Child Protection and Safeguarding Audit within the Regional Child and Adolescent Inpatient Service

Contents

Introduction

Following allegations of sexual abuse of children and vulnerable adults while inpatients in Muckamore Abbey Hospital Linda Brown, Deputy Secretary, Social Policy Group, Department of Health, Social Services and Public Safety requested that a retrospective sampling be undertaken of individual inpatient files for learning disability and mental health hospitals. This was to ensure that where incidents of abuse may have occurred in the past that patients and their carers were appropriately supported and that procedures to identify the abuse, either by staff or patients were followed.

The scope of the audit was restricted to the periods 1970 - 1979 and 1990 – 1999. The Eastern Health and Social Services Board had previously commissioned an audit focusing on the period 1980 – 1989. Therefore this period was excluded from this audit. The Trust is currently awaiting this audit report.

The period 1970 – 1979 relates to inpatients files of patients admitted to Lissue Hospital. The period 1990 – 1999 relates to inpatients files of young people admitted to the Young People's Centre, College Gardens and Forster Green Hospital. It was agreed that an audit team comprising of a Child Protection Nurse Advisor and a Principal Practitioner for Child Protection would undertake the audit during September 2009 and complete the report by the end of October. Advice was also sought from Simon Dunlop, Multi Professional Audit Manager and Verdi Jarvis, Audit Facilitator, Standards, Quality and Audit Department.

Current Practice

- Staff working within Child and Adolescent Mental Health Service (CAMHS) participate in the Trust's Child Protection Training programme.

- The Trust has a Complaints Procedure and Untoward Incident reporting mechanism which can highlight areas of poor practice.

- Supervision policies are in place within the Trust. Nursing staff within CAMHS recently participated in a supervision pilot project arising from the Department of Health's publication 'Draft Regional Safeguarding Children Supervision for Nurses and Midwives'. This pilot is currently being evaluated. It is hoped that the final document will identify regional standards for safeguarding children supervision for nursing staff working within CAMHS.

- Staff can also access child protection advice from the Child Protection Nursing Team within the Trust and Family and Child Care Social Services.

- In exceptional circumstances due to current capacity issues within Specialist Adolescent Mental Health Inpatient Services young people may have to be admitted to Adult Mental Health wards. The Trust has in place a protocol 'Admission Protocol for Young People in the Care of the Child and Adolescent Mental Health Services who are admitted to Acute Adult Mental Wards' to manage admission of young people aged 16 years and over who primarily present with a mental health disorder. This protocol is currently being reviewed.

- The Trust is currently participating in the national initiative, 'Think Child, Think Parent, Think Family' led by the Social Care Institute of Excellence (SCIE). This initiative aims to improve practice by enhanced collaborative working between Mental Health and Children Services.

- Induction – All new staff are required to complete an induction programme which includes the skills and competencies required to work in CAMHS.

- Quality Network For Inpatient CAMHS Service Standards (QNIC) – For the past 2 years CAMHS have been audited against the National QNIC Standards. These reports have been positive in terms of safeguarding children.

Terms of Reference for the Child Protection and Safeguarding Audit within the Regional Child and Adolescent Inpatient Service

Rationale for the Audit:

Child and Adolescent Mental Health Services (CAMHS) governance arrangements require that policies and procedures relating to Child Protection/Safeguarding are being fully adhered to and implemented throughout the service.

Scope of Audit:

This audit will in the first instance be applied to Regional Child and Adolescent Inpatient Services. It was decided to restrict the scope of the audit to the periods 1970 - 1979 and 1990 – 1999. The Eastern Health and Social Services Board had previously commissioned a report to focus on the period 1980 – 1989. Therefore this period was not included in this audit.
The period 1970 – 1979 relates to inpatients files of patients admitted to Lissue Hospital, which was operational until 1989 and admitted children up to the age of 14 years. The period 1990 – 1999 relates to inpatients files of children/young people admitted to Forster Green Hospital and the Young People's Centre, College Gardens. Forster Green Hospital was operational from 1989 and admitted children up to the age of 14 years. The Young People's Centre, College Gardens was operational from 1990 to 2004 and admitted young people between the ages of 14 to 18 years.

Overall aim of the audit:

To identify any cause of professional concern in relation to the management of child protection/ safeguarding issues within Regional CAMHS Inpatient Service.

Objectives:

1. To assess compliance with and implementation of the relevant Child Protection and Safeguarding Procedures of the time period.
2. To assess the management of child protection/safeguarding issues within the units.
3. To assess how issues raised by children and young people regarding potential abuse were followed up by staff within the units.
4. To immediately report to the Trust any matter of concern, which arises during the course of the audit.

Methodology:

Study Period – 1st January 1970 to 31st December 1979 and 1st January 1990 to 31st December 1999

- Retrospective Audit of 15 files randomly selected for each period.
- All files to be analysed using an audit proforma agreed by the Co-Director of Child and Adolescent Mental Health Services.
- Clinical files to be representative of all practitioners including Medical, Nursing, Social Work and Psychology Professions.
- Clinical files to be representative of all Inpatient Units.
- The Audit to be independently conducted by Geraldine Sweeney, Child Protection Nurse Advisor and Margaret Burke, Principal Practitioner for Child Protection.
- The Audit to be undertaken during September 2009 and a report submitted by the first week of October 2009.

Child Protection Policies identified as relevant to the periods 1970 – 1979 and 1990 - 1999

Child Protection Procedures –

- Non-Accidental Injury to Children - Dept of Health and Social Security (1975)
- Procedures for Dealing with Cases of Child Abuse and Neglect - Eastern Health and Social Services Board (April 1983)
- Co-operating to Protect (DHSS 1989)
- Child Protection Policy and Procedures - Eastern Health and Social Services Board (May 1991)

Results of Audit:

L – Lissue (1970 – 1979, **Y** – Young People's Centre (1990- 1999), **F**- Forster Green (1990 – 1999).

Patient Identifier	Child protection/safeguarding concerns identified during admission.	Were procedures followed	Additional Comments
L1	No	N/A	
L2	No	N/A	
L3	Yes. a) Reported in nursing records that the child went over to his father who struck him in the face. b) In the outpatient medical notes it is recorded 'he hits me with a belt' referring to his father.	No record of action taken following either of these incidents.	Child was involved with Family and Child Care (F&CC).
L4	Yes. a) Nursing records contain very subjective comments to describe child's behaviour e.g. 'usual sly behaviour ' 'born niggler'. b) Social work records indicate that mother felt she could do the child serious injury. c) There is also an incident recorded in the medical notes where mother reported that L4 'tried to strangle 8 year old sister'.	No record of action taken following these incidents.	F&CC did not appear to be involved with this family.
L5	Yes. a) Letter from doctor in another hospital where the child (L5) had been admitted indicated that L5 had been involved with an older child in an assault on a 5 year old child. L5 and the other child had attempted to insert a piece of plastic into the 5 year olds penis. Five year old is not identified. b) In the nursing records prior to admission an incident is recorded where the mother describes how she brought L5's sister inside the home and swung her round by the hair and then she threw L5 upstairs hitting his head.	No record of action taken following this incident.	Child was involved with F&CC.
L6	Yes The child was subject to a Fit Person's Order and was admitted to prepare him for admission to a Children's Home. Body map on admission indicated bruises and flea marks on child.	No record of action taken following these observations.	Child was involved with F&CC.
L7	Yes. a) In the nursing records the child is described as 'has appearance of a rejected child' 'underclothes are stained with poor hygiene'. b) Records contain a statement that the male went to prison for neglect but there is no further information as to this person's identity. Records were difficult to read.	No record of action taken following this incident.	F&CC did not appear to be involved with this family. Child observed with his arms around another child and kissing her in a hut. There was no context to this information. Therefore no conclusion could be reached in relation to this incident.

L8	No	N/A	
L9	Yes. This child had 14 admissions over an 8 year period. a) In nursing records there are a number of recorded incidents of alleged physical abuse which do not appear to have been followed up e.g. 'lifted hand to hit father. Father hit him back' 'mother came into office stating 'she was going to f.... kill him as he had tried to choke her in the car'. b) Child had a black eye. c) There are also descriptions in the nursing records of when the child returned from home leave he was very unkempt. d) Reports of a sexual relationship with a 15 year old girl. L9 was 14 years.	No record of action taken in relation to these incidents.	Child was involved with F&CC.
L10	Yes a)Two letters within the file written after his admission which outline concerns in relation 3 overdoses and allegations of 'cruelty' by his father which resulted in the child been taken in care.	No further information contained in the file in relation to these.	Child was involved with F&CC.
Y1	Yes. a) In the medical notes there are details of a number of incidents recorded relating to alleged sexual and physical abuse by an older male whom the young person claimed to have had a relationship with for 3 years. b) In the restricted section of the file there is an incident recorded of an alleged physical assault by a male known to the young person while she was out in a car with him and 2 other people.	No record of action taken in relation to these incidents.	Young person is involved with F&CC. While there is evidence of liaison with F&CC it is not clear if they were aware of the alleged sexual and physical abuse by an ex boyfriend. There is an entry which is not signed when the young person makes threats to kill her brother and everyone in her school. However the minutes of a review meeting indicates that this issue was discussed. F&CC social worker was present at this meeting.
Y2	No.	N/A	Young person was involved with F&CC who were already aware of child care concerns.
Y3	Yes. a) This young person discloses sexual abuse by her uncle's brother to a nurse during her admission. It is not clear from the records if this information was known to social services or was this new information.	No record of action taken.	Young person was involved with F&CC. There is evidence within the records of communication with F&CC in relation to a disclosure from the young person that her father hitting her with a belt.
Y4	Yes. a) During admission the young person indicated on paper to a therapist that she had to prostitute herself to prevent her father being killed and out of fear for her animals. b) Mother also reported to nursing staff	No record of action taken.	No record of F&CC involvement.

	alleged physical abuse by the father and a domestic violence incident.		
Y5	Yes. a) During a therapy session with the doctor the young person alleged that her mother's boyfriend sexually abused her at the age of 12 years.	No record of action taken	Young person was involved with F&CC.
Y6	Yes. a) Incident recorded in nursing records where staff in another children's home reported that the young person had gone home yesterday and was sexually abused by her brother. It was known to F&CC that there was a history of Y6's brother sexually abusing her.	No record of action taken by staff in children's home.	Young person was involved with F&CC.
Y7	Yes. Young person made a disclosure to the Therapist about alleged abuse by a male who was known to her. Male not identified within the records. Two months later young person disclosed to nursing staff an incident alleging abuse by a male. Records do not indicate if this is the same incident or a new one. Y7 was advised to inform the police but it is not clear in the records if F&CC were informed.	No record of action taken	Young person was involved with F&CC.
Y8	No. Records contain two statements of witness documents which outline in great detail disclosures relating to the alleged abuse.	N/A	Young person was involved with F&CC who were already aware of child care concerns. There is evidence of good communication between professionals working within CAMHS and F&CC. However it is not clear from the records that the witness statements were shared with F&CC.
Y9	Yes. a) The young person disclosed to nursing staff that her uncle had physically assaulted her. Young person had been sexually abused by her father.	No record of action taken.	Young person was involved with F&CC due to father sexually abusing her. With the exception of this incident there is evidence of good liaison between professionals working within CAMHS and F&CC.
Y10	Yes. a) Young person alleged to nursing staff that her mother had physically and emotionally abused her. She alleged that her mother had dragged her by the hair, that her mother had broken Y10's finger and that she feared that mother would use a knife as she carried a knife in her bag. b) Young person also talked about memories of possible inappropriate sexual behaviour by a babysitter's son in England. c) It was recorded in nursing records that mother had a history of alcohol misuse and mental health problems.	No record of action taken.	No evidence in records that F&CC were involved with the family

F1	No	N/A	Child was involved with F&CC
F2	Yes. a) Child had a history of a brain tumour. In the nursing records it is recorded that the child made allegations that staff were abusive.	No record of investigations into these allegations within the file.	Child was involved with F&CC
F3	Yes. a) Nursing records indicate that child bought a gun for a tenner. While it is documented that the doctor informed the parents it is not clear that F&CC were informed.	No record of action taken following this incident.	Child was involved with Family and Child Care Social Service. With the exception of this incident there is evidence within the records of ongoing communication between the doctor and Family and Child Care Social Service in relation to child protection concerns.
F4	Yes. a) Referral letter indicate that the child is displaying sexualised behaviour. b) Nursing records also describe a babysitter's inappropriate behaviour.	No record of action taken	No evidence in records that F&CC were involved with the family
F5	Yes. Concerns were identified during admission but were referred to social services.	Yes	Concerns were identified during the admission but were referred to social services.
F6	No	N/A	
F7	No	N/A	
F8	Yes. a) Child had a history of self harm following the suicide of his brother. Medical records also indicated marital disharmony. While an inpatient, child attempted to hang himself.	No record of action taken	No evidence in records that F&CC were involved with the family
F9	Yes. a) In the nursing records there are 3 separate incidents recorded. One related to allegations of peer abuse and 2 relate to allegations of staff abuse.	The records record that these incidents were investigated but does not indicate the outcomes of any investigations	Child was involved with F&CC. Records lack clarity in relation to investigation of these allegations.
F10	No	N/A	

Analysis of Files Reviewed:

The total number of files audited was thirty. Of these files ten related to the period 1970 – 1979, eighteen files related to the period 1990 -1999 and 3 files related to the period 2000 – 2003. In some instances both inpatient and outpatient files were made available to us. Some of the information contained in the outpatient files related to the admission periods. Therefore the outpatient files were reviewed as well. This provided us with information relating to the context of the information.

The following is a summary of the main themes identified from the audit:

- **Evidence of good practice**

Within some files there was evidence of good practice in terms of responding appropriately to child protection concerns, good record keeping and effective liaison between the various agencies involved with the family. This included CAMHS professionals informing Family and Child Care Social Services of any child care concerns identified during the child/young person's admission and Family and Child Care Social Workers attending review meetings held in the Inpatient Hospitals. A number of the children/young people were already involved with Family and Child Care Social Services and some of the child care concerns were already known to Family and Child Care Social Services. Where this was evidenced within the files we have highlighted this in the additional comments column of the previous table.

- **Communication**

There was some evidence of good communication between CAMHS professionals and other professionals involved with the family such as Family and Child Care Social Workers. However of the thirty files reviewed twenty highlighted some child protection concerns which have been brought to the attention of the Trust. It is unclear whether these concerns were new information or whether Family and Child Care Social Services were already aware of this information. Of the total sample where there were child

protection concerns fourteen of these children/young people were currently known to Family and Child Care Social Services.
Some files lacked written evidence of ongoing liaison between CAMHS and Family and Child Care Social Services in relation to the management of the case.

- **Record Management Systems and Recording**

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

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

- There was a lack of evidence within the files in relation to whether the child/young person's name was on the Child Protection Register and of the child/young person's legal status.
- In the files relating to the 1970s there were a number of subjective statements made about the children indicating a possible lack of understanding of why the children were displaying challenging behaviour. However this was not a feature in files relating to the period 1990 – 1999.

- **Allegations made against staff**

In two files relating to the period of 1990 – 2003 children made allegations of abuse by staff.

- One file contains allegations that staff had hit, slapped and swore at the child but it does not contain any written evidence of the outcome of how these allegations were investigated.
- Within the other file there were 2 separate allegations, one related to an allegation that a doctor had sexually inappropriately touched a child and the other that nursing staff had bullied and mistreated the child. The file records indicate that these allegations were investigated although the outcome of the investigation was not evidenced. While the detail of the investigation would not be recorded on the child/young person's file but rather kept on the staff member's personnel file one would have expected that the outcome would have been recorded.

Conclusion

This audit found some evidence of good practice. However as outlined in the analysis the main issues arising were concerns relating to communication between professionals involved with the child/young person, record management systems and recording and allegations being made against staff.

Caution must be exercised in the interpretation of the findings due to the limited number of files audited and the retrospective nature of the audit. They also need to be considered within the context of professional's understanding of child protection issues and the relevant Child Protection Policies and Procedures applicable to the study period. However in a number of cases there would have been an expectation of a different response to identified child protection concerns.

The Trust needs to address any issues arising from the audit in relation to risk particularly in relation to the allegations made against staff.

Given the number of developments within Child and Adolescent Mental Health Services and Child Protection Services it would be hoped that practice has improved. It would be incumbent on the Trust to undertake an audit of current practice to ensure appropriate governance in terms of safeguarding children/ young people.

The complex and stressful nature of the work undertaken by professionals working within Child and Adolescent Mental Health Services must be acknowledged. Therefore it is essential that staff continue to be supported though the provision of relevant training and robust monitoring systems to allow them to work to safeguard children in their care.

Recommendations

1. The Trust should undertake an urgent audit of current child protection practice within CAMHS to ensure compliance with Chapter 3 of Co-operating to Safeguard (DHSSPS 2003), Chapter 3 of Regional Child Protection Policy and Procedures (ACPC 2005), Trust's Policy on Recording, Guidelines for Records and Record Keeping (NMC 2009), relevant Professional Codes and relevant Supervision Policies.

2. The Trust should undertake a review to ensure that all current staff working within CAMHS have attended Child Protection Training, Record Keeping Training and UNOCINI Module One Training and that staff are aware of their roles and responsibilities in relation to safeguarding children.

3. The Trust should review the current record management system within CAMHS to ensure that this is compliant with all procedural requirements and that files are readily accessible for auditing purposes.

4. The Trust should assure itself that all staff are aware of the action to be taken when a child makes an allegation against a member of staff. Consideration should be given to ensuring that this is addressed in local Policy and Procedures and that such Procedures are fully consistent and compliant with the Trust's Child Protection Policy and Procedures.

5. In relation to the two files where allegations were made against staff, the Trust should immediately review these circumstances in order to agree and promptly address any further enquiries/action deemed necessary.

6. The Trust, through its CAMHS, Family & Child Care and Child Health Programmes, should undertake a joint review of the historical concerns regarding individual children and agree whether any further action is required in relation to individual children/families.

Appendix 1

SAFEGUARDING CHILDREN – AUDIT OF CAMHS INPATIENT SERVICE

IDENTIFIER

Date of admission

Date of Discharge

1. Were there any child protection/safeguarding concerns identified during this admission?

YES ☐ NO ☐

If YES what was the nature of these concerns?

Sexual ☐

Physical ☐

Emotional ☐

Neglect ☐

Details of concerns

Action taken

2. Does this comply with relevant Child Protection and Safeguarding Procedures relevant of the time period?

NO ☐ YES ☐ UNSURE ☐

If 'NO' why and what action was taken?

If yes what action was taken?

If unsure state reason why

3. Were issues raised by children and young people regarding potential abuse followed up by staff?

NO ☐ YES ☐

If 'NO' why and what action was taken?

If yes what action was taken

4.Does this case require further consideration?

YES ☐ NO ☐

If 'YES' give reasons

Details of Action taken by Auditors

YES ☐ NO ☐

If 'YES' give reasons

Details of Action taken by Auditors

BELFAST HEALTH & SOCIAL CARE TRUST

RETROSPECTIVE CHILD PROTECTION AND SAFEGUARDING AUDIT – REGIONAL CHILD & ADOLESCENT INPATIENT SERVICE ACTION PLAN

Ref	Recommendation	Action Required	Responsible Lead	Timescale	Progress
1.	The Trust should share this report and consult with Board colleagues in relation to the outcome of a similar review recently undertaken by the then Eastern Health & Social Services Board of Children's Inpatient Services during 1980s in order to agree a consistent and co-ordinated approach to reported concerns.	Share report and arrange joint planning meeting to agree co-ordinated action.	John Veitch	28.2.10	Report was shared with Board and joint planning meeting at Department was held on 9th February 2010. A subsequent review meeting was held at Board on 14th April 2010.
2.	The Trust should undertake an urgent audit of current child protection practice within CAMHS to ensure compliance with Chapter 3 of Co-operating to Safeguard (DHSSPS 2003), Chapter 3 of Regional Child Protection Policy and Procedures (ACPC 2005), Trust's Policy on Recording, Guidelines for Records and	Commission and complete further audit of current practice to address recommendation	John Veitch	30.4.10	The Trust undertook an audit of child protection practice within Tier 4 CAMHS which concluded in May 2010. The Audit found that there was evidence of good practice and compliance with Regional Child Protection Policy and Procedures. There were no major child protection concerns identified during the audit.

Ref: Tdrive/JV/CAMHS/Action Plan CAMHS Child Protection Audit 1.2.10

	Record Keeping (NMC 2009), relevant Professional Codes and relevant Supervision Policies.				

Ref	Recommendation	Action Required	Responsible Lead	Timescale	Progress
3.	The Trust should undertake a review to ensure that all current staff working within CAMHS have attended Child Protection Training, Record Keeping Training and UNOCINI Module One Training and that staff are aware of their roles and responsibilities in relation to safeguarding children.	CAMHS Management to review staff attendance at Child Protection, Record Keeping and UNOCINI training report accordingly and promptly address any additional training required.	Barney McNeany	31.3.10	A review of Child Protection Training in CAMHS was undertaken in March 2010. Of the 131 staff identified within the network 104 had attended Child Protection Training. Of those who had not been trained the majority (over 90%) were either newly recruited or were temporary staff. A rolling programme of additional Child Protection Training was established to ensure these staff were trained and with staff turnover this programme is on-going. A rolling programme of UNOCINI training has also been commenced with both Social Work staff and ward managers in Tier 4 already trained to level 3 and acting as a resource to the service. Child protection supervision training has been provided to the ward managers who incorporate this into supervision of their staff and teams.

					The CAMHS Child protection nurse provides regular multi disciplinary child protection supervision as a result of the regional guidance for nurses regarding the roles and responsibilities for all staff.
4.	The Trust should review the current record management system within CAMHS to ensure that this is compliant with all procedural requirements and that files are readily accessible for auditing purposes.	Trust to review current record management system to ensure compliance.	Barney McNeany	30.4.10	CAMHS have reviewed the records management process for Tiers 3 and 4 and identified the need for additional administration resources for Tier 4 and for specialist Tier 3 teams e.g. Eating Disorder. Additional resources have now been put in place to ensure CAMHS is complaint across the network with all procedural requirements. In addition the PARIS system has now been rolled out to the CAMHS Tier 3 teams in the SE Sector which will improve access to information on patients across the network and will streamline procedures for data gathering and production. The Child Protection Audit undertaken in Tier 4 CAMHS which concluded in May 2010 also identified areas of excellent practice with regard to record keeping and these systems are in the process of being rolled out across Tier 4.

Ref: Tdrive/JV/CAMHS/Action Plan CAMHS Child Protection Audit 1.2.10

Ref	Recommendation	Action Required	Responsible Lead	Timescale	Progress
5.	The Trust should assure itself that all staff are aware of the action to be taken when a child makes an allegation against a member of staff. Consideration should be given to ensuring that this is addressed in local Policy and Procedures and that such Procedures are fully consistent and compliant with the Trust's Child Protection Policy and Procedures.	Matter to be addressed through team meetings and formal notification to all staff	John Veitch Barney McNeany	31.3.10	This matter was raised at all team meetings within CAMHS during January/February 2010 following which a formal reminder was issued to all staff confirming that any allegation of this nature must be immediately reported through line management and the requirements of Child Protection Procedures fully implemented. This was subsequently reinforced in a series of planned child protection training events in February - March 2010. In addition the CAMHS Governance Forum regularly reviews this issue as part of its Risk Register Management activity. These meetings are held quarterly.

Ref	Recommendation	Action Required	Responsible Lead	Timescale	Progress
6.	In relation to the two files where allegations were made against staff, the Trust should immediately review these circumstances in order to agree and promptly address any further enquiries/action deemed necessary	Concerns to be reviewed to establish any urgent action required in relation to staff including any current staff.	John Veitch Barney McNeany	31.1.10	The Trust reviewed these circumstances through examining records and clarifying issues with staff. While there is clear evidence on file concerns were reported appropriately through line management and to Social Services in accordance with Child Protection Procedures further enquiries are being pursued to ensure issues have been fully addressed.

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*

(c) General comments and conclusions

- There are no recommendations made, however the report does reflect reasonable self-examination, and there is indication of training measures being put in place regarding child protection and protection of vulnerable adults.

2. BHSCT RETROSPECTIVE CHILD PROTECTION AND SAFEGUARDING AUDIT WITHIN THE REGIONAL CHILD AND ADOLESCENT INPATIENT SERVICE

This report differs from the previous Trust reports within the retrospective exercise which concern adult facilities and **would therefore benefit from specific comments by Child Care Branch.**

(a) Methodology

- The report states that it covers the years 1970 to 1999 (excluding the period 1980-1989. See below). However the retrospective exercise was intended to focus on the 20 year time period between 1985 and 2005. We also note that 3 files relate to the period 2000 to 2003.

- A separate EHSSB commissioned exercise regarding Forster Green and Lissue Hospitals (see below) is stated as addressing the 1980 to 1989 period for the purpose of the overall retrospective sampling exercise.

- Under the methodology it states there were 15 files randomly selected from each period (1970-79 and 1990-99) when in reality there were 10 selected from each

setting (Lissue, Forster Green and the Young People's Centre, College Gdns), with 2 of the 3 settings relating to the 1990 to 1999 period. Also there is no evidence that the 30 files represent 10% of all admissions – the intended sample size.

- The files reviewed included medical, nursing, social work, psychology, inpatient and outpatient files
- The review was undertaken by 2 experienced safeguarding professionals (nursing and social work).
- The categories recorded appear to have been adapted for children, and there are 4 categories in total used in this report.

(b) Key findings and circumstances of abuse/suspected abuse

- The files of 30 children were reviewed. Of these 30, 21 files fell into categories 1-4: 7 children from Lissue, 8 from YPC, and 6 from Forster Green. The files indicate that these 21 children experienced 27 incidents in total. There were 14 incidents of sexual activity and 13 incidents of physical abuse or neglect.
- Although specific information for each child is provided, the date of the incident is not provided, making it difficult to consider in terms of "standard practice at the time"
- In 2 case files, there are 3 allegations made against staff (physical abuse and maltreatment by nursing staff, and inappropriate sexual touching by a doctor). In the files, there is evidence of

investigation in 2 of the 3 incidents, but no information or evidence regarding outcome. The recommendations within this report propose that the Trust immediately review these circumstances in order to agree and promptly address any further enquiries/action deemed necessary.

- No staff have been named.

- On the results of the audit it is very frequently recorded there is no record of action. This may be qualified with additional comments that the case was known to, or involved with, family and childcare community services. However there is no evidence that the family and childcare team acted any more appropriately than the inpatient service in implementing appropriate procedures. An example is on page 10 –case of Y3 – a disclosure regarding sexual abuse by an uncle, however no record of action taken by inpatient services and the additional comment that the young person was involved with family and childcare and that within their records there was disclosure regarding physical abuse, again without any note of whether or not appropriate actions were taken.

- The quality of recording within files appears systematically to be very poor throughout the sample cases within this report. There is also on page 13 under "Communication" evidence that the recording of information within family and childcare social services is also poor as it states 'it is unclear

whether these concerns were new information or whether family and childcare social services were already aware of this information'.

(c) General comments and conclusions

- There is a section on current practice, which outlines a range of initiatives intended to ensure good governance within CAMHS services in the Trust.
- The recommendations would have benefitted from a timeline for completion and audit of implementation as well as identifying those responsible for these actions.
- We note the attached template within the BHSCT report in their Appendix 1, which we assume was used, and would draw attention in particular to question 2 on page 19, regarding compliance with relevant child protection and safeguarding procedures relevant to the time period, which crucially this report does not appear to have answered.

3. EHSSB/HSCB REPORTS ON LISSUE AND FORSTER GREEN HOSPITALS

(a) Methodology

- This report was commissioned specifically by EHSSB as a consequence of an allegation made by a previous patient in April/May 2008. Consequently it fell outside of

setting (Lissue, Forster Green and the Young People's Centre, College Gdns), with 2 of the 3 settings relating to the 1990 to 1999 period. Also there is no evidence that the 30 files represent 10% of all admissions – the intended sample size.

- The files reviewed included medical, nursing, social work, psychology, inpatient and outpatient files
- The review was undertaken by 2 experienced safeguarding professionals (nursing and social work).
- The categories recorded appear to have been adapted for children, and there are 4 categories in total used in this report.

(b) Key findings and circumstances of abuse/suspected abuse

- The files of 30 children were reviewed. Of these 30, 21 files fell into categories 1-4: 7 children from Lissue, 8 from YPC, and 6 from Forster Green. The files indicate that these 21 children experienced 27 incidents in total. There were 14 incidents of sexual activity and 13 incidents of physical abuse or neglect.
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investigation in 2 of the 3 incidents, but no information or evidence regarding outcome. The recommendations within this report propose that the Trust immediately review these circumstances in order to agree and promptly address any further enquiries/action deemed necessary.

- No staff have been named.

- On the results of the audit it is very frequently recorded there is no record of action. This may be qualified with additional comments that the case was known to, or involved with, family and childcare community services. However there is no evidence that the family and childcare team acted any more appropriately than the inpatient service in implementing appropriate procedures. An example is on page 10 –case of Y3 – a disclosure regarding sexual abuse by an uncle, however no record of action taken by inpatient services and the additional comment that the young person was involved with family and childcare and that within their records there was disclosure regarding physical abuse, again without any note of whether or not appropriate actions were taken.

- The quality of recording within files appears systematically to be very poor throughout the sample cases within this report. There is also on page 13 under "Communication" evidence that the recording of information within family and childcare social services is also poor as it states 'it is unclear

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EASTERN HEALTH SOCIAL SERVICES BOARD (EHSSB)

Review of the Standard of Nursing Care Provided to Children and Adolescents as Part of the Lissue Hospital Historic Case Review

Maura Devlin

Director of Nursing and Midwifery Education

Beeches Management Centre

May 2009

TABLE OF CONTENTS

1. BACKGROUND

1.1. Following an allegation made by a previous patient regarding her care at Lissue Hospital a Serious Adverse Incident Report was received on 2 May 2008 by the EHSSB from the Belfast Health and Social Care Trust. The Trust advised that an internal review was being conducted in respect of allegations made about staff employed in Lissue and Foster Green Hospitals between 1985 and 1991. The allegations related to sexual and physical abuse. The Department of Health and Social Services and Public Safety (DHSSPS) was aware of two previous allegations made in respect of Lissue in 1993 and 1994 and on receipt of the SAI report brought this information to the attention of the EHSSB and Belfast Trust.

1.2. As the EHSSB was directly managing the service provision at Lissue and Foster Green Hospitals at the time of the alleged abuse it has taken the lead on an investigation of the historic aspects of the allegations. This report sets out the findings of the standards of nursing care provided to children and adolescents during the period of the historic review.

2. TERMS OF REFERENCE AND METHODOLOGY

2.1. To assist the EHSSB in providing a high level overview of the standard of nursing care provided to children and adolescents in Lissue Hospitals and Foster Green during the period 1975 to 1995 and to ascertain if nursing care was compliant with the Code of Professional Conduct laid down by the United Kingdom Central Council for Nurses, Midwives and Health Visitors (based on ethical concepts) (UKCC 1983).

2.2. Methodology

A sample of 4 children's case files were selected and the Nursing In Patients notes were reviewed against the Code of Professional Conduct.(UKCC 1983).

2.3. The information collated through a sifting exercise of 34 files by an Independent Reviewer was further examined to determine trends or general issues relating to expected standards of nursing care.

3. DEFINITION OF NURSING PRACTICE AND REGULATION

3.1. The practice of nursing means contributing to the promotion of health, the prevention of ill health, the alleviation of suffering, the restoration of health, the optimum development of health potential and a peaceful death. This should be carried out within a framework of a philosophy of care where there is a recognition of the nurse as the patient's advocate.

3.2. In 1983, the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC) was established in order to safeguard the health and well being of the public. In doing so it set standards of professional conduct that nurses were required to adhere to in order to maintain their professional registration. In April 2002 the UKCC ceased to exist and its functions were taken on by a new Nursing and Midwifery Council (NMC).

4. FINDINGS

4.1. This section sets out the findings under the following headings

- 4.1.1. **Safeguarding The Well Being And Interest Of Patients**
- 4.1.2. **Having Regard to the Environment of Care**
- 4.1.3. **Managing Challenging Behaviour**

4.2. The section also reports on the assessed conduct of one nurse named by the complainant and currently employed within the HPSS. The nurse is named as Mr Law.

4. 1.1 SAFEGUARDING THE WELL BEING AND INTERESTS OF PATIENTS

The Code of Professional Conduct is recognised as a key tool in safeguarding the health and well being of patients. It states that '*at all times nurses should act in such a way to promote and safeguard the well being and interests of patients /clients for whose care she is professionally accountable and ensure that by no action or omission on her part their condition or safety is placed at risk*'. [1]

An examination of the records suggest that there were many occasions when nursing staff failed to comply with this standard, either by their actions or omissions.

This is evidenced in the records by a lack of appropriate care planning and planned responses to children and adolescents engaged in sexualised behaviours or bullying. There is also a lack of procedures and protocols aimed at promoting the safe management of relationships and boundaries between young people and staff, including appropriate touch. This resulted in placing other children and staff themselves in vulnerable situations and enhanced the vulnerability of children who were admitted to the unit having been victims of abuse in the past. The promotion of physical care to young children by adolescent patients also demonstrates a lack of awareness of the risk factors in abuse and abuse to others.

Good communication is essential in safeguarding the interests and well being of patients. Outside of ward rounds there is no documentation to suggest multidisciplinary working. This is particularly evidenced in the recordings of the teacher which shows a clear lack of understanding in the management of a young child with Gilles de la Tourettes syndrome.

[1] UKCC 1983 (in the text the use of the female gender equally implies the male)

4.1.2 HAVING REGARD TO THE ENVIRONMENT OF CARE *(PHYSICAL, PSYCHOLOGICAL AND SOCIAL)*

Whilst it is recognised that nursing staff were working in a challenging and often difficult environment the review once again suggests that nursing staff at times failed to promote the physical, psychological and social well being of their patients.

This is evidenced by nursing notes that indicate adolescent female patients being made to undress in rooms with the door open, use the toilet facilities in the presence of male staff or forced to use a commode, not as a result of physical frailty or poor mobility, but because of the care delivered in response to risk of self harm. One of the key foundations of professional nursing care is the protection of dignity and respect for patients, such a harsh regime could only serve as a humiliating experience for young teenage girls and as such fail to promote psychological well being.

This is particularly evidenced in the nursing notes of a female child who was subjected to enforced intimate care by a male nurse and another 6 year old child who was forced to hand wash his soiled undergarments. It is suggestive of a harsh regime which promoted authoritarian control of nurses over patients where children were already vulnerable. Such practice could only serve to increase vulnerability and humiliation, and abuses the privileged relationship nurses have with their patients.

4.1.3 MANAGING CHALLENGING BEHAVIOUR

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

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

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

4.2 HIGH LEVEL OVERVIEW OF THE PROFESSIONAL CONDUCT OF STAFF NURSE LAW

This review draws attention to the conduct of Mr Law on the basis that outside of the common standards of nursing care in the period of review, Mr Law's own records suggest an abuse of the nurse/patient relationship and a repetitive practice of allowing himself to be placed in very vulnerable situations. It should however, be noted that these findings are suggestive rather than substantive and are not based on an in depth review of his professional conduct. In particular these concerns arise because it is also known that Staff Nurse Law continues to be employed in a Child and Adolescent Mental Health Services Unit.

Staff Nurse Law, during the period of the review, was accountable for his own Professional Practice and bound by the UKCC Code of Professional Conduct (Appendix 1). In notes examined, there are indications that Staff Nurse Law failed to recognise the boundaries of appropriate and inappropriate touching and through his own record keeping highlighted occasions where he left himself very vulnerable through kissing, hair stroking and the delivery of personal intimate care to young female adolescents.

His professional knowledge in the protection of vulnerable children is also questionable. There are occasions where he actively encouraged the disclosure of potential sexual abuse and did not take the appropriate follow up action i.e. Referral to Social Services. Whilst it is acknowledged that some of this care was delivered on night duty when there was less scope to remove himself from vulnerable situations he did have a responsibility through his Code of Professional Conduct to bring any such concerns to the attention of his superiors.

Whilst it is not possible to provide a comprehensive review of Staff Nurse Law's professional conduct there is sufficient suggestion in the limited records reviewed to warrant further investigation.

RECOMMENDATIONS

- The Trust should review the delivery of Safeguarding Children education and training needs of Child and Adolescents Mental Health Nursing Staff (CAHMS).

- The Trust should consider the effectiveness of collaborative working between nursing and teaching staff.

- The Trust should assure themselves that nursing care plans are person centred and address the needs for the appropriate supervision of personal care.

- The EHSSB or the new authority should seek from the Trust assurance that the CAMHS are using practice compliant with DHSSPS guidance on 'zero tolerance of violence' and staff are receiving regular updated accredited training on the use of restraint in managing challenging behaviour.

- The Belfast Health and Social Care Trust, as the current employers of Staff Nurse Law should conduct a further in-depth review of his professional conduct during his employment in Lissue and Foster Green Hospital with a view to appropriate Referral to Nursing and Midwifery Council.

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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 methodology parameters for the other reports considered above.

- There was an initial "sift" of 30 files, centred on identification of physical and/or sexual abuse, between peers or by staff. Grooming activity and any indication of a "harsh regime" were also to be documented.

- In total, files relating to 34 children were eventually examined.

- This methodology resulted in 4 reports being completed:

  - A review and analysis of the case files by R.S. Stinson dated January 2009
  - A review of the nursing care provided to children, based on review of 4 files by Maura Devlin, dated May 2009.
  - An overview summary of issues and progress to date, completed by Marion Reynolds in July 2009.
  - A February 2010 report from Dr. Brian Jacobs, Consultant Psychiatrist, with a brief to provide a view on the standard of medical intervention which should in our opinion have included clinical and their role in managing the Units concerned.

- On Page 3, para 1 of Marion Reynolds' report, it states that all children had their field work files reviewed but according to the Stinson Report, para 2.2, this would appear not to be the case.

- A range of care issues were also categorised within the Stinson report, including restraint, victimisation, sanctions, humiliation, supervision/staffing levels and staff/child relationships.

(c) The severity and frequency of findings documented, and the lack of follow-up or robustness of any action taken, raises very serious concerns, especially the repeated failings in staff leadership, accountability and governance.

(d) A major flaw in this report is that in the many examples of serious abuse there is a lack of comparison with the professional standards and policies/procedures/guidance extant at that time.

(e) An update regarding para 7.3 in relation to the action plan and its implementation may be useful in any further work taken forward by other agencies.

Maura Devlin's report on the standard of nursing care – May 2009

(a) The methodology for this report would appear flawed in that a sample of just 4 files (how were these chosen and were they part of the original 34 sampled for Stinson?) would seem insufficient to determine the standard of nursing care against the UKCC Code of Professional Conduct across 2 hospitals and over a significant time span.

(b) Several nurses who were mentioned in the Stinson Report, and the relevant incidents, are areas of concern which might reasonably have been expected to have been commented on.

(c) Would the information provided from 34 files provide enough information regarding trends to draw any robust conclusions?

Marion Reynolds' interim report – July 2009.

(a) This report provides a useful over-arching perspective of the Stinson Report.

(b) The BHSCT internal review (page 1, third paragraph) of staff from Forster Green and Lissue is not provided and findings may be of relevance in respect of any future required actions. This apparently links with page 2, para (ii) and overall would expect assurance from HSCB and BHSCT that all staff mentioned in these reports have been considered and any necessary appropriate action taken.

(c) An issue to be clarified is on page 1, para 3 regarding the timescale and method of DHSSPS being made aware of the 2 allegations regarding 1993 and 1994 and subsequent follow up and actions taken.

(d) In Ms Reynolds concluding remarks it might have been more useful if in the first paragraph attention was drawn to the need to compare standards in existence at the time with the relevant reported incident. Also in the second paragraph while we note the comment 'on balance of probability it is, however, likely that her complaint had a basis' there does not appear to be provision of the supporting evidence for this conclusion.

had allegations made against them, yet the focus of follow up appears strongly weighted towards one member of nursing staff (H L). It is therefore surprising that the independent nurse consultant report only reviewed four of the files, and focused on one member of nursing staff and did not provide a wider overview. The medical report by Jacobs had access to all the files reviewed by Stinson. This should at least have been the case for the nursing report, considering the range of allegations made against nursing staff.

(c) General comments and conclusions. These are outlined below in relation to each of the 4 reports received.

In respect of the specific reports provided.

R.S. Stinson's report, January 2009.

(a) Methodology requires clarification:

- How, and by whom, were the 30 files selected?
- Who completed the initial sift in phase 1?
- How were files divided across age groups, gender, etc?
- Why were 30 cases (+4) considered a sufficient sample?
- What percentage of the total young people to pass through Forster Green and Lissue in the timeframe 1975 to 1995 does this sample represent?

(b) A serious breach of confidentiality occurred in including names and dates of birth in this report as initially presented to the Department.

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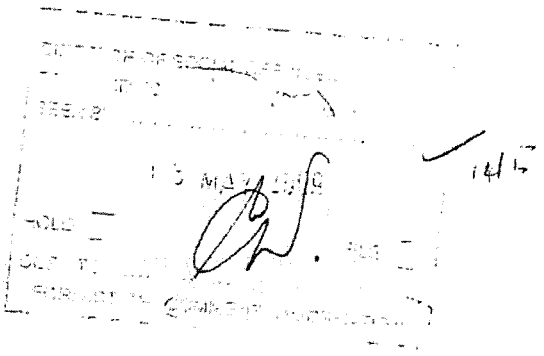
Your Reference:

Our Reference:



Marion Reynolds
Deputy Director Social Services
Champion House
12-22 Linenhall Street
BELFAST

6 May 2009

Dear Marion

RE: INDEPENDENT REPORT LISSUE AND FOSTER GREEN HOSPITALS HISTORIC CASE REVIEW

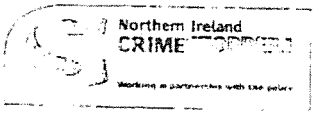
I have considered the report by RS Stinson and for ease of reference will consider each appendix attached to the report.

Appendix 1 Allegations Of Sexual Abuse By Peers

Child A 8 yrs makes allegations of indecent assault against another male child but then told staff it was all lies. Of more concern are outpatient notes recording the child was raped while at home by a friends uncle. The same child also made an allegation in 1990 that a male member of staff at Lissue had indecently assaulted her in 1986. From documentation traced it appears police were informed of this allegation and the matter, for reasons which are not apparent, dragged on until 1995 when the child stated she did not wish to pursue the allegations. It is also recorded the child could not identify the staff member involved in this incident. In an attempt to clear up the apparent ambiguity I had a police officer call at this persons last known address to establish if she wished to pursue any complaints. Unfortunately she has not resided at the address known to police for some time.

Child R 9yrs makes allegations of indecent assault against another female child.
Child U 14yrs makes allegations of indecent assault against another male child
Child BB 13yrs makes allegations of indecent assault against another child.

CHILD ABUSE INVESTIGATION UNIT
Antrim PSNI
24 Castle Street, ANTRIM BT41 4AU
Tel: 028 94482633



Calls within Police Service of Northern Ireland telephone system may be monitored or recorded

Child EE 10yrs makes allegations of indecent assault against an 11 yr old boy.

In the above four cases the offences amount to minor indecent assaults between children ranging in dates between 1980 and 1993. There is a conclusive presumption, that the prosecution must prove that offences committed by children between the ages of 10yrs and 14yrs, is that the child knew what he or she did was wrong. This would be difficult given the children were all particularly vulnerable and had varying degrees of illness and learning disabilities. I am of the view that any evidence obtained from such historic cases would be limited given the passage of time and the tender age of the children involved at the time of the offences.

Child EE 10yrs allegedly told staff that he had sex with a 9yr old girl GG before she was discharged. Police have spoken with GG who does not wish to make any complaint regarding Lissue and stated she just wants to get on with her life.

In respect of children S and T I have asked D/Inspector Richard Graham PPU Dundonald to respond given these offences occurred in Foster Green Hospital.

Appendix 2. Details Of Allegations Of Sexual Abuse Against Peers

Child B 11yrs concerns allegations that she indecently assaulted other male and female children.
Child Y 14 yrs is alleged to have committed indecent assaults on other children
Child EE 11yrs was reported to have sex with child FF 11yrs.
Child P 9yrs is alleged to have been in a sexual relationship with a 13 yr old girl while at Somerton Children's home.

In the case of child P 9yrs, the unnamed 13yr old girl would have committed the offence. Police have been unable to trace child FF. Police will not investigate minor indecent assaults for reasons described under appendix 1.

In respect of child X 14yrs I have asked D/Inspector Richard Graham PPU Dundonald to respond given these offences occurred in Foster Green Hospital.

Appendix 3 Details Of Sexual Abuse By Staff

Child A alleges being indecently assaulted by an unidentified male member of staff
See comments in respect of child A at appendix 1 above.

Child BB
These allegations were investigated by the RUC. A file was sent to the then DPP who directed no prosecution.

Child E

In respect of child E 8yrs I have asked D/Inspector Richard Graham PPU Dundonald to respond given these offences occurred in Foster Green Hospital.

Appendix 4 Details Of Allegations Of Physical Abuse By Staff

Child D 12yrs alleges staff hit him on the arm
Child E 6yrs alleges a Social Worker pulled her by the arm

CHILD ABUSE INVESTIGATION UNIT
Antrim PSNI
24 Castle Street, ANTRIM BT41 4AU
Tel: 028 94482633

Child J Investigated by PSNI and a file is being submitted to the PPS.
Child BB see comments above under Appendix 3

Of the two cases of children D and E these amount to very minor allegations of common assault in 1992 and 1993, which would be, statute barred.

Appendix 5 Restraint

These cases outline instances of restraint exercised by staff. While there may or may not be evidence of common assaults these matters would be statute barred.

Appendix 6 to 10 are not criminal matters and are matters for the Board

Appendix 11 Child J

Investigated by PSNI and a file is being submitted to the PPS.

With any historic investigation consideration must be given to the resources deployed to investigate them, the seriousness of the abuse and the likelihood of gathering evidence to secure prosecutions. All patients from Lissue are now adults, the majority of which have never made any complaints of a criminal nature concerning Lissue to police. Care must be taken in reaching a decision to approach alleged victims or witnesses based on limited information contained in patient's notes. There is no possibility of prosecution in any of the above historic cases relating to the offences of common assault, as the offences would be statute barred. PSNI would investigate offences of penetrative sexual intercourse between children. Of the cases identified one person has been spoken to by police and no complaints were forthcoming while in the other two cases the victims have not been traced.

Police would also investigate any sexual offence against children or physical abuse amounting to actual bodily harm or above, committed by staff. Of the cases identified I believe they have been adequately dealt with by Police

Unless further evidence comes to light PSNI will conduct no further investigations in respect of Lissue Childrens Home.

If I can be of any further assistance please contact me.

Yours sincerely

R Black

Reuben Black
Detective Inspector
Public Protection Unit
Antrim

CHILD ABUSE INVESTIGATION UNIT
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Director of Social Care and Children:
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Mr Sean Holland
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BT4 3SQ

5th June 2009

Dear Sean

UPDATE ON LISSUE AND FORSTER GREEN INVESTIGATION (SAI 0336)

I thought I should write to provide you with an update on the investigation of allegations made in respect of the care of children at the above named children's psychiatric units during the 1970's and 1980's. An SAI was referred to the legacy EHSSB by Belfast HSC Trust on 2 May 2008 which included allegations of physical, mental and sexual abuse of children.

A three strand approach was taken to the investigation:

(i) the legacy EHSSB led on a review of a sample of 34 children's hospital case files and where available social services file;
(ii) Belfast HSC Trust led on the investigation of allegations made by JH who as a child had had inpatient treatment;
(iii) a review of the staff files of staff named by the complainant JH and previous complainants (KW and MA). This work was led by both Trusts.

The Board has concluded its investigation and a report of its findings has been prepared which is to be brought to the August

7/09 (1)

INTERIM REPORT IN RESPECT OF HISTORIC REVIEW OF CHILDREN ADMITTED TO LISSUE & FORSTER GREEN HOSPITALS ASSOCIATED WITH SAI 117-08

Background

Lissue and Forster Green Hospitals were directly managed services within the Eastern Health and Social Services Board (EHSSB) until the establishment of Health and Social Services Trusts in 1994. The relevant units of each hospital were managed within the Child Psychiatric Service based at the Royal Group of Hospitals. Both units provided inpatient care of children with a range of mental health difficulties including anorexia, enuresis, encopresis, depressive type illnesses, suicidal and self-harming behaviours, obsessive compulsive disorder, Tourettes syndrome, and a range of conduct and behavioural problems. Some children and young people were also treated on an out-patient basis. The units also had facilities to admit children with their families for assessment and family therapy.

Two consultant psychiatrists were responsible for the service and provided cover from their base at the Child Psychiatry Unit based on the RVH site as the services provided were Consultant-led. Both units treated children across the full age range. Lissue Hospital in addition to its child psychiatry unit also provided a service for infants with serious congenital issues. Lissue Hospital ceased operation as a Child Psychiatry Unit in the early 1990s.

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

The EHSSB historic review of records sought to determine the nature and extent of any abusive type behaviours and was augmented by work lead by both the Belfast and South Eastern Trusts in relation to:

(i) JH's complaints regarding her care while an in-patient at the regional child psychiatric units between 1987 and 1991 (5 admissions);

The Belfast Trust was tasked to lead on this work. The latest update from the PSNI is that a file has been prepared for the Public Prosecution Service in respect of JH's allegations, although given her mental health it is uncertain whether or not any further action will ensue.

(ii) reviews of the records of the 6 staff named by JH to determine who remained in practice and what if any risk they posed to children.

The Trusts identified three staff who remained in their employment. Each Trust agreed to review the HR records of these staff and report any concerns to the EHSSB. To date a report has been provided in respect of one staff member (HL) who has been off on sick leave since mid 2008 and is now seeking to leave the service. The Chief Executive of the EHSSB wrote to the Chief Executives of the Belfast and South Eastern Trusts on 19 March 2009 regarding this aspect of the review process.

Methodology for Historic case Review

Initially it was intended that a total of 30 children's CAMHS, and where available their F&CC, files would be examined to determine whether or not a fuller investigation was required into the operation of both of the Child Psychiatry Units. As several other children were named in case files the number of case files examined was increased by 4. The following approach was developed to select the case files for examination:

1) examine 7 children's file associated with the JH allegation;

2) examine the 3 children's files associated with the KW allegation;
3) take a random sample of 20 case files drawn from the Admissions Register to bring the number up to 30.

All children known to Social Services had their fieldwork files reviewed post their discharge from Lissue and/or FGH to ascertain if at any time following their discharge they had made a complaint about the care they received while receiving treatment.

The historic review had 2 Phases:

Phase 1 – sift of all CAMHS and F&CC files to ascertain if there were potential areas for concern.

The criteria to be employed at this stage were:

1) information is available suggestive of physical and/or sexual abuse by peers;
2) information is available suggestive of physical and/ or sexual abuse by staff;
3) information is available suggestive of grooming activity.

Any information of a harsh regime was also to be annotated at this stage.

Phase 2 - professional staff will focus attention on relevant information highlighted by the sift process and report on findings.

Findings

The attached report was developed using the findings extracted from the sift of children's case files; the Consultant also had access to the case files to clarify any matters which remained outstanding or upon which he required additional information.

(i) Allegations of sexual abuse by peers: 8

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

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

(ii) Allegations of sexual abuse against peers: 6

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

(iii) Allegations of sexual abuse by staff: 3

The 3 allegations within this category related to girls whose ages ranged from 8 to 13 years (average age 10 years). Two of the allegations relate to unnamed staff, while one named a staff member. One of the former and the latter were referred to the Police Service for investigation. In one case, as the 8 year old could not name the staff member, no outcome is recorded. In the case of the 13 year old girl, the absence of corroborating evidence when a disclosure was made some 15 years following her discharge from Lissue meant that there was no police action.
The remaining allegation related to an 8 year old girl whose mother alleged that a doll's arm had been put up her daughter's bottom by staff in July 1993. This matter appears to have been resolved to the satisfaction of the parent, however, the records do not specify how.

(iv) Allegations of physical abuse by peers

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

(v) Allegations of physical abuse against peers

While the above may also be said about allegations of physical abuse against peers, one child, Child BB was noted as having committed 42 assaults on a number of named children. Overall, there was no evidence to suggest that any violence was premeditated. In all cases, the records show it was opportunistic and, therefore, difficult to control.

(vi) Allegations of physical abuse by staff: 4

A total of 4 allegations were made against staff, three of the allegations were made by girls who ranged in age from 6 to 13 years (average age 10 years), and the boy was 12 years of age. The nature of the allegations included staff allegedly hitting a child, being given "an awful kick up the behind"; this complainant alleged that 2 named members of staff were "always violent with the children". This complainant made a written statement to the Police Service in 1993 detailing her allegations.

A further complaint was made to the Police in 2008 by JH who alleged physical abuse by teaching and insensitive handling by nursing staff

(vii) Grooming.

Grooming is the cultivation of a relationship by a stronger person with a weaker person for some ulterior motive. A number of older children formed relationships with more vulnerable younger children; from the records no motive was ascertained, other than to help staff or to get personal satisfaction. The history of some of the children involved in assisting younger children raises questions about this practice.

Child / Child

In almost every file submitted for review there are references to older girls being encouraged to, or being allowed to, help with the care of younger patients, including helping at bath time. Most references are positive. In some cases, however, there are comments which give rise to concern.

As many of the children admitted to Lissue had experienced significant adverse family situations, including physical and sexual abuse, the practice of letting them assist with the care of younger children was questionable.

Staff / Child

Incidents involving two children **Child A and Child H** were considered for inclusion in this category but due to the difficulty in discovering any positive evidence of intent in both cases, they were not been included in this section.

Care Practices were considered under the following headings@

(i) Restraint: 6

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

- restraint being used when a child threatened or attempted an action, rather than poses a risk to self or others;
- involvement of patient's relative, bus driver or student nurses in restraint;
- injury to children, one child sustained a black eye, another friction burns, while one complained of her arm being twisted;
- use of restraint when in pre-admission reports Social Services noted that it was counter-productive;
- the limited staffing resources which were at times diverted to restraining children;
- the length of time restraint was employed;
- restraining a child in her bed; particularly of concern with

one 11 year old girl with a previous history of being sexually abused.

(ii) Sanctions: 4

The four incidents relate to 3 girls aged from 11-15 years (average age 13 years) and one 7 year old boy. In 2 cases children were not permitted a visit home due to failing to comply. One of these was in respect of an anorexic teenage girl who had failed to gain a kilogram in weight. The other was in relation to a 7 year old boy with a history of encopresis and nocturnal enuresis. The third child for whom denial of leave was used as a sanction was in respect of a child in care who was refused an overnight stay at her children's home.

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

(iii) Victimisation: 1

Staff were faced with a wide range of challenging behaviour, some of which were tolerated and some of which were punished with a range of sanctions. Based on the information provided, there was only one boy who was put to bed early as punishment for his series of misdemeanours.

(iv) Humiliation: 11

The review identified 11 children's cases where humiliation appears to have been used, 3 boys and 9 girls. The boys ranged in age from 6 to 13 (average 9 years), much younger than the girls who ranged in age from 4 to15 (average age 12 years). With the exception of a 4 and 10 year old girl the remainder were teenage girls. The majority of the incidents included in this section relate to bathing of children. From the records it was unclear how observation was carried out.

(v) Supervision / Staffing Levels: 4

Two girls aged 10 and 13 and 2 boys aged 9 and 14 were identified by staff as requiring higher levels of supervision than staffing levels

permitted. The implication for the supervision of children and their care are evident from these records, which may not fully reflect the position given that only a small sample of cases was reviewed.

(vi) Staff / Child Relationships

There were 2 girls aged 8 and 14 (Child A and Child H) about whom the records suggested issues relating to the appropriateness of the staff/child relationship.

(vii) Child JH

[redacted]as an adult made a complaint about her treatment at Lissue. Child J was first admitted to Lissue in1987 suffering from Tourette's Syndrome when she was 12 years old. In 2008 at the age of 33 years she described her treatment at Lissue to the Police on the 23rd May 2008 and 3rd June 2008. [redacted]alleges an institution at Lissue and Forster Green Hospitals run on the basis of threat, the installation of fear among vulnerable children, the deliberate deprivation of their dignity and bullying by senior staff.

CONCLUDING REMARKS

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

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

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

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

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

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

Marion Reynolds

July 2009

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

(c) Would the information provided from 34 files provide enough information regarding trends to draw any robust conclusions?

Marion Reynolds' interim report – July 2009.

(a) This report provides a useful over-arching perspective of the Stinson Report.

(b) The BHSCT internal review (page 1, third paragraph) of staff from Forster Green and Lissue is not provided and findings may be of relevance in respect of any future required actions. This apparently links with page 2, para (ii) and overall would expect assurance from HSCB and BHSCT that all staff mentioned in these reports have been considered and any necessary appropriate action taken.

(c) An issue to be clarified is on page 1, para 3 regarding the timescale and method of DHSSPS being made aware of the 2 allegations regarding 1993 and 1994 and subsequent follow up and actions taken.

(d) In Ms Reynolds concluding remarks it might have been more useful if in the first paragraph attention was drawn to the need to compare standards in existence at the time with the relevant reported incident. Also in the second paragraph while we note the comment 'on balance of probability it is, however, likely that her complaint had a basis' there does not appear to be provision of the supporting evidence for this conclusion.

(e) The Reynolds report is titled as an "interim" report. Was there an intention to have a final report?

Dr Jacobs report regarding interventions by medical staff : Feb 2010.

(a) The process for identifying Dr Jacobs as an independent expert is not evident and Appendix 2 regarding the initial approach is not included in the documents provided to the Department. This information would be required to assure the provenance of this report.

(b) There are key issues unanswered in Dr Jacobs report:

- Details are absent of the medical staff and their specific responsibilities within the context of their job descriptions in respect of the 2 units, including the expected direct involvement in patient care and managerial or leadership responsibilities, over the time in question.

- How much information about the apparent incidents of abuse should the medical staff have been aware of and when/if they were actually aware of any such concerns what actions did they take?

(c) This report contains information and discussion regarding individual cases, and indeed names nursing staff, which in our view is outwith appropriate terms of reference to ascertain if standards of medical interventions were reasonable.

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South London and Maudsley NHS
NHS Foundation Trust

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February 7, 2010

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

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

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

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

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

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

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

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

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

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

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

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

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

Commentary on Lissue Historic Case Review

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

5. Section 5.1.4 & 5.1.5

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

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

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

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

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

6.1. Child D: No comment possible

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

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

6.3. Child J: see section where greater detail

6.4. Child BB: I have discussed this under 4.3

7. Section 5.1.7 – Grooming (category 7)

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

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

8. Section 6.1.1 Restraint and Appendix 5

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

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

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

Overall Conclusions

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

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

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

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

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

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

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

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

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

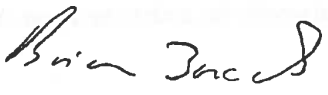
but also have a very clear understanding that they are slightly separate from it in this regard.

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

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

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

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



Brian W Jacobs (MRCP(UK) MPhil FRCPsych)

(Consultant Child & Adolescent Psychiatrist)

Appendix 1 – Documents made available:

1. Independent Report Lissue and Forster Green Hospitals Historic Case Review (R.S. Stinson, January 2009)
2. Appendix to the above with details of the allegations
3. "SIFT" document of 150 pages
4. Case notes on the following children:
   - 4.1. Child A
   - 4.2. Child B
   - 4.3. Child E
   - 4.4. Child H
   - 4.5. Child P
   - 4.6. Child X
   - 4.7. Child BB
   - 4.8. Child GG
   - 4.9. Child HH

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

the methodology parameters for the other reports considered above.

- There was an initial "sift" of 30 files, centred on identification of physical and/or sexual abuse, between peers or by staff. Grooming activity and any indication of a "harsh regime" were also to be documented.

- In total, files relating to 34 children were eventually examined.

- This methodology resulted in 4 reports being completed:

  - A review and analysis of the case files by R.S. Stinson dated January 2009
  - A review of the nursing care provided to children, based on review of 4 files by Maura Devlin, dated May 2009.
  - An overview summary of issues and progress to date, completed by Marion Reynolds in July 2009.
  - A February 2010 report from Dr. Brian Jacobs, Consultant Psychiatrist, with a brief to provide a view on the standard of medical intervention which should in our opinion have included clinical and their role in managing the Units concerned.

- On Page 3, para 1 of Marion Reynolds' report, it states that all children had their field work files reviewed but according to the Stinson Report, para 2.2, this would appear not to be the case.

- A range of care issues were also categorised within the Stinson report, including restraint, victimisation, sanctions, humiliation, supervision/staffing levels and staff/child relationships.

(d) The Conclusions Section:

- As noted from para 3 and comments on limited information there are questions of the robustness of this report.
- Para 6 comments on nursing staff and is in our view outwith the apparent terms of reference.
- Para 12 – we do not feel there is sufficient evidence provided to support his conclusion that the service by the medical staff was 'clinically good'.

Other additional questions/comments from this specific review

- Why was a multi-disciplinary approach not considered, rather than uni-disciplinary processes? There are existing models of good practice which have robust methodology for undertaking reviews such as this e.g. Case Management Reviews where a multidisciplinary panel is convened, chair appointed and clear terms of reference developed at the outset in relation to how work will be taken forward. It is not clear why this methodology or similar was not used and future learning is required to ensure that processes are in place for handling similar situations. One possible explanation is that the complaint was made by an adult and therefore child protection processes/procedures were not considered. If so, then vulnerable adult methodology should have been used.
- Given the serious nature of concerns identified, why were key individuals not interviewed nor further records reviewed?
- Has consideration been given to the impact abuse may have had on individuals who came through these services – e.g. they may now be vulnerable adults as a result of their experiences and would this

RETROSPECTIVE SAMPLING OF CASES IN BELFAST TRUST/ SAI 117-08

INTERIM REPORT TO DHSSPS

Introduction

The legacy EHSSB received a Serious Adverse Incident Report from Belfast Trust in May 2008. This related to an internal review being conducted by the Trust in respect of allegations of abuse at Lissue and Forster Green between 1985 and 1991. As the EHSSB was directly accountable for service provision on both sites during this period, it led on an investigation of the historic aspects of the alleged abuse.

Independent reports

The legacy EHSSB commissioned a series of reviews in respect of professional practice at Lissue and Forster Green which are outlined below.

RS Stinson , Social Services Manager, SET (retired), File review, January 2009.

M Devlin, Director of Nursing and Midwifery Education, Beeches Management Centre, Review of the Standard of Nursing Care, May 2009.

Dr B Jacobs, Consultant Child and Adolescent Psychiatrist, South London and Maudsley NHS Foundation Trust, 'Independent Child, Psychiatry Comment on report by RS Stinson', February 2010.

In addition the Board is in receipt of the report of the Belfast Trust 'Retrospective Child Protection and Safeguarding Audit within Regional Child and Adolescent Inpatient Service' and their action plan.

It is understood that a number of allegations have been considered by PSNI. Further information was passed to PSNI following receipt of Dr Jacobs report and a strategy group meeting in April 2010.

CONFIDENTIAL

RETROSPECTIVE SAMPLING EXERCISE - PROFESSIONAL COMMENTS ON REPORTS

INTRODUCTION

An extensive retrospective review of all patient case files within Muckamore Abbey Hospital, completed by EHSSB/N&WBT in 2009 following a patient complaint, led to the DHSSPS instigating a retrospective sampling exercise across all Trusts to identify if there were concerns/significant prevalence of similar findings within any other mental health or learning disability inpatient hospitals.

At a meeting held in Castle Buildings on 28th June 2007, involving Departmental and Trust representatives, it was agreed that a retrospective sampling exercise should focus on those most at risk especially minors/children admitted to mental health and learning disability hospitals) over a 20 year period (1985-2005), taking a 10% sample of relevant files from each year. Trusts were asked to follow the rigorous methodology applied in the Muckamore Review although it has not been possible to retrieve any formal minutes of this meeting

As a consequence the scale and scope of sampling has been interpreted by Trusts in different ways, and it is apparent that there are significant inconsistencies and variances in both methodology and sampling applied by the Trusts and within the commissioned reports. Although this variance does not allow for a consistent and objective critique of these reports/reviews, we have identified a number of flaws and/or gaps in the reports, but it is important to consider this in the context of lack of terms of reference.

The retrospective sampling exercise encompassed the adult mental health hospitals, learning disability hospitals (excluding Muckamore Abbey Hospital which had already been reviewed) and regional child and adolescent inpatient mental health services (which included a specific investigation of Lissue and Forster Green Hospitals commissioned by the EHSSB / HSCB as a result of a

complaint detailing serious allegations when the above exercise was being planned).

The scope of this paper is to provide a professional overview and perspective on the following specific written reports, and our conclusions and recommendations may therefore require further examination by other agencies.

1. HSC Trust reports on adult mental health hospitals and learning disability hospitals:

   - WHSCT – Stradreagh, Tyrone and Fermanagh, and Gransha Hospitals
   - BHSCT – Knockbracken Hospital site
   - SHSCT - St Luke's, Craigavon Psychiatric Unit and Longstone Hospital
   - NHSCT - Holywell Hospital
   - SEHSCT – Downshire Hospital

HSC Trust reports on child and adolescent inpatient mental health facilities:

2. BHSCT's retrospective child protection and safeguarding audit within the regional child and adolescent inpatient service.

3. EHSSB/HSCB commissioned reports on Lissue and Forster Green Hospitals.

For each report we have provided comments under 3 broad headings;

a) Methodology
b) Key findings and circumstances of abuse/suspected abuse
d) General comments and conclusions

We have provided a summary and conclusion at the end of the report which highlight a number of options to be considered for any way forward.

1. TRUST REPORTS: ADULT MENTAL HEALTH AND LEARNING DISABILITY FACILITIES

1.1 WESTERN TRUST

The Western Trust response to the retrospective exercise has already been thoroughly and rigorously reviewed. The methodology applied was robust and was the measure against which we compared reports from the other 4 Trusts. Key points from the Western Trust are summarised below:

1.1.1 Learning Disability - Stradreagh hospital

(a) Sampling and methodology correct - 142 files identified for the period 1985 to 2005, 75% of which had at least 3-4 volumes, therefore approximately 300 files in total were examined;

(b) Evidence of initial examination, re-examination and relevant cross-referencing.

1.1.2 Adult Mental Health – Tyrone and Fermanagh, and Gransha Hospitals

(a) Appropriate methodology applied and relevant sampling;

(b) T&F - 63 male patient files and 48 female patient files were examined of which 13 were noted within report, 98 files therefore did not have any references to abuse;

(c) Gransha Hospital – 24 files examined of which 3 were noted for report falling into relevant categories;

(d) Relevant detail regarding classification into various categories;

(e) Evidence of appropriate care planning and multi-disciplinary case reviews, risk assessments ongoing;

(f) No evidence of vulnerable adult or child protection training;

(g) Overall excellent coverage and relevant detail provided.

NB. The Western Trust is satisfied that any allegation, suspicion or actual evidence of sexually inappropriate behaviour was dealt with promptly and appropriately. They have also taken the view of PSNI regarding 3 cases within the report, and the PSNI have advised that nothing further can be done and that the Trust have responded appropriately to events.

1.2 BELFAST TRUST – KNOCKBRACKEN SITE

(a) Methodology

With regard to this retrospective sample exercise, this report

- spans only 16 years (1970-1986)
- focuses only on children and does not appear to work to the 8 specific categories agreed with PSNI for the Muckamore Abbey review
- does not consider all of the mental health inpatient facilities in the Trust such as the Mater Hospital Unit and Windsor House, where children may have been admitted.

During the years 1970-1986, 195 U18s were admitted. The Trust took a sample of 20%, the equivalent of 39 patients, and also included 6 patients who were compulsorily admitted without explanation why this latter group was chosen.

The review was completed by 3 members of Belfast trust staff

(b) Key Findings and circumstances of abuse/suspected abuse

- In this report, 7 files/cases (out of a total of 45) were highlighted specifically within the report. 3 of these cases were from the adult sample of 6 (50% of the sample).
- The level of detail provided for each individual case was minimal, although the report states that there is evidence to indicate that where abuse, and any alleged criminal acts, had taken place appropriate action was taken.
- It is important to note that the outcomes of a number of these investigations were not always recorded.
- From the cases sampled in this report, we have no indication that there are victims and/or perpetrators of abuse who require to be followed up.
- 2 staff members (unnamed) were involved in 2 of the incidents. One involved allegations of being forced to eat by "staff" (no evidence of investigation) and the other centred on an allegation against a teacher, punching a 15 year old boy (evidence that this was investigated and dealt with).

(c) General comments and conclusions:

Although the predominant rationale for this report was to complete a retrospective review, Belfast Trust strongly emphasises a range of developments in relation to current and future practices:

i. General practice – this highlights compliance with procedures such as Area Child Protection Committee (ACPC) and Vulnerable Adult (VA), staff supervision, role of

RQIA, complaints procedures, untoward incidents procedures, and the plan to appoint Band 7 Social Worker to investigate VA issues;

ii. Mental Health/child care interface – this emphasises implementation of the recommendations coming out of the O'Neill report etc, Trust protocol to safeguard children, ongoing staff supervision, and the identification of 4 additional beds for U18s;

iii. Vulnerable Adults – training in this area is given emphasis, the appointment of Band 7 Social Worker for VA investigation, the re-establishment of adult protection forum, PECS checks, and the review of Shannon to be completed 2009/2010.

While the Trust does not make any specific recommendations, it has drawn up an action plan, which identifies for each action an Officer responsible for implementation. This action plan is equivalent to a series of recommendations within the context of improving practice to children and vulnerable adults, according to appropriate policies and procedures.

1.3 SOUTHERN TRUST

1.3.1 St Luke's Hospital and Craigavon Psychiatric Unit

(a) Methodology

- The focus within this exercise was completely on children/minors.

- During the period 1985-2005, 116 children were admitted and 29 were chosen for the purposes of this Review. This was a 25% sample.

- 85 files were examined relating to the 29 children chosen.

- The report does not apply the 8 specific categories agreed with PSNI. Only sexual abuse was considered.

- The report was completed by 2 senior members of staff from within the Southern Trust.

(b) Key findings and circumstances of abuse/suspected abuse

This audit uncovered records of a sexual nature in the files of five patients. However, the authors of the St Luke's report are satisfied that there is nothing within the retrospective exercise of a serious nature that would warrant further action, or which warrants a referral to any outside agency.

From the cases sampled in this report, we have no indication that there are victims and/or perpetrators of abuse who require to be followed up, and there are no indications that any staff involved at the time require to be followed up.

The Trust highlights a series of failings at the time in terms of poor documentation and communication, lack of evidence of reference to child protection procedures and vulnerable adult procedures, no evidence of multi-disciplinary assessment and care planning, no sharing of information;

These findings reflect a fair degree of self-criticism and the conclusions and recommendations made in the report are in keeping with the need to address these concerns.

(c) General comments and conclusions

There is nothing significant to add, except to point out that the issue of finding and storage of the files of mental health patients was problematic in this review, and may be an important issue to consider regionally. It should also be noted vulnerable adults were not considered.

1.3.2 Learning Disability – Longstone Hospital

(a) Methodology

- The focus within this exercise was completely on children/minors.
- During the period 1985-2005, 115 children were admitted and 22 were chosen for the purposes of this Review. This was a 20% (approx) sample.
- However, using the concentric ring principle a further 10 patients were identified. 32 children in total were considered and a total of 91 files were examined. .

- The report does not work to the 8 specific categories agreed with PSNI, however both sexual and physical abuse are considered (yet the initial brief stated sexual abuse only).

- The report was completed by 2 senior members of staff within Southern Trust

(b) Key findings and circumstances of abuse/suspected abuse

- Fifteen incidents of a sexual nature and 2 cases of physical abuse. Most of the incidents took place between 2 vulnerable people.
- Staff members were involved in 2 incidents. Outside agencies such as PSNI involved, and on each occasion, the staff member was dismissed.
- It was noted that this review followed up both perpetrators and victims and services were provided as appropriate (care packages, risk assessment, referral to psychosexual services).

(c) General comments and conclusions

- Once again, these findings support a reflective self-examination on a retrospective basis.

- The report makes a series of recommendations which have been converted into a working action plan.

- There are some anomalies in the numbers within this review. For example, it originally states that 10 further cases were followed up, and then later on, this figure changes to 11.
- Vulnerable adults were not considered.

1.4 NORTHERN TRUST – HOLYWELL

(a) Methodology

- A random sample of 27 patients were chosen (eventually reduced to 25 because of missing files).
- These were long stay patients who had been in the hospital during the period 1985 – 2005. It is unclear how the sample was chosen, and whether this is a percentage of total admissions over the 20 year period.
- There is no reference to children, so one is left to assume that the 25 patients were all adults
- Medical and nursing files were examined, but in only 18 cases was it possible to review both medical and nursing files (due to missing files).
- A range of data is provided such as date of birth, diagnosis, gender etc is provided which is mostly irrelevant.
- The report does apply the 8 specific categories agreed with PSNI.
- The specific authors of the report are not identified.

(b) Key findings and circumstances of abuse/suspected abuse

- In total, 33 incidents were identified across all of the categories. 17 of these incidents relate to sexualised/disinhibited behaviour.
- Allegations made on 3 occasions against staff. No substance (from records) to 2 allegations. The other

incident regarding sexual advances by a "porter" states that there was limited information available and no record of any action taken.

- If the 25 patients are truly a random sample, sexualised behaviour in Holywell could be perceived as being more prevalent than expected (19 patients (76%) of sample had evidence of sexualised behaviour). However, it is apparent that these were patients who had been residing in wards that routinely accommodated adults with challenging or disinhibited behaviour.

- The authors of this report state that "appropriate action/intervention would appear to have been undertaken with the exception of one patient, who is currently being followed up by mental health staff". It may be necessary that further details regarding this specific case are sought.

(c) General comments and conclusions

The report makes 5 very broad recommendations around the need for proper investigation, documentation and adherence to procedure and training in future. There is no consideration of children nor, as with the Belfast Trust, of other mental health facilities (e.g. Whiteabbey Hospital), within the Northern Trust.

1.5 SOUTH EASTERN TRUST – DOWNSHIRE

(a) Methodology

- Worked to the 10% sampling process and the timeline was 1985 – 2005.

- Focus was on adults.

- The Trust also applied the 8 categories of abuse. However, they only reported on categories 1-3, stating that there were incidents that fell into the other categories (43 patients in total), but that these were to be "subject to further internal multi-disciplinary review" and were not reported on within this report. It may be necessary that further details of these reviews are sought.

- 191 files were examined in total, 71 male and 120 female, of which 59 identified incidents that fell into categories 1 to 8.

- 16 of these (59) incidents fell into categories 1 – 3, and it is these that were reported upon.

- No indication who completed this report.

(b) Key findings and circumstances of abuse/suspected abuse

- Appendix 1 of the Downshire report provides a detailed breakdown of the 16 incidents that fell into categories 1-3 including details of the incident, the action taken (as indicated within the files), and date of the incident.

- No indication of any staff involved in any of these incidents.

- Detail provided regarding the one category 1 incident, and the one female who fell into category 2. The report states that both were dealt with appropriately.

- Some of the actions taken, or not taken, as a consequence of the incidents is concerning, but is acknowledged within the Trust report (e.g. triggering of safeguarding procedures).

(c) General comments and conclusions

- There are no recommendations made, however the report does reflect reasonable self-examination, and there is indication of training measures being put in place regarding child protection and protection of vulnerable adults.

2. BHSCT RETROSPECTIVE CHILD PROTECTION AND SAFEGUARDING AUDIT WITHIN THE REGIONAL CHILD AND ADOLESCENT INPATIENT SERVICE

This report differs from the previous Trust reports within the retrospective exercise which concern adult facilities and **would therefore benefit from specific comments by Child Care Branch.**

(a) Methodology

- The report states that it covers the years 1970 to 1999 (excluding the period 1980-1989. See below). However the retrospective exercise was intended to focus on the 20 year time period between 1985 and 2005. We also note that 3 files relate to the period 2000 to 2003.

- A separate EHSSB commissioned exercise regarding Forster Green and Lissue Hospitals (see below) is stated as addressing the 1980 to 1989 period for the purpose of the overall retrospective sampling exercise.

- Under the methodology it states there were 15 files randomly selected from each period (1970-79 and 1990-99) when in reality there were 10 selected from each

setting (Lissue, Forster Green and the Young People's Centre, College Gdns), with 2 of the 3 settings relating to the 1990 to 1999 period. Also there is no evidence that the 30 files represent 10% of all admissions – the intended sample size.

- The files reviewed included medical, nursing, social work, psychology, inpatient and outpatient files
- The review was undertaken by 2 experienced safeguarding professionals (nursing and social work).
- The categories recorded appear to have been adapted for children, and there are 4 categories in total used in this report.

(b) Key findings and circumstances of abuse/suspected abuse

- The files of 30 children were reviewed. Of these 30, 21 files fell into categories 1-4: 7 children from Lissue, 8 from YPC, and 6 from Forster Green. The files indicate that these 21 children experienced 27 incidents in total. There were 14 incidents of sexual activity and 13 incidents of physical abuse or neglect.
- Although specific information for each child is provided, the date of the incident is not provided, making it difficult to consider in terms of "standard practice at the time"
- In 2 case files, there are 3 allegations made against staff (physical abuse and maltreatment by nursing staff, and inappropriate sexual touching by a doctor). In the files, there is evidence of

investigation in 2 of the 3 incidents, but no information or evidence regarding outcome. The recommendations within this report propose that the Trust immediately review these circumstances in order to agree and promptly address any further enquiries/action deemed necessary.

- No staff have been named.

- On the results of the audit it is very frequently recorded there is no record of action. This may be qualified with additional comments that the case was known to, or involved with, family and childcare community services. However there is no evidence that the family and childcare team acted any more appropriately than the inpatient service in implementing appropriate procedures. An example is on page 10 –case of Y3 – a disclosure regarding sexual abuse by an uncle, however no record of action taken by inpatient services and the additional comment that the young person was involved with family and childcare and that within their records there was disclosure regarding physical abuse, again without any note of whether or not appropriate actions were taken.

- The quality of recording within files appears systematically to be very poor throughout the sample cases within this report. There is also on page 13 under "Communication" evidence that the recording of information within family and childcare social services is also poor as it states 'it is unclear

whether these concerns were new information or whether family and childcare social services were already aware of this information'.

(c) General comments and conclusions

- There is a section on current practice, which outlines a range of initiatives intended to ensure good governance within CAMHS services in the Trust.
- The recommendations would have benefitted from a timeline for completion and audit of implementation as well as identifying those responsible for these actions.
- We note the attached template within the BHSCT report in their Appendix 1, which we assume was used, and would draw attention in particular to question 2 on page 19, regarding compliance with relevant child protection and safeguarding procedures relevant to the time period, which crucially this report does not appear to have answered.

3. EHSSB/HSCB REPORTS ON LISSUE AND FORSTER GREEN HOSPITALS

(a) Methodology

- This report was commissioned specifically by EHSSB as a consequence of an allegation made by a previous patient in April/May 2008. Consequently it fell outside of

the methodology parameters for the other reports considered above.

- There was an initial "sift" of 30 files, centred on identification of physical and/or sexual abuse, between peers or by staff. Grooming activity and any indication of a "harsh regime" were also to be documented.

- In total, files relating to 34 children were eventually examined.

- This methodology resulted in 4 reports being completed:

  - A review and analysis of the case files by R.S. Stinson dated January 2009
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  - An overview summary of issues and progress to date, completed by Marion Reynolds in July 2009.
  - A February 2010 report from Dr. Brian Jacobs, Consultant Psychiatrist, with a brief to provide a view on the standard of medical intervention which should in our opinion have included clinical and their role in managing the Units concerned.

- On Page 3, para 1 of Marion Reynolds' report, it states that all children had their field work files reviewed but according to the Stinson Report, para 2.2, this would appear not to be the case.

- A range of care issues were also categorised within the Stinson report, including restraint, victimisation, sanctions, humiliation, supervision/staffing levels and staff/child relationships.

- Page 1 of Stinson's report notes a time span for this review of 1975 to 1995. However the previous BHSCT report on Regional Inpatient CAMHS had intimated that the time span for this review of Lissue and Forster Green would be for the period 1980-89.

(b) Key findings and circumstances of abuse/suspected abuse

- The frequency, range and serious nature of incidents/ practice reported and apparent prevalence of abuse is very high. From the initial 34 children identified, 23 encountered abuse/alleged abuse, with the files specifying 38 specific incidents of concern.

- The severity and frequency of findings documented, and the lack of follow-up or robustness of any action taken, raises very serious concerns, including the failings in staff leadership, accountability and governance.

- There is a lack of comments on the actions taken subsequent to such incidents.

- There is a lack of comment on the disparity between the then extant guidance/procedures/professional standards compared to events/practice described. This is a serious flaw within this exercise.

- There have been very serious allegations made against a range of staff members. Although it is apparent from the reports that follow up action has been taken to address allegations made against a number of staff, we could not be assured that this has taken place for all staff mentioned. A considerable number of nursing staff have

had allegations made against them, yet the focus of follow up appears strongly weighted towards one member of nursing staff (H L). It is therefore surprising that the independent nurse consultant report only reviewed four of the files, and focused on one member of nursing staff and did not provide a wider overview. The medical report by Jacobs had access to all the files reviewed by Stinson. This should at least have been the case for the nursing report, considering the range of allegations made against nursing staff.

(c) General comments and conclusions. These are outlined below in relation to each of the 4 reports received.

In respect of the specific reports provided.

R.S. Stinson's report, January 2009.

(a) Methodology requires clarification:

- How, and by whom, were the 30 files selected?
- Who completed the initial sift in phase 1?
- How were files divided across age groups, gender, etc?
- Why were 30 cases (+4) considered a sufficient sample?
- What percentage of the total young people to pass through Forster Green and Lissue in the timeframe 1975 to 1995 does this sample represent?

(b) A serious breach of confidentiality occurred in including names and dates of birth in this report as initially presented to the Department.

(c) The severity and frequency of findings documented, and the lack of follow-up or robustness of any action taken, raises very serious concerns, especially the repeated failings in staff leadership, accountability and governance.

(d) A major flaw in this report is that in the many examples of serious abuse there is a lack of comparison with the professional standards and policies/procedures/guidance extant at that time.

(e) An update regarding para 7.3 in relation to the action plan and its implementation may be useful in any further work taken forward by other agencies.

Maura Devlin's report on the standard of nursing care – May 2009

(a) The methodology for this report would appear flawed in that a sample of just 4 files (how were these chosen and were they part of the original 34 sampled for Stinson?) would seem insufficient to determine the standard of nursing care against the UKCC Code of Professional Conduct across 2 hospitals and over a significant time span.

(b) Several nurses who were mentioned in the Stinson Report, and the relevant incidents, are areas of concern which might reasonably have been expected to have been commented on.

(c) Would the information provided from 34 files provide enough information regarding trends to draw any robust conclusions?

Marion Reynolds' interim report – July 2009.

(a) This report provides a useful over-arching perspective of the Stinson Report.

(b) The BHSCT internal review (page 1, third paragraph) of staff from Forster Green and Lissue is not provided and findings may be of relevance in respect of any future required actions. This apparently links with page 2, para (ii) and overall would expect assurance from HSCB and BHSCT that all staff mentioned in these reports have been considered and any necessary appropriate action taken.

(c) An issue to be clarified is on page 1, para 3 regarding the timescale and method of DHSSPS being made aware of the 2 allegations regarding 1993 and 1994 and subsequent follow up and actions taken.

(d) In Ms Reynolds concluding remarks it might have been more useful if in the first paragraph attention was drawn to the need to compare standards in existence at the time with the relevant reported incident. Also in the second paragraph while we note the comment 'on balance of probability it is, however, likely that her complaint had a basis' there does not appear to be provision of the supporting evidence for this conclusion.

(e) The Reynolds report is titled as an "interim" report. Was there an intention to have a final report?

Dr Jacobs report regarding interventions by medical staff : Feb 2010.

(a) The process for identifying Dr Jacobs as an independent expert is not evident and Appendix 2 regarding the initial approach is not included in the documents provided to the Department. This information would be required to assure the provenance of this report.

(b) There are key issues unanswered in Dr Jacobs report:

- Details are absent of the medical staff and their specific responsibilities within the context of their job descriptions in respect of the 2 units, including the expected direct involvement in patient care and managerial or leadership responsibilities, over the time in question.

- How much information about the apparent incidents of abuse should the medical staff have been aware of and when/if they were actually aware of any such concerns what actions did they take?

(c) This report contains information and discussion regarding individual cases, and indeed names nursing staff, which in our view is outwith appropriate terms of reference to ascertain if standards of medical interventions were reasonable.

(d) The Conclusions Section:

- As noted from para 3 and comments on limited information there are questions of the robustness of this report.
- Para 6 comments on nursing staff and is in our view outwith the apparent terms of reference.
- Para 12 – we do not feel there is sufficient evidence provided to support his conclusion that the service by the medical staff was 'clinically good'.

Other additional questions/comments from this specific review

- Why was a multi-disciplinary approach not considered, rather than uni-disciplinary processes? There are existing models of good practice which have robust methodology for undertaking reviews such as this e.g. Case Management Reviews where a multidisciplinary panel is convened, chair appointed and clear terms of reference developed at the outset in relation to how work will be taken forward. It is not clear why this methodology or similar was not used and future learning is required to ensure that processes are in place for handling similar situations. One possible explanation is that the complaint was made by an adult and therefore child protection processes/procedures were not considered. If so, then vulnerable adult methodology should have been used.
- Given the serious nature of concerns identified, why were key individuals not interviewed nor further records reviewed?
- Has consideration been given to the impact abuse may have had on individuals who came through these services – e.g. they may now be vulnerable adults as a result of their experiences and would this

information be useful in current therapeutic analysis/care or clinical processes supporting such individuals?

- The methodology used in this review of Lissue and Forster Green hospitals would appear to have been disjointed and as a result there does not appear to have been appropriate communication across the system. Given the sensitivites, nature and complexity of this work this is understandable, however lessons must be learnt from this in relation to how this can be avoided in the future so there is a joined up and seamless approach at all levels including DHSSPS, HSCB, and Trusts.

- In terms of overall governance/accountability, the responsibilities of key individuals in positions of management/leadership throughout the HSC needs to be considered.

- Do we need a written record of actions taken to ensure coverage of all staff mentioned in this report?

- The Stinson report was completed in January 2009, yet DHSSPS have received it over one year later.

4. SUMMARY

4.1 It is important not to underestimate the internal difficulties which Trusts had in carrying out these retrospective exercises. Allocation of adequate resources and poor record keeping over the 20 year period have impacted on the gathering of necessary evidence. Furthermore, the history of caring culture within psychiatric institutions over this period of time needs to be kept in mind – what was acceptable 20 years ago is no longer acceptable and many policies and procedures which we have now, were then not in place.

4.2 A caveat that must also be borne in mind when considering the Trust reviews of their adult mental health and the learning disability hospitals, is that there were significant weaknesses in the methodologies applied.

4.3 Nevertheless there is very clear evidence of numerous accounts of failure to implement recognised child care procedures and vulnerable adult guidance. All Trusts reference their failure and shortcomings in this area and most have stated that they have drawn up training plans to address this concern. Also, some Trusts have made recommendations which have been converted into action plans in order to ensure the current and future safety of patients and this should be considered the most reassuring outcome of this Retrospective Sampling Exercise.

4.4 In ensuring regional learning occurs it is vital to note the findings and recommendations of the Regional review undertaken by RQIA into the 'Safeguards in place for children and vulnerable adults in mental health and learning disability hospitals' in HSC Trusts. This took place during September/October 2007 and an Overview Report was available in June 2008.

4.5 The findings contained in the RQIA Overview Report identified concerns in a number of key areas including:

- the failure to implement child protection procedures;
- the failure to implement vulnerable adult policy and guidance;
- significant variance in the implementation of comprehensive risk assessment processes;
- similar variances in relation to Looked After Children (LAC);
- variance in review and audit activity;
- and concerns regarding the amount and quality of training in respect of the above key policies and procedures.

4.6 With regard to the recommendations made in the RQIA Overview Report which seeks to address the above concerns, they include:

- the establishment of robust individual and group supervision structures, which take account of relevant professional guidelines;
- the implementation of policies and procedures for Looked After Children;
- the identification of a named nurse and named doctor for child protection cases;
- the implementation of appropriate child protection procedures and training;
- the implementation of adult protection (vulnerable adult) procedures and associated training;
- a 'consistent' approach to the management of aggression;
- the full implementation of regional adult protection policy and procedural guidance.

4.7 As a mechanism for providing assurance on current and future governance arrangements being robust, it is important to note that this Overview Report does not give any clear indication of commitment for follow up of implementation of its' recommendations other than the following statement: 'the findings from this Review and **any subsequent follow-up** Review will be shared with the Minister for Health, Social Services and Public Safety and made available in the context of open reporting'. It would therefore be imperative that RQIA ensure that the recommendations of this Report are followed up, and furthermore, it would be essential to seek assurance from RQIA that such monitoring of safeguards of children and vulnerable adults is conducted on a regular basis (and including spot checks). These inspections should not only take account of the implementation of RQIA recommendations, but also examine the implementation of recommendations made by Trusts in their respective reports.

4.8 The HSCB and PHA met with the Belfast HSCT in April 2010 regarding the Lissue and Forster Green Hospital reports and agreed the following actions:

(a) HSCB to obtain written assurance from PSNI that they have completed their investigations for any cases identified in the retrospective exercise, according to the joint protocol under child protection procedures. Also HSCB to forward Jacob's Report to PSNI regarding comment on page 8 regarding identifying staff to ensure they have all information available before they make their final determination.

(b) HSCB to write to BHSCT seeking assurance regarding current policy/procedures/audit and governance measures in respect of issues and relevant recommendations emanating from all CAMHS reports.

(c) The BHSCT to respond to HSCB with assurances and action plan for any matters outstanding.

(d) HSCB to disseminate learning regionally by a general letter to all HSCTs regarding overall learning and recommendations for good practice. Also a summary of incidents found and background to be circulated through RCPC regionally to the Trust child protection leads.

(e) HSCB to forward the findings from the retrospective exercise and actions taken to Department for their consideration around end of May 2010.

5. CONCLUSION

5.1 It is likely to be necessary at this stage for the Department to consider if any further investigation or review is warranted, and the following points may be pertinent;

- any random sampling exercise has fundamental weaknesses, for example the sample in this case (10% over 20 years) does not in any way equate with a full and comprehensive review;
- given the nature and level of concerns raised by these reports, it would be useful to have a chronology/timeline of significant events drawn up to understand the process, roles and responsibilities of individuals and assist identification of possible failings of either individuals or systems within the HSC;
- if a full investigation (similar to Muckamore) was conducted this may not necessarily lead to legal intervention and could prove nugatory in terms of successful prosecutions;
- a further detailed review is unlikely to increase our knowledge of the improvements that should be made to ensure the safety of future patients;
- it is essential to ensure there is recognition in such investigations, whilst specific individuals may perpetrate offences against vulnerable adults or children, that any system (including key individuals within it) which does not detect nor appropriately address this may be, and often is, equally liable for the offence(s) and their consequences;
- there are potentially unmet needs of identified victims and their families, particularly following the reviews carried out in children's services, including acknowledgement of abuse and any required support;
- the apparent limitation of the retrospective samples in assuring us that all likely perpetrators (especially staff in the CAMHS reports)

have been identified and appropriate actions taken to minimise the ongoing risk they might present to vulnerable people;

5.2 Whilst recognising that the findings from this retrospective exercise will be disseminated through RCPC, together with the other steps above taken by the Trusts, Board and RQIA to ensure the risk of future such incidents is minimised, **there are also several possible options** for further consideration by the Department regarding potential future further retrospective review/investigation:

(a) Do not carry out any further retrospective review or investigation since unlikely to gain additional learning, successful prosecutions or even provide support that improves the outcome for victims. This is particularly true within adult mental health services and learning disability hospitals.

(b) Ask the BHSCT to carry out a targeted review, following the Muckamore Terms of Reference, of Regional CAMHS Inpatient Services in response to the severity, nature and frequency of findings. This would address the probability that further staff could be identified who could still be working within HSC and would also be perceived as taking appropriate and proportionate action to the findings. The size of the units (Lissue, Forster Green, Young People's Centre) would lend itself to such an exercise not being excessively resource intensive. If this is done a robust methodology and process should be provided and overseen to assure the quality of the exercise.

(c) Carry out a further exercise using Muckamore Terms of Reference across all Trusts. This would prove very resource intensive and would be expected largely not to result in any outcome of significance, except for within CAMHS services.

(d) Await possible wider OFMDFM review as a vehicle under which any further investigation of inpatient services could be carried out. This may lead to significant delay in any action being taken.

5.3 Finally it is our concluding view that a clear Departmental corporate view, including Chief Officers for the relevant disciplines, should be taken in respect of the concerns identified by this retrospective exercise. This exercise is fundamentally a child protection and vulnerable adult issue, occurring within mental health and learning disability hospitals, and in future options should be addressed within this context.

Ian McMaster
Charles Bamford
Maurice Devine

21st May 2010

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21st May 2010

1. BACKGROUND

In June 2007, following a retrospective review of patient case files within Muckamore Abbey Hospital completed between 2005 and 2009 by the Eastern Health and Social Services Board (EHSSB) and North and West Belfast Health and Social Services Trust, the Department of Health Social Services and Public Safety (DHSSPS) instigated a retrospective sampling exercise across all 5 Health and Social Services Trusts to identify if there were concerns, significant prevalence or similar findings within any other mental health or learning disability inpatient hospital.

The DHSSPS required the retrospective sampling exercise to focus on those people most at risk especially minors (children under the age of 18 years) admitted to mental health and learning disability hospitals over a twenty year period between 1985 and 2005. A 10% sample of relevant files was agreed.

The retrospective sampling exercise encompassed long stay wards in adult mental health hospitals, learning disability hospitals (excluding Muckamore Abbey Hospital which had already been reviewed) and regional child and adolescent inpatient mental health services (which included a specific investigation of Lissue and Forster Green Hospitals commissioned by the EHSSB and latterly the Health and Social Care Board (HSCB) as a result of a complaint detailing serious allegations made when the above exercise was being planned).

Each Trust was asked to follow the methodology applied in the Muckamore Abbey Review which characterised the incidents as follows:

- Category 1: Sexualised behaviour between adult and minor
- Category 1a: Sexualised behaviour between minor and minor
- Category 2: Sexualised behaviour between adult and adult (non-consenting)
- Category 3: Sexualised behaviour between adult and adult (consent unclear)
- Category 4: Sexualised behaviour (consenting)
- Category 5: Suspected sexualised activity (general details unknown)
- Category 6: Physical abuse involving actual bodily harm and above
- Category 7: Sexualised behaviour query significance
- Category 8: Issues noted and dealt with thoroughly using recognised procedures

Between April 2008 and August 2009 eight reports were submitted to the DHSSPS covering ten sites. In late 2011 these reports and other reporting documents (thirteen in total) were handed over by the DHSSPS to the PSNI for further investigation under Operation Danzin.

The PSNI analysis noted that in some of the reported incidents no further police action was required. Other incidents required more detailed information to enable the PSNI to determine what further action, if any, was required.

It was also evident from the PSNI analytical review that the scale and scope of the sampling had been interpreted by Trusts in different ways. This resulted in significant inconsistencies and variances in both methodology and sampling applied within the commissioned reports.

The DHSSPS subsequently requested that the HSCB and PSNI review the retrospective sampling process. The purpose of this review was to provide assurance to the DHSSPS that, where incidents of abuse were noted in the retrospective sampling exercise reports, these had been appropriately identified and dealt with.

After a series of discussions with the DHSSPS, HSCB and PSNI it was agreed to set up a Strategic Management Group (SMG) in accordance with the Protocol for Joint Investigation of Alleged and Suspected Cases of Child Abuse in Northern Ireland (2004), Although established under the provisions of the Protocol in relation to children, in this case the remit of the SMG was extended to include vulnerable adults.

BBC NEWS

NORTHERN IRELAND

26 October 2011 Last updated at 21:31

Concern at Lissue and Forster Green abuse report 'secrecy'

Stormont health committee chair Michelle Gildernew has raised concerns about the "secrecy" around a report into abuse at two children's hospitals.

The 2009 review, which was never published, detailed abuse at Lissue hospital in Lisburn and Forster Green in Belfast in the 1980s and 90s.

Three allegations were made against members of staff over claims that girls aged between eight and 13 were abused.

The Irish News broke the story after obtaining a copy of the report.

Humiliation

It was compiled by independent health consultant Bob Stinson and completed in January 2009.

It said that two of the allegations of abuse were referred to police but a third was not because it was made some years after the alleged incident took place and, in the view of the report's author, was not corroborated.

The report also detailed concerns about children being asked to undress in front of staff.

In 14 cases, children were alleged to have sexually abused other children while staff also allegedly used humiliation to discipline children.

The 11 such cases of humiliation in the report were described by Mr Stinson as "one of the most disturbing elements of the review."

The review was instigated by the Belfast Trust and the Eastern Health Board after one former patient made a complaint to police.

After a meeting of the health committee on Wednesday afternoon, Michelle Gildernew said the report had "raised more questions than answers".

'Disturbing'

"I think we will certainly want to speak to senior officials within the department (of health) to see why there was such secrecy about this report," Ms Gildernew said.

"I think in the current climate of transparency and accountability, the secrecy around this is very disturbing.

"It will be interesting to see just at what level of the department decisions were taken to keep this so quiet.

"If it was done in the best interests of children, that's one thing. If it was done in the interests of staff, that's another thing entirely."

The health minister Edwin Poots has called the allegations "horrific and appalling".

"People who have vulnerabilities are people who you want to give as much protection to as possible and if what has been alleged transpires to be true, that has obviously not been the case," he added.

BBC NEWS

NORTHERN IRELAND

27 October 2011 Last updated at 17:50

Police to review Lissue House child abuse allegations

The police have said they will carry out a full review into all matters relating to allegations of child abuse at Lissue House near Lisburn.

On Wednesday, the Irish News published details about a report into abuse at the children's hospital and at Forster Green in Belfast in the 1980s and 90s.

The 2009 review, by an independent health consultant, was never published.

Three allegations were made against members of staff over claims that girls aged between eight and 13 were abused.

It said that two of the allegations of abuse were referred to police but a third was not because it was made some years after the alleged incident took place and, in the view of the report's author, was not corroborated.

The report also detailed concerns about children being asked to undress in front of staff.

In 14 cases, children were alleged to have sexually abused other children while staff also allegedly used humiliation to discipline children.

The 11 such cases of humiliation in the report were described by the consultant who compiled it, Bob Stinson, as "one of the most disturbing elements of the review".

The review was instigated by the Belfast Trust and the Eastern Health Board after one former patient made a complaint to police.

The Belfast Health Trust said it reported allegations to the Eastern Board and to the Department of Health.

"We participated fully in the board investigation which followed and carried out all its recommendations to ensure the protection of vulnerable people," it said.

"Where allegations related to people who were working for the trust at that time, these were thoroughly investigated in line with normal disciplinary procedures.

"No formal disciplinary action was taken so no referral was made to the Nursing and Midwifery Council (NMC) in that regard, but the NMC were alerted to an individual who left the trust."

Chairman defended

Earlier, Health Minister Edwin Poots defended the chairman of a new child safeguarding board.

The Irish News reported that Hugh Connor suggested that "some discrimination" should be used when providing police with information from a trust report into allegations of historic child abuse.

Mr Poots said Mr Connor's remarks had been taken out of context.

He said it related only to information which was not relevant.

The Irish News was given a confidential email which was written by Mr Connor, who was then director of social services at the former Eastern Health and Social Services Board.

BBC NEWS

NORTHERN IRELAND

27 October 2011 Last updated at 22:52

Victim recalls Lissue Hospital 'beatings'

A man who says he was abused at Lissue Children's Hospital in Lisburn has given the BBC a harrowing account of suffering at the hands of staff.

The hospital was the subject of a 2009 report into allegations of abuse in the 1980s and 90s.

"The main memories of it were that the staff were terrible. They were always hitting people", said the man, who wished to remain anonymous.

"Personally, I got beat a lot because I didn't eat any dinner," he added.

"Or if I did something stupid, I got the beatings or thrown against the wall or thrown across a table."

Lissue and another hospital, Forster Green in Belfast, were the subject of a report in 2009.

It was never published but a copy was leaked to the Irish News which has reported extensive details of its contents.

The report was commissioned following allegations that girls aged between eight and 13 were abused in both hospitals.

"There was maybe four or five of us that were treated bad," the victim said.

"Any time, there was a window broken, or say, someone drew along the walls with a felt-tip pen, one of us five would have been the ones dragged out and punished for it."

In a statement, police said that they had carried number of investigations into alleged abuse over a number of years.

"In July this year, police received a copy of reviews carried out by various trusts and boards and an intitial assessment and review was carried out by police," the statement said.

"Police are fully committed to carrying out a full and thorough review of all material and have requested further information to assist in this."

More Northern Ireland stories

Talks 'limited but ambitious': Haass
/news/uk-northern-ireland-24128630
The man chairing inter-party talks designed to resolve issues over parades, flags and Northern Ireland's past, says he has a "limited but ambitious" agenda.

Three men admit beating man to death
/news/uk-northern-ireland-24122514

Second north coast whale dies
/news/uk-northern-ireland-24128907

BBC NEWS

NORTHERN IRELAND

31 October 2011 Last updated at 13:26

Former patient John Rooney 'haunted' by Lissue House abuse

A former patient at Lissue House Children's Hospital in Lisburn has said his memories of the abuse that took place there are frightening.

John Rooney, now a boxing promoter in London, said he is particularly haunted by what happened to a friend of his who suffered from anorexia.

The boy, named Eamon, was weighed every morning and made to stay in bed if he had not gained any weight.

He was also frequently beaten by one male nurse.

"I saw this guy lifting him off the floor and throwing him against the wall," Mr Rooney said.

"The beatings were not a smack or a cuff around the ear, they were physical beatings.

"Eamon was like a little doll... for a grown man to beat him the way he did. The treatment of that kid was totally barbaric."

He said his friend, who was not allowed to speak to his parents if he did not gain weight, later died at the age of 18.

[/news/uk-northern-ireland-15551103]

Lisburn man speaks out about years of suffering at Lissue House

[redacted] claims he was locked in his room, stripped naked, beaten on a regular basis and dragged by the hair down the corridors

Lissue House - the hospital there closed in the late 198Os

A LISBURN man who was abused at Lissue House has spoken out about his years in care.

HIA 172 who still lives in the city, was taken into care at the age of 7 after his parents separated. He was sent to Lissue House where he says he was badly beaten and humiliated on a daily basis.

In 1993, after leaving the care system, HIA 172 reported the abuse to the police but, he says, nothing was ever done about it.

When I told staff at Lissue that I would report them to the police, they laughed in my face and told me no-one would believe me," said HIA 172

"What I have written down is nothing compared to what I had to go through on a daily basis. It wasn't just me."

In a statement made to the police in 1993 HIA 172 told of the treatment he received at the Lisburn hospital, including being locked in his room, stripped naked, beaten on a daily basis and being dragged by the hair down the corridors.

After being caught in the kitchen one night, HIA recalls: "Before I got out of the kitchen door, a member of staff burst through the door and grabbed me by the hair. He dragged me out of the kitchen on my back. I was screaming and shouting. He dragged me along three corridors, through doors where my legs caught. I was in pyjamas and bare feet. He dragged me up two flights of stairs on my back and threw me into my room."

On another occasion HIA remembers having water thrown over him after he tried to barricade himself in his room. "I was pinned down to the floor and stripped naked," he explained. "I was held down on my stomach and given an injection. I was put onto the bed and passed out."

HIA 172 also recalls the harsh treatment another child at the hospital received. "A young girl who was emaciated and had short cropped dyed blonde hair wasn't allowed out of her room.

"She was anorexic and was kept in the furthest room from the common area. She was locked in isolation, given rags to wear and had to earn every privilege by putting on weight.

You had to go past her room to the toilet and she would be standing at the door begging for help, for anyone to talk to. She was never allowed visitors.

"She was a couple of years older than me and I used to sneak her books to read. Her time in Lissue revolved around that room."

HIA 172 who is trying to write a book about his experience of the care system in Northern Ireland, says he is still suffering as a result of his treatment at Lissue House.

"I had shoulder surgery a few years ago because my shoulders were so weak," he explained. 'After I left care they kept dislocating. I believe it was a direct link to the abuse I suffered in care. Staff would often restrain you by putting your arm up your back to the point of dislocation."

HIA has Facebook, where people can share their experiences at the Lisburn hospital.

Police pledge to review abuse allegations

THERE will be a full review of all matters relating to alleged child abuse at the Lissue Hospital in Lisburn, the PSNI has said.

A number of police investigations have already been carried out over a number of years with files sent to the Director of Public Prosecutions and Public Prosecution Service.

The latest investigation will focus on allegations relating to both Lissue House and Forster Green in Belfast-during the 1980s and 1990s.

According to the PSNI, in July this year they received a copy of reviews carried out by various trusts and boards and an initial assessment and review was carried out by police.

A PSNI spokesman said: "When an allegation of criminality is identified, an investigation will be duly conducted by police.

"We would strongly urge any victims of abuse to contact their local team of specially-trained detectives from the Public Protection Unit. All allegations and any new information will be thoroughly investigated."

Health minister Edwin Poots has insisted that his department is cooperating fully with the review.

"I want to reassure the public that my officials have been co-operating fully with PSNI in its investigation into allegations of abuse at Lissue House and Forster Green," he said.

"The PSNI has stated that it is fully confident that senior trust, Board and Department officials are sharing and will continue share information with its investigating team. My officials have shared their internal review reports with the PSNI and will continue to offer whatever assistance they can to see this investigation through to its conclusion.

"I want to make it clear that anyone with any information of use in this investigation should share it with the PSNI," he concluded.

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Ulster Star
04/11/2011

DHI/11/243920

Health and Social Care Board

Monday 28th November, 2011
Lissue and Forster Green Hospitals: statement to *The Irish News*

The HSC Board today acknowledged a request for further information from *The Irish News* about the former Lissue and Forster Green Hospitals. Allegations about the abuse of patients in these former facilities remain a matter of great concern for both the Board and a range of partner agencies. These allegations will be included within and fully considered under an independent Inquiry into historical abuse that has been commissioned by Ministers and the Northern Ireland Executive. This position was confirmed to the Northern Ireland Assembly by the Minister, Mr Edwin Poots MLA, on 7th November, 2011.

With regard to files relating to the former Lissue and Forster Green Hospitals, these are in the possession of the Belfast Trust. It is the Board's expectation that these are being held in safe and secure storage and will be made fully available to the independent historical Inquiry. The Board will, moreover, wish to lend its full assistance to the work of the independent historical Inquiry.

The Board also remains keenly aware that aspects of the allegations involving these former hospitals remain under consideration by the Police Service of Northern Ireland and could result in the future prosecution of individuals. This factor, together with the inclusion of these matters within the forthcoming independent Inquiry into historical abuse, preclude the Board from making further substantive comment or disclosures on the former Lissue and Forster Green Hospitals.

Nevertheless, and throughout all of this, the Board – and the partner agencies – remain mindful of the hurt and trauma that has been suffered by some former patients at Lissue and Forster Green. Arrangements are in place to provide assistance to these individuals, to whom the fullest sympathy and understanding is expressed on behalf of everyone involved.

ENDS.

LIS-11550

DH 1/12/15198

McCullough, Joy

From: Williams, Sarah
Sent: 19 January 2012 08:55
To: Henry, Ronan; Holland, Sean; Jendoubi, Christine; SpAd, DHSSPS; Private Office DHSSPS
Cc: Dempster, Lesley; Hughes, Gerard; Jordan, William; Starrs, Tony; Eland, Joanne; Spence, Thomas; McComish, Paula
Subject: FW: Evening Extra-M Gildernew-Lissue House, Forster Green-18.01.12

FYI – Evening Extra - Lissue

From: EIS Typists [mailto:EISTypists@dojni.x.gsi.gov.uk]
Sent: 19 January 2012 08:53
Subject: Evening Extra-M Gildernew-Lissue House, Forster Green-18.01.12

Programme	**Evening Extra**
Date & Time	**18.01.12 (17.16)**
Subject	**Lissue House/Forster Green abuse allegations**
Prepared By	**Typist: Jennifer Higgins** **MMU: KC**

SEAMUS McKEE

We've more on the Health Minister's announcement that there'll be no further police action in allegations of abuse at Lissue House in Lisburn and Forster Green Hospital in Belfast. Edwin Poots was speaking to the Health Committee on leaked documents which exposed allegations of years of abuse at both institutions.

EDWIN POOTS

We have not been in a position where we could safety take someone to court and prove beyond reasonable doubt that they have been engaged in abuse. That is something that I deeply regret.

SEAMUS McKEE

That was Edwin Poots. Well the chair of the Health Committee was listening to him, Michelle Gildernew's with us. Do you accept what he said that they simply can't bring people to court because they don't have evidence that would bring about a conviction beyond all reasonable doubt?

MICHELLE GILDERNEW

No, I don't and that was put to the Minister quite forthrightly today at the Committee. I believe that the Minister needs to do much much more in terms of identifying the issues at Lissue and building up an evidence base and we saw a situation, indeed I was on the BBC before Christmas talking about the robustness and the way in which John Compton and the Minister went looking for the person who leaked documents to the Irish News. Had the same, I suppose, vigour been applied to trying to speak to members of staff in an environment that enabled them to open up and to talk about their experiences at Lissue, what they saw, what they witnessed, what they experienced, that he could have actually found the evidence. I believe, the Minister did share copies of reports with us, they made very harrowing reading…

SEAMUS McKEE

What do you mean by that? What was harrowing? Just explain what you mean.

MICHELLE GILDERNEW

Well much of what was published in the Irish News back in October/November time was, I suppose, written in a way that didn't, certainly I know the journalist in question Seanin Graham has been accused of sensationalising this story. I read every single report that she did at the time, it was nothing compared to reading the actual Stinson Report, now with names redacted and all the rest of it, but even so, the actual Stinson Report made much much more difficult reading than the reports in the Irish News. So I believe that the journalist who covered that story did it in a very responsible manner. The Minister was able to tell us, when he did the statement to the House, that he had read the Stinson Report. I feel that there is so much in the Stinson Report that I don't believe that enough was done to try and ascertain people's guilt or innocence and to, if people were guilty of, whether it was physical, emotional or sexual abuse of children, that enough was done to bring a case forward and to be able to prosecute.

SEAMUS McKEE

He said considerable effort had been made to recover information and it had been passed to the police?

MICHELLE GILDERNEW

Well I don't believe that considerable effort was enough and I don't believe that this case should be closed and that we should, we can move on. A lot of people who suffered in Lissue or Forster Green or other institutions can't move on, we've seen that very clearly, and I did put it to the Minister that, while we don't hold him accountable for what happened at the time, we'll look to him to ensure that the right thing is done now. That efforts are made to talk to the patients, that efforts are made to talk to the staff and that people who are able now to work within the voluntary sector, within the private sector, who have the ability to work with vulnerable adults and children who have never been brought to book, still have that ability, and I don't believe that enough is being done to protect future generations of children from people who have wrongdoing on their mind.

SEAMUS McKEE

What about the other subject we've been discussing tonight, and that is the condition for patients at Antrim Area Hospital. We've heard a GP on the programme tonight say that he wouldn't want to go there because conditions are so bad and we've heard stories of one person waiting on a trolley, going to the toilet, and coming back to find someone else was occupying that trolley. That's just one instance of what people have been telling the BBC. What's your reaction to that?

MICHELLE GILDERNEW

Well obviously I didn't hear the report from earlier on, I was in the Health Committee. But that certainly is not good enough and for a GP to come out and say that he wouldn't want to go there because of the level of care, that is a very serious allegation to make and I would want the people responsible for managing Antrim Area Hospital to do much much more to ensure that people are being dealt with, they're admitted when they need to be admitted and while they're waiting for admission that they have all of their needs met. I have, I am aware that concerns have been made around time on a trolley and using oxygen and when the canister runs out that it might be a while before a porter is available to change the oxygen container. I would fear, and I don't want to, again I don't want to hype this up or sensationalise it, but certainly it sounds like much more needs to be done to provide a level of care at Antrim Area Hospital where people can be satisfied that everything is being done for the people who come to that hospital.

SEAMUS McKEE

Michelle Gildernew, thanks.

DH/1124554

DRAFT PRESS RELEASE

Thursday 19th January 2012

MINISTER MAKES NEW PLEA FOR INFORMATION ON LISSUE AND FORSTER GREEN

Health Minister Edwin Poots today made a fresh appeal for anyone with information about suspected abuse around Lissue and Forster Green come forward.

"Let me make one thing clear - this case is not closed. I would appeal to anyone, but particularly to people who were on the staff of these facilities, that if they have anything that they could bring forward that would assist us, please come forward and give us the information to the PSNI , to the Health and Social Care Board, or to the Department" he said.

"This is a complex exercise involving people working together across a number of different agencies. We, in the health service, are continuing to liaise with the PSNI to make sure all information is taken into account and nothing is overlooked.

"As my officials told the DHSSPS Committee yesterday we have reconvened the Strategic Management Group which has been convened, not only in respect of any ongoing investigations into the care of children at Lissue and Forster Green Hospitals but also into the historic care of vulnerable adults".

He advised that this SMG has been established in accordance with the "Protocol for Joint Investigations of Alleged and Suspected Cases of Child Abuse – Northern Ireland. The remit of this Group has however been extended to consider how to proceed with regard to any concerns that may arise in relation to the historic care of vulnerable adults which emerge from recent work undertaken by the 5 Health and Social Care Trusts.

He further advised that the SMG will also be the vehicle to co-ordinate joint investigations of any cases of alleged or suspected child abuse that may emerge from the Historical Abuse Inquiry.

Speaking today Minster Poots confirmed that **"Whilst the PSNI have confirmed that no action will be taken in respect of any allegations which have already been investigated unless new evidence comes to light; any recent allegations which have been made and, which are made in the future will be investigated. This includes some new information which has recently been received".**

Notes to Editors:

1. A joint protocol exists for the establishment of a Strategic Management Group to investigate allegations of abuse which can be found at

http://www.google.co.uk/url?q=http://www.rcpc.hscni.net/Publications/ProtocolVideoEvidence.pdf&sa=U&ei=vvoXT8DtBMrKhAfYpszEDA&ved=0CBoQFjAC&usg=AFQjCNF1kLHDrw0WuKW_gcuKK_iOrkIJ-g

2. **Media enquiries to the DHSSPS Press Office on 028 9052 2841. Out of office hours please contact the Duty Press Office via pager number on 07699 715 440 and your call will be returned.**

DH1/11/222486

Draft Press Release

Poots vows to protect the most vulnerable

Health Minister Edwin Poots today promised the Assembly that he would do all in his power to protect children and vulnerable adults from potential abusers.

The Minister was briefing the Assembly on complaints of abuse of children at Lissue and Forster Green Hospitals dating back to the 1980s.

The Minister assured members there has been no cover up within the Health and Social Care sector in investigating allegations of abuse at Lissue and Forster Green Hospitals. He said: **"I can be absolutely clear that there will never be, nor has there previously been any form of a cover up within the Department or the Health and Social Care service, though some individuals who may have been involved in abuse will have tried to cover their tracks.**

"Mr Speaker, let me assure the Assembly, that this issue has never stopped being the focus of attention in my Department, in the Health and Social Care system, and, I believe, in the PSNI.

"I am determined that within my department it is clear that this behaviour was and remains unacceptable and all historical abuse complaints will be dealt with seriously. I want to know what happened. I will demand answers about who was involved so that we can ensure that this type of behaviour is identified quickly and addressed urgently."

The Minister also said that his officials would share all information with the Historical Abuse Inquiry.

"The scope of this inquiry makes it clear that institutions like Lissue and Forster Green are unequivocally within its remit. My Department will co-operate fully with the inquiry team and all information gathered or recorded into historic abuse of individuals or within institutions by the Health and Social Care Board or Trusts or, indeed, by my Department will be shared," he said.

Mr Poots told MLAs in the Assembly Chamber: **"I come to the Assembly today to bring three things: acknowledgement of a very serious situation from the past; assurance that nothing has been, is or will be hidden about what has happened; and assurance of the much improved systems to protect children and vulnerable adults, and minimise the risk in the present day."**

The Minister said he was relieved that the systems set up for protecting children are today more sophisticated.

He said: **"We have come a long way in the past 20 years in making our services for children more caring, safer and more child-centred. Today, all health and social care services for children and vulnerable adults are regulated. Today, our doctors, our nurses, our social workers are all trained in child protection no matter where they work. Today, services are delivered to clear standards.**

And most importantly, today, we realise the importance of listening to children and vulnerable adults, and taking seriously what they tell us."

Notes to Editors:

1. Media enquiries about this press release to DHSSPS Press Office on 028 9052 0074, or out of ours contact the Duty Press Officer via pager number 07699 715 440 and your call will be returned.

2. The statement in full can be read at www.

BBC NEWS

NORTHERN IRELAND

26 October 2011 Last updated at 21:31

Concern at Lissue and Forster Green abuse report 'secrecy'

Stormont health committee chair Michelle Gildernew has raised concerns about the "secrecy" around a report into abuse at two children's hospitals.

The 2009 review, which was never published, detailed abuse at Lissue hospital in Lisburn and Forster Green in Belfast in the 1980s and 90s.

Three allegations were made against members of staff over claims that girls aged between eight and 13 were abused.

The Irish News broke the story after obtaining a copy of the report.

Humiliation

It was compiled by independent health consultant Bob Stinson and completed in January 2009.

It said that two of the allegations of abuse were referred to police but a third was not because it was made some years after the alleged incident took place and, in the view of the report's author, was not corroborated.

The report also detailed concerns about children being asked to undress in front of staff.

In 14 cases, children were alleged to have sexually abused other children while staff also allegedly used humiliation to discipline children.

The 11 such cases of humiliation in the report were described by Mr Stinson as "one of the most disturbing elements of the review."

The review was instigated by the Belfast Trust and the Eastern Health Board after one former patient made a complaint to police.

After a meeting of the health committee on Wednesday afternoon, Michelle Gildernew said the report had "raised more questions than answers".

'Disturbing'

"I think we will certainly want to speak to senior officials within the department (of health) to see why there was such secrecy about this report," Ms Gildernew said.

"I think in the current climate of transparency and accountability, the secrecy around this is very disturbing.

"It will be interesting to see just at what level of the department decisions were taken to keep this so quiet.

"If it was done in the best interests of children, that's one thing. If it was done in the interests of staff, that's another thing entirely."

The health minister Edwin Poots has called the allegations "horrific and appalling".

"People who have vulnerabilities are people who you want to give as much protection to as possible and if what has been alleged transpires to be true, that has obviously not been the case," he added.

BBC NEWS

NORTHERN IRELAND

27 October 2011 Last updated at 17:50

Police to review Lissue House child abuse allegations

The police have said they will carry out a full review into all matters relating to allegations of child abuse at Lissue House near Lisburn.

On Wednesday, the Irish News published details about a report into abuse at the children's hospital and at Forster Green in Belfast in the 1980s and 90s.

The 2009 review, by an independent health consultant, was never published.

Three allegations were made against members of staff over claims that girls aged between eight and 13 were abused.

It said that two of the allegations of abuse were referred to police but a third was not because it was made some years after the alleged incident took place and, in the view of the report's author, was not corroborated.

The report also detailed concerns about children being asked to undress in front of staff.

In 14 cases, children were alleged to have sexually abused other children while staff also allegedly used humiliation to discipline children.

The 11 such cases of humiliation in the report were described by the consultant who compiled it, Bob Stinson, as "one of the most disturbing elements of the review".

The review was instigated by the Belfast Trust and the Eastern Health Board after one former patient made a complaint to police.

The Belfast Health Trust said it reported allegations to the Eastern Board and to the Department of Health.

"We participated fully in the board investigation which followed and carried out all its recommendations to ensure the protection of vulnerable people," it said.

"Where allegations related to people who were working for the trust at that time, these were thoroughly investigated in line with normal disciplinary procedures.

"No formal disciplinary action was taken so no referral was made to the Nursing and Midwifery Council (NMC) in that regard, but the NMC were alerted to an individual who left the trust."

Chairman defended

Earlier, Health Minister Edwin Poots defended the chairman of a new child safeguarding board.

The Irish News reported that Hugh Connor suggested that "some discrimination" should be used when providing police with information from a trust report into allegations of historic child abuse.

Mr Poots said Mr Connor's remarks had been taken out of context.

He said it related only to information which was not relevant.

The Irish News was given a confidential email which was written by Mr Connor, who was then director of social services at the former Eastern Health and Social Services Board.

BBC NEWS

NORTHERN IRELAND

27 October 2011 Last updated at 22:52

Victim recalls Lissue Hospital 'beatings'

A man who says he was abused at Lissue Children's Hospital in Lisburn has given the BBC a harrowing account of suffering at the hands of staff.

The hospital was the subject of a 2009 report into allegations of abuse in the 1980s and 90s.

"The main memories of it were that the staff were terrible. They were always hitting people", said the man, who wished to remain anonymous.

"Personally, I got beat a lot because I didn't eat any dinner," he added.

"Or if I did something stupid, I got the beatings or thrown against the wall or thrown across a table."

Lissue and another hospital, Forster Green in Belfast, were the subject of a report in 2009.

It was never published but a copy was leaked to the Irish News which has reported extensive details of its contents.

The report was commissioned following allegations that girls aged between eight and 13 were abused in both hospitals.

"There was maybe four or five of us that were treated bad," the victim said.

"Any time, there was a window broken, or say, someone drew along the walls with a felt-tip pen, one of us five would have been the ones dragged out and punished for it."

In a statement, police said that they had carried number of investigations into alleged abuse over a number of years.

"In July this year, police received a copy of reviews carried out by various trusts and boards and an intitial assessment and review was carried out by police," the statement said.

"Police are fully committed to carrying out a full and thorough review of all material and have requested further information to assist in this."

More Northern Ireland stories

Talks 'limited but ambitious': Haass
/news/uk-northern-ireland-24128630
The man chairing inter-party talks designed to resolve issues over parades, flags and Northern Ireland's past, says he has a "limited but ambitious" agenda.

Three men admit beating man to death
/news/uk-northern-ireland-24122514

Second north coast whale dies
/news/uk-northern-ireland-24128907

BBC NEWS

NORTHERN IRELAND

31 October 2011 Last updated at 13:26

Former patient John Rooney 'haunted' by Lissue House abuse

A former patient at Lissue House Children's Hospital in Lisburn has said his memories of the abuse that took place there are frightening.

John Rooney, now a boxing promoter in London, said he is particularly haunted by what happened to a friend of his who suffered from anorexia.

The boy, named Eamon, was weighed every morning and made to stay in bed if he had not gained any weight.

He was also frequently beaten by one male nurse.

"I saw this guy lifting him off the floor and throwing him against the wall," Mr Rooney said.

"The beatings were not a smack or a cuff around the ear, they were physical beatings.

"Eamon was like a little doll... for a grown man to beat him the way he did. The treatment of that kid was totally barbaric."

He said his friend, who was not allowed to speak to his parents if he did not gain weight, later died at the age of 18.

[/news/uk-northern-ireland-15551103]

Lisburn man speaks out about years of suffering at Lissue House

[redacted] claims he was locked in his room, stripped naked, beaten on a regular basis and dragged by the hair down the corridors

Lissue House - the hospital there closed in the late 198Os

A LISBURN man who was abused at Lissue House has spoken out about his years in care.

HIA 172, who still lives in the city, was taken into care at the age of 7 after his parents separated. He was sent to Lissue House where he says he was badly beaten and humiliated on a daily basis.

In 1993, after leaving the care system, HIA reported the abuse to the police but, he says, nothing was ever done about it.

When I told staff at Lissue that I would report them to the police, they laughed in my face and told me no-one would believe me," said HIA 172

"What I have written down is nothing compared to what I had to go through on a daily basis. It wasn't just me."

In a statement made to the police in 1993 HIA 172told of the treatment he received at the Lisburn hospital, including being locked in his room, stripped naked, beaten on a daily basis and being dragged by the hair down the corridors.

After being caught in the kitchen one night, HIA recalls: "Before I got out of the kitchen door, a member of staff burst through the door and grabbed me by the hair. He dragged me out of the kitchen on my back. I was screaming and shouting. He dragged me along three corridors, through doors where my legs caught. I was in pyjamas and bare feet. He dragged me up two flights of stairs on my back and threw me into my room."

On another occasion HIA 172 remembers having water thrown over him after he tried to barricade himself in his room. "I was pinned down to the floor and stripped naked," he explained. "I was held down on my stomach and given an injection. I was put onto the bed and passed out."

HIA also recalls the harsh treatment another child at the hospital received. "A young girl who was emaciated and had short cropped dyed blonde hair wasn't allowed out of her room.

"She was anorexic and was kept in the furthest room from the common area. She was locked in isolation, given rags to wear and had to earn every privilege by putting on weight.

You had to go past her room to the toilet and she would be standing at the door begging for help, for anyone to talk to. She was never allowed visitors.

"She was a couple of years older than me and I used to sneak her books to read. Her time in Lissue revolved around that room."

HIA, who is trying to write a book about his experience of the care system in Northern Ireland, says he is still suffering as a result of his treatment at Lissue House.

"I had shoulder surgery a few years ago because my shoulders were so weak," he explained. 'After I left care they kept dislocating. I believe it was a direct link to the abuse I suffered in care. Staff would often restrain you by putting your arm up your back to the point of dislocation."

HIA

Police pledge to review abuse allegations

THERE will be a full review of all matters relating to alleged child abuse at the Lissue Hospital in Lisburn, the PSNI has said.

A number of police investigations have already been carried out over a number of years with files sent to the Director of Public Prosecutions and Public Prosecution Service.

The latest investigation will focus on allegations relating to both Lissue House and Forster Green in Belfast-during the 1980s and 1990s.

According to the PSNI, in July this year they received a copy of reviews carried out by various trusts and boards and an initial assessment and review was carried out by police.

A PSNI spokesman said: "When an allegation of criminality is identified, an investigation will be duly conducted by police.

"We would strongly urge any victims of abuse to contact their local team of specially-trained detectives from the Public Protection Unit. All allegations and any new information will be thoroughly investigated."

Health minister Edwin Poots has insisted that his department is cooperating fully with the review.

"I want to reassure the public that my officials have been co-operating fully with PSNI in its investigation into allegations of abuse at Lissue House and Forster Green," he said.

"The PSNI has stated that it is fully confident that senior trust, Board and Department officials are sharing and will continue share information with its investigating team. My officials have shared their internal review reports with the PSNI and will continue to offer whatever assistance they can to see this investigation through to its conclusion.

"I want to make it clear that anyone with any information of use in this investigation should share it with the PSNI," he concluded.

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Ulster Star
04/11/2011

DHI/11/243920

Health and Social Care Board

Monday 28th November, 2011
Lissue and Forster Green Hospitals: statement to *The Irish News*

The HSC Board today acknowledged a request for further information from *The Irish News* about the former Lissue and Forster Green Hospitals. Allegations about the abuse of patients in these former facilities remain a matter of great concern for both the Board and a range of partner agencies. These allegations will be included within and fully considered under an independent Inquiry into historical abuse that has been commissioned by Ministers and the Northern Ireland Executive. This position was confirmed to the Northern Ireland Assembly by the Minister, Mr Edwin Poots MLA, on 7th November, 2011.

With regard to files relating to the former Lissue and Forster Green Hospitals, these are in the possession of the Belfast Trust. It is the Board's expectation that these are being held in safe and secure storage and will be made fully available to the independent historical Inquiry. The Board will, moreover, wish to lend its full assistance to the work of the independent historical Inquiry.

The Board also remains keenly aware that aspects of the allegations involving these former hospitals remain under consideration by the Police Service of Northern Ireland and could result in the future prosecution of individuals. This factor, together with the inclusion of these matters within the forthcoming independent Inquiry into historical abuse, preclude the Board from making further substantive comment or disclosures on the former Lissue and Forster Green Hospitals.

Nevertheless, and throughout all of this, the Board – and the partner agencies – remain mindful of the hurt and trauma that has been suffered by some former patients at Lissue and Forster Green. Arrangements are in place to provide assistance to these individuals, to whom the fullest sympathy and understanding is expressed on behalf of everyone involved.

ENDS.

LIS-391

STRICTLY CONFIDENTIAL

STRATEGIC MANAGEMENT GROUP

DRAFT FINAL REPORT

DECEMBER 2013

STRICTLY CONFIDENTIAL

CONTENTS:

1. BACKGROUND

In June 2007, following a retrospective review of patient case files within Muckamore Abbey Hospital completed between 2005 and 2009 by the Eastern Health and Social Services Board (EHSSB) and North and West Belfast Health and Social Services Trust, the Department of Health Social Services and Public Safety (DHSSPS) instigated a retrospective sampling exercise across all 5 Health and Social Services Trusts to identify if there were concerns, significant prevalence or similar findings within any other mental health or learning disability inpatient hospital.

The DHSSPS required the retrospective sampling exercise to focus on those people most at risk especially minors (children under the age of 18 years) admitted to mental health and learning disability hospitals over a twenty year period between 1985 and 2005. A 10% sample of relevant files was agreed.

The retrospective sampling exercise encompassed long stay wards in adult mental health hospitals, learning disability hospitals (excluding Muckamore Abbey Hospital which had already been reviewed) and regional child and adolescent inpatient mental health services (which included a specific investigation of Lissue and Forster Green Hospitals commissioned by the EHSSB and latterly the Health and Social Care Board (HSCB) as a result of a complaint detailing serious allegations made when the above exercise was being planned).

Each Trust was asked to follow the methodology applied in the Muckamore Abbey Review which characterised the incidents as follows:

- Category 1: Sexualised behaviour between adult and minor
- Category 1a: Sexualised behaviour between minor and minor
- Category 2: Sexualised behaviour between adult and adult (non-consenting)
- Category 3: Sexualised behaviour between adult and adult (consent unclear)
- Category 4: Sexualised behaviour (consenting)
- Category 5: Suspected sexualised activity (general details unknown)
- Category 6: Physical abuse involving actual bodily harm and above
- Category 7: Sexualised behaviour query significance
- Category 8: Issues noted and dealt with thoroughly using recognised procedures

Between April 2008 and August 2009 eight reports were submitted to the DHSSPS covering ten sites. In late 2011 these reports and other reporting documents (thirteen in total) were handed over by the DHSSPS to the PSNI for further investigation under Operation Danzin.

The PSNI analysis noted that in some of the reported incidents no further police action was required. Other incidents required more detailed information to enable the PSNI to determine what further action, if any, was required.

It was also evident from the PSNI analytical review that the scale and scope of the sampling had been interpreted by Trusts in different ways. This resulted in significant inconsistencies and variances in both methodology and sampling applied within the commissioned reports.

The DHSSPS subsequently requested that the HSCB and PSNI review the retrospective sampling process. The purpose of this review was to provide assurance to the DHSSPS that, where incidents of abuse were noted in the retrospective sampling exercise reports, these had been appropriately identified and dealt with.

After a series of discussions with the DHSSPS, HSCB and PSNI it was agreed to set up a Strategic Management Group (SMG) in accordance with the Protocol for Joint Investigation of Alleged and Suspected Cases of Child Abuse in Northern Ireland (2004), Although established under the provisions of the Protocol in relation to children, in this case the remit of the SMG was extended to include vulnerable adults.

2. STRATEGIC MANAGEMENT GROUP

The SMG was chaired by Fionnuala McAndrew, Director of Social Care and Children, HSCB and Brian Hanna, Detective Superintendent, Serious Crime Branch, PSNI.

The terms of reference for the SMG are included in Appendix 1

A list of members of the SMG is contained in Appendix 2.

The SMG met for the first time on 25 April 2012, and met on a total of 5 occasions. A calendar of meetings is attached in Appendix 3.

The SMG ensured the active cooperation and coordination of all relevant agencies, agreed a joint communication plan (See Appendix 4) and a Human Resources flowchart (See Appendix 5) to assist in the review process. At each meeting of the SMG progress was reviewed. It was agreed that at the conclusion of the SMG process a report would be submitted which addresses the key issues that emerged from the review of the retrospective sampling exercise.

The SMG set up two subgroups to progress the work, one in relation to adult services and the other in relation to children's services.

Each sub-group met on a number of occasions and the terms of reference of each sub-group are contained in Appendix 6 (Adults) and Appendix 7 (Children's).

Health and Social Care Trusts identified senior members of staff to participate in both the Children's and Adults' Sub-groups. They completed audit documentation in relation to either the Children's or Adults Sub-groups on behalf of the Trust and also acted as key liaison individuals in reviewing the information presented within each of the Trust reports.

The PSNI identified a Detective Inspector who participated in both the Children's and Adults Sub-groups and provided advice and guidance in relation to the potential for criminal proceedings in specific cases.

Given the complexity and number of facilities which were subject to the review, members of both the SMG and the relevant sub-groups signed a "Declaration of Interest" indicating whether or not they had managerial or any other type of involvement with the various facilities during the time period under investigation.

A copy of the Declaration of Interest pro forma is included at Appendix 8.

3. HISTORICAL INSTITUTIONAL ABUSE INQUIRY

On 31 May 2012 the First Minister and Deputy First Minister announced an Inquiry into historical institutional abuse in Northern Ireland. The Northern Ireland Executive Inquiry and Investigation into Historical Institutional Abuse Inquiry (HIAI) will examine if there were systematic failings by institutions or the state in their duties towards those children in their care between the years 1922 – 1995.

The Inquiry and Investigation will take the form of

- An Acknowledgement Forum;
- A Research and Investigative Team; and
- An Inquiry and Investigation Panel with a statutory power which will submit a Report to the First Minister and the Deputy First Minister.

A number of cases of interest to the HIAI have already been referred to PSNI for investigation.

As the HIAI has indicated that Lissue and Foster Green will be included in its consideration it is anticipated that the SMG report will be made available to the HIAI to assist where possible.

4. METHODOLOGY:

Given the complexity of the previous exercise and the apparent inconsistencies which had been identified by both the DHSSPS and the PSNI, it was agreed that, in order to provide a more consistent analysis of the exercise, the SMG would develop audit templates to quality assure and analyse the available information.

Audit Template 1 was applied across all the original retrospective sampling exercise reports to ensure that any childcare or adult safeguarding concerns have been identified and addressed, either within Trusts policies and procedures and/or Protocols for Joint Investigation processes with the PSNI.

The template considered the following:

1. Has the Trust complied with the initiating request from DHSSPSNI to undertake a retrospective sampling exercise? If not, what gaps have been identified and what steps is the Trust taking to address these gaps?

2. Have individuals identified as victims been referred to the PSNI for further investigation?

3. Have members of staff in any of the institutions about whom concerns have been expressed been subject to police referral and/or referral to the relevant regulatory and/or professional bodies? If so, when and who took lead responsibility for progressing the concerns within the Trusts?

4. Where investigations were completed at the time of the original allegations, was reference made to the relevant policy and procedures as they pertained at that time and were the investigations carried out in line with the legislation, policy and best practice in place at that time?

5. Were appropriate safeguarding arrangements in place in each of the institutions at the time?

6. What actions, if any, has the Trust set in place following the retrospective sampling exercise and how are these being progressed?

A copy of Audit Template 1 is included in Appendix 9.

The SMG also developed **Audit Template 2** which was designed to capture key information across all Trusts and asked:

- Are the terms of reference included in the report?
- Does the report address the timescale 1985-2005?
- Does the report confirm the 10% sample was reviewed?
- How many files were reviewed in total?

- Does the report address children's files?
- Are specific incidents referred to which identify the victims as adults?
- Is an action plan referenced in the report?
- If yes is it available?
- Are any actions outstanding?
- Does the report fully address the terms of reference?

Each Trust was required to complete this audit template in order to provide a consistent analysis across the five Trust areas in relation to the reports that have been produced. A copy of Audit Template 2 is included in Appendix 10.

Finally, the SMG developed **Audit Template 3** in order to capture specific details on individual cases. A copy of Audit Template 3 is included in Appendix 11.

5. ANALYSIS- ADULT SUB-GROUP

Following the establishment of the SMG, the Adult Sub-group met on 7 occasions. In addition, 2 joint meetings were held with the Children's Sub-group.

4.1 Terms of Reference:

The Sub-group has addressed the Terms of Reference agreed by SMG, that is, to:

- Quality assure the retrospective review process and reports in relation to adults;
- Ensure any issues or concerns in relation to individual adults have been actioned appropriately;
- Ensure that any criminal concerns or issues have been referred to PSNI; and
- Ensure that any Human Resources and regulatory issues have been taken forward by the appropriate Trust or employer.

4.2 Cases involving children:

The initial review of the reports of retrospective sampling exercise indicated that a number of cases involving children had been reported on by adult services. These cases were extracted from the Adult Sub-group return and referred to the Children's Sub-group for their consideration.

4.3 Western HSCT

The retrospective sampling exercise identified **10** incidents where an in-patient or visitor to the hospital may have been subjected to abuse. 1 incident where the victims were noted as being under the age of 18 was passed to the Children's Sub-group for their consideration. Of the adult patients, 6 were identified as female, with gender unspecified for the remainder. All 9 incidents involving adults were described as being of a sexual nature, ranging from alleged indecent exposure to rape.

- 3 incidents occurred in Mourne House (a unit for people with learning disabilities) and involved the same alleged perpetrator ;
- 3 incidents involved patients in the Tyrone and Fermanagh Hospital. One of these patients made 2 allegations of abuse;

- 2 incidents were reported from Gransha Hospital; and
- 1 incident did not indicate which facility was involved.

In all 9 cases, these matters were referred to the PSNI at the time of the original retrospective sampling exercise. 7 were subsequently noted as requiring no further police action, and 2 required further police consideration.

All but one case was closed following review by the PSNI. This case required police investigation but the victim was subsequently assessed as being unfit to engage in any investigative process. The case has now been closed by the PSNI.

No members of staff were named as either alleged perpetrators or victims in any of these allegations.

SMG can, therefore, be satisfied that in relation to the retrospective sampling exercise in the Western Trust:

- any issues or concerns identified in relation to individual adults have been actioned appropriately; either
  - At the time of the original incident;
  - As a result of the retrospective sampling exercises; or
  - As a result of the SMG review process
- any criminal concerns or issues identified were referred to PSNI; and
- no Human Resources or regulatory body issues were identified

4.4 South Eastern HSCT

The methodology adopted by the South Eastern Trust at the time of the retrospective sampling exercise identified a total of 45 incidents for consideration. 39 of these involved patients identified as female, 4 were male, and the patient's gender was unspecified in 2 cases. 1 incident involving a child was referred to the Children's Sub-group for their consideration.

All incidents were categorised as of a sexual nature, ranging from allegations of common assault and indecent exposure to gross indecency. All incidents were reported from the Downshire Hospital.

- 39 of the total of 45 incidents involved 10 alleged perpetrators. Of these, 3 were involved in 2 separate incidents; 3 individuals were involved in 3 separate incidents; 1 was involved in 4 incidents; 1 was involved in 5 incidents; 1 was involved in 6 alleged incidents and 1 was involved in a total of 9 incidents;
- 6 patients alleged that they had been subjected to unwanted sexual advances on more than 1 occasion, ranging from 2 to 8 incidents;
- 1 incident involved the alleged rape of a 76 year old woman. This was reported to the police at the time, and was subject to an initial police investigation. Unfortunately however, due to the circumstances of the offence and the frailty of the victim, it was not possible to pursue a criminal investigation any further;
- Records indicated that on 7 occasions, staff members were subjected to alleged sexual assaults by patients.

No members of staff were named as alleged perpetrators in any of these incidents.

Following the SMG review, a total of **38** incidents, including those incidents where staff may have been subjected to assault, were passed to the PSNI for review. On review of the full papers, all but 5 of these were closed.

Of these 5, which were deemed to require police investigation, 3 have been closed as the victims have been assessed as being unfit to engage in any investigative process. The other 2 relate to cases where the victims are staff members rather than patients and identification details are required to progress the matters any further.

The Trust states that no specific Down Lisburn Trust policies covering the early period of the original retrospective sampling exercise were found, with the earliest extant policies dating from 2002.

Reference was also made by the Trust review team to Eastern Health and Social Services Board policies that were extant in the mid years of the audit, i.e. EHSSB Guidance on Abuse of Vulnerable Adults (1996 and 1997).

SMG can, therefore, be satisfied that in relation to the retrospective sampling exercise in the South Eastern Trust:

- any issues or concerns identified in relation to individual adults have been actioned appropriately; either
  - At the time of the original incident;
  - As a result of the retrospective sampling exercises; or
  - As a result of the SMG review process
- any criminal concerns or issues identified have been referred to PSNI; and
- no Human Resources or regulatory body issues were identified

4.5 Northern HSCT

Due to problems with the original methodology, the Northern Trust took the decision to review all available patients notes considered as part of the retrospective sampling exercise, with the exception of one young person where the Trust could not identify the original incident. This re-audit identified **10** incidents involving adults which required further consideration. 1 of these patients was identified as male. All incidents were categorised as of a sexual nature and were reported from Holywell Hospital.

- An additional incident was identified which involved a 17 year old. To date the Trust has not been able to trace the identity of this young person. Nevertheless, this was referred to the Children's Sub-group for their consideration.
- In 3 of these incidents it is alleged that a member of Trust staff was involved.
- In 1 incident the staff member was named. Trust records show that this incident was investigated on the ward at the time, in that the patient was interviewed by a Consultant Psychiatrist and a Senior Nurse. No contact was made with the PSNI, and the allegation was withdrawn by the patient on the same day. The Trust review team has not been able to find any record either of the allegation or any subsequent investigation.

  The member of staff named was not subject to any internal disciplinary processes, and remained in employment. The staff member resigned from the Trust to work for another provider, but was re-employed by the Trust shortly afterwards. He has since worked in a variety of roles within the Trust, including the provision of community-based care. This matter has now been investigated by the PSNI and the Trust under the Protocol for the Joint

Investigation of Cases of Alleged and Suspected Cases of the Abuse of Vulnerable Adults (2009) and the relevant Human Resources procedures. Both investigations have now concluded and no further action will be taken.

The PSNI reviewed a total of 7 incidents. Upon full review, only one case required police investigation. This has now been investigated by the police and has been closed.

SMG can, therefore, be satisfied that in relation to the retrospective sampling exercise in the Northern Trust:

- any issues or concerns identified in relation to individual adults have been actioned appropriately; either
  - At the time of the original incident;
  - As a result of the retrospective sampling exercises; or
  - As a result of the SMG review process
- any criminal concerns or issues identified have been referred to PSNI; and
- any Human Resources and regulatory issues identified have been taken forward by the Trust.

4.6 Belfast HSCT

The retrospective sampling exercise identified a total of **8** incidents for further consideration, all of which were reported from Knockbracken Healthcare Park. Of these, 5 were categorised as physical, 2 of a sexual nature and 1 case of theft. 6 patients were female.

It was noted that 6 incidents appeared to involve 5 children under the age of 18 years. All of these were referred to the Children's Sub-group for consideration.

One allegation of physical assault was reported to the PSNI and investigated at the time of the incident.

The retrospective sampling exercise also identified one incident which involved the suspected theft of a patient's handbag. Records indicate that this was not referred to the PSNI but was dealt with within the hospital. The PSNI have indicated that no further action is required in relation to this matter.

No members of staff were named or identified as alleged perpetrators in any of these incidents.

SMG can, therefore, be satisfied that in relation to the retrospective sampling exercise in the Belfast Trust:

- any issues or concerns identified in relation to individual adults have been actioned appropriately; either
  - At the time of the original incident;
  - As a result of the retrospective sampling exercises; or
  - As a result of the SMG review process
- any criminal concerns or issues identified have been referred to PSNI; and
- no Human resources or regulatory issues were identified.

4.7 Southern HSCT

The retrospective sampling exercise in relation to adult patients identified a total of **14** incidents for further consideration. 13 of these were drawn from wards in Longstone Hospital (a facility for people with learning disabilities) and 1 was from St Luke's Hospital. 10 cases were categorised as being of a sexual nature, 1 of a physical nature and 3 were uncategorised. 8 cases involved male patients, 2 involved females and in 4 cases the gender of the patient was not specified.

- One incident of physical assault involved a member of staff. The matter was referred to the police. The staff member was subsequently dismissed and was later convicted of assault occasioning actual bodily harm. The individual had been employed as a Nursing Assistant and so was not a member of any regulatory or professional body.
- 1 female patient alleged she had been abused on more than 1 occasion. Insufficient detail is available within the records to clarify if either of these incidents constituted a crime
- 1 male patient alleged he had been abused on 2 occasions. An allegation of physical assault resulted in a prosecution and conviction of a staff member. The records do not contain sufficient detail of the remaining incident to assess if a possible crime may have been committed.

- The retrospective analysis indicates that 3 cases were subject to Strategy Discussions under the Protocol for the Joint Investigation of Alleged and Suspected Cases of Abuse of Vulnerable Adults. However, the outcome of those discussions is not recorded in the hospital notes.

Eight incidents remain outstanding, none of which involved members of trust staff as either alleged perpetrator or victim. The Trust and the PSNI continue to work together to investigate these incidents and this work is almost complete.

The Trust notes that the original retrospective sampling report did not make any comment on whether the practice noted was in accordance with policy or best practice guidance at the time.

SMG can, therefore, be satisfied that in relation to the retrospective sampling exercise in the Southern Trust:

- any issues or concerns identified in relation to individual adults have been actioned appropriately; either
  - At the time of the original incident ;
  - As a result of the retrospective sampling exercises; or
  - As a result of the SMG review process
- any criminal concerns or issues identified have been referred to PSNI; and
- any Human Resources and regulatory issues identified have been taken forward by the Trust.

6. ANALYSIS: CHILDREN'S SUB-GROUP

Children identified through information contained within the relevant reports were subject to discussion within the Children's Sub-group and information forwarded to PSNI for their consideration. While the PSNI will report on their deliberations in a separate section of the report (See Chapter 7), it is clear that a number of cases should have been reported to PSNI either at the time of the incident or during the retrospective sampling exercise.

5.1 Western HSC Trust

Only one incident in the Western Trust was reviewed in the retrospective sampling exercise. The incident involved an adult male patient from Tyrone and Fermanagh Hospital in 1989 and involved 2 child victims. The incident was not referred to police but was referred during the retrospective review. The victims were not known to social services and were not referred for social work intervention at the time. The Protocol for Joint investigation only came into place in 1991 and was therefore not relevant. There will be no further investigation as the victims' identities are not known and cannot now be confirmed.

SMG can, therefore, be satisfied that in relation to the retrospective sampling exercise in the Western Trust:

- any issues or concerns identified in relation to individual children have been actioned appropriately; either
  - At the time of the original incident;
  - As a result of the retrospective sampling exercises; or
  - As a result of the SMG review process
- any criminal concerns or issues identified have been referred to PSNI; and
- no Human Resources or regulatory issues were identified.

5.2 South Eastern HSC Trust

One incident was reviewed under the retrospective sampling exercise which involved sexualised behaviour between an adult patient and a minor. It was reported at the time and police were involved. The alleged offender self-referred to police and subsequently signed the Sex Offenders Register in 1999. The offender was a patient in Downshire Hospital. There is no further follow up required.

SMG can, therefore, be satisfied that in relation to the retrospective sampling exercise in the South Eastern Trust:

- any issues or concerns identified in relation to individual children have been actioned appropriately; either
  - At the time of the original incident;
  - As a result of the retrospective sampling exercises; or
  - As a result of the SMG review process
- any criminal concerns or issues identified have been referred to PSNI; and
- no Human Resources or regulatory issues were identified.

5.3 Northern HSC Trust

One incident was reviewed under the retrospective sampling exercise. The incident involved a 17 year old female patient in Holywell Hospital and involved sexualised behaviour between an adult and a minor. The Trust is unable to identify the original case file so little information is available about the case, and no further information is available that could assist in identifying the case.

In these circumstances therefore, SMG cannot be completely satisfied that in relation to the retrospective sampling exercise in the Northern Trust:

- any issues or concerns identified in relation to individual children have been actioned appropriately; either
  - At the time of the original incident;
  - As a result of the retrospective sampling exercises; or
  - As a result of the SMG review process
- any criminal concerns or issues identified have been referred to PSNI; and
- any Human Resources and regulatory issues identified have been taken forward by the Trust.

5.4 Belfast HSC Trust

At the time of the original retrospective sampling exercise, Belfast Trust reviewed **30** sample incidents, 10 from Lissue Hospital, 10 from Forster Green Hospital and 10 from the Young People's Centre. The audit was undertaken by 2 senior staff from outside the Child and Adolescent Mental Health Service (CAMHS). The audit did not include the 8 point classification used by the Muckamore Audit Team and it remains unclear why this classification was not used.

5.4.1 *Lissue Hospital*

The review of 10 cases within Lissue did not present with any new concerns. A number of former patients have, however, already made contact with the PSNI in relation to historical allegations of abuse. These are being investigated by the PSNI and sit outside the SMG process.

5.4.2 *Young People's Centre*

As part of the retrospective sampling exercise the Trust reviewed facility files but did not review fieldwork or other files. 10 cases were reviewed, none of which identified issues of concern from within the facility. 7 of the cases referenced contextual issues that involved allegations of abuse prior to admission to the Unit. Whilst outside the scope of the SMG these incidents are being reviewed by Trust staff to ensure that any allegations of abuse have been appropriately identified and responded to within agreed protocol and procedures. This includes further discussions with the PSNI to determine if these cases should be referred to the Public Prosecution Service.

5.4.3 *Forster Green Hospital*

Examination of the files from Forster Green revealed that in all but one case, concerns were in respect of overall family functioning or allegations of mistreatment within the wider family circle. One file referenced a young person's allegation of sexual mistreatment by a "doctor"- with another young person in the Forster Green site. This allegation was reviewed by the Children's Sub-group.

The Belfast Trust confirmed that this incident was investigated following the original retrospective sampling exercise. The incident was referred to both the PSNI and the General Medical Council, the professional and regulatory body for doctors. The matter has now been fully addressed and no further action is required.

5.4.4 *Knockbracken Healthcare Park*

As a result of the SMG process, the Belfast Trust identified a further **6** cases in the Knockbracken facility where children and young people may have been involved in incidents which required further investigation. These cases were referred to the PSNI for consideration. While the PSNI concluded that there are no outstanding policing issues and no further police involvement is required, it should be noted that papers in relation to these cases had been destroyed in line with the procedures and timescales set out in Good Management: Good Records (DHSSPS 2011) and so were not available for inspection. Details of the incidents are therefore unknown and cannot be progressed by any police investigation.

SMG can, therefore, be satisfied that in relation to the retrospective sampling exercise in the Belfast Trust:

- any issues or concerns identified in relation to individual children have been actioned appropriately; either
  - At the time of the original incident;
  - As a result of the retrospective sampling exercises; or
  - As a result of the SMG review process

- any criminal concerns or issues identified have been referred to PSNI; and
- any Human Resources and regulatory issues identified have been taken forward by the Trust.

5.5 Southern HSC Trust

There were **19** incidents identified within the Southern HSCT area involving 10 victims. Two victims were involved in two separate incidents, one was involved in three incidents, and one was involved in 5 separate incidents. 6 of the alleged perpetrators' identities are not known and 13 of the alleged perpetrators are recorded as patients.

- One incident from 1997 involved a staff member. The records indicate that the staff member allegedly discussed pornographic material with a 16 year old (male) patient. This case is being reviewed by police and Trust personnel. The staff member is no longer employed by the Trust. In reviewing the files in relation to this case, the police identified a further allegation by the victim of rape when he was aged 5 and living in a Children's Home This had not been previously reported to Police but is now subject to further investigation by police and Trust personnel. This part of the investigation is not part of the SMG process.

- One alleged perpetrator is involved in two incidents; another is involved in 4 incidents.

- One alleged perpetrator offender is deceased and one victim is believed to be deceased.

- The police are actively reviewing Trust files to further investigate 15 of the incidents to determine if they can be cross referenced and additional information obtained.

- 6 incidents are recorded as category 1 with a further 2 considered as category 1. There are 5 deemed as category 5 with a further 1 considered as category 5. There is one case noted as category 7 and a further case assessed as possibly category 8. There are 3 incidents where it is not recorded.

In a number of the noted incidents the information available to the retrospective sampling exercise was limited. As a consequence, the Trust set up a process to review information contained in other files not considered by the retrospective sampling exercise, such as field work files to determine if further investigations or actions may be required.

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Following full review of the available information by the PSNI, 4 cases were identified as requiring police investigation. These 4 cases all involve the same victim. 2 of the cases have been referred for investigation; the remaining 2 require further information from the trust to enable the PSNI to progress the investigation.

SMG can, therefore, be satisfied that in relation to the retrospective sampling exercise in the Southern Trust:

- any issues or concerns identified in relation to individual children have been actioned appropriately; either
  - At the time of the original incidents a result of the retrospective sampling exercises; or
  - As a result of the SMG review process
- any criminal concerns or issues identified have been referred to PSNI; and
- any Human Resources and regulatory issues identified have been taken forward by the Trust.

7. PSNI ANALYSIS FROM AUDIT RETURNS

The PSNI provided the following report for the SMG:

6.1 Adult Sub-Group

Police were handed documents relating to the Belfast and Western Health & Social Care Trusts on 16th November 2012 during a meeting with Ms Joyce McKee, Regional Adult Safeguarding Officer, Health and Social Care Board. The remainder of the Trusts then submitted reports via email following internal audits.

6.1.1. Belfast Health & Social Care Trust

Belfast Health & Social Care Trust referred 8 cases as part of their audit.

Of these 8 cases 2 (one relating to a physical assault and the other to a theft) were reviewed and no police investigation was required.

The remaining 6 cases all involved a child victim and, as such, were referred to the Children's Sub-group for comment.

6.1.2. Western Health & Social Care Trust

Western Health & Social Care Trust referred 10 cases as part of their audit.

Of these 10 cases only 1 was reported to Police at the time however there were a further 7 cases which contain reference to having been reported to Police at a later date as part of a retrospective review and Police recommended no further action at that stage.

In the remaining 2 cases one case was closed during review. One case was identified as requiring police investigation. However, the victim had been assessed as unfit to engage in any investigation and therefore the case has been closed.

There is 1 case reported by Western Health & Social Care Trust which has been duplicated on the Child return – this case is one of those which were retrospectively reviewed by Police and no further action was recommended.

6.1.3. Southern Health & Social Care Trust

Southern Health & Social Care Trust referred 14 cases as part of their audit.

Of these 14 cases there were 3 cases which had previously been reported to Police and therefore no further report is required.

Following an initial review 8 cases have been identified as requiring further information. Full papers are awaited so that decision can be made as to whether a police investigation is required.

There are also 4 cases included in Southern Health & Social Care Trust's Child Return which involve an adult injured party but where the suspect in the case is a minor. These four cases require further information in order that Police can make a formal decision whether to investigate the matter or not.

7.1.4. South-Eastern Health & Social Care Trust

South-Eastern Health & Social Care Trust referred 45 cases as part of their audit.

Of these 45 cases there were 2 cases which were reported to Police at the time of the alleged offence and therefore no further report is required.

Following an initial review, 38 cases were identified as requiring further information. Papers in these cases have now been reviewed and 5 were identified as requiring police investigation.

Of these 5 cases, 3 have been closed as the victims have been assessed as unfit to engage in any investigative process. The remaining 2 cases involve members of staff as victims rather than patients. Identification and contact details are required to progress these details.

There is one duplication of a case with the Child return. However this was one of the cases which were reported to Police at the time of the alleged offence and therefore no further report is required.

6.1.5. Northern Health & Social Care Trust –

Northern Health & Social Care Trust referred 11 cases as part of their audit.

Of these 11 cases there were 4 cases which were reported to Police at the time of the alleged offence and therefore no further report is required.

There are a remaining 7 cases where further information was required in order that Police could make a formal decision whether to investigate the matter or not. Following this review only one case required police investigation. This was passed to the relevant department and an investigation was initiated. This has now concluded and no further action is required.

6.2 Children Sub-Group

6.2.1 Belfast Health & Social Care Trust

Belfast Health & Social Care Trust referred 6 cases as part of their audit. All of these 6 cases had previously been raised under the Adult SMG return.

Of these 6 cases there was only 1 case reported to Police at the time of the alleged offence and therefore no further action is required.

Papers for the remaining 5 cases have been destroyed and therefore none of these matters could be fully progressed or reviewed. A specific query was raised by Belfast Health & Social Care Trust in relation to a complaint against a doctor attached to Forster Green In-Patient Unit in 1993. A report was prepared as the case had come to light following an audit of files in October/November 2009. The report has been reviewed and as the Trust cannot identify the nurse no further action is required.

A further 7 cases have been referred from the Young People's Centre. These relate to matters occurring outside of a care environment but which had been reported or disclosed whilst the victims were in care. These cases all require police investigation. However, current contact details need to be confirmed before this matter can be progressed.

6.2.2. Western Health & Social Care Trust

Western Health & Social Care Trust referred 1 case as part of their audit. This case had already been highlighted as part of the Adult return and, whilst the matter was not reported to Police at the time of the alleged offence, the papers comment that the case was the subject of a retrospective review and was discussed with Police at that time and no further action was recommended.

6.2.3. Southern Health & Social Care Trust

Southern Health & Social Care Trust referred 19 incidents as part of their audit. One of these cases has already been highlighted within the Adult return.

Of these 19 incidents there were 3 cases which were reported to Police at the time of the alleged offence and therefore no further report is required (although it is believed one of these may be a duplication).

There are 4 cases included in the return which involve an adult injured party but where the suspect in the case is a minor.

All the referred cases have been reviewed and a police investigation is required in relation to 4 cases. These 4 cases all involve the same victim. 2 of the cases have been referred to the relevant department for investigation and the matters are on-going. The remaining 2 cases await information from the Trust in order to progress.

6.2.4. South-Eastern Health & Social Care Trust

South-Eastern Health & Social Care Trust referred 1 case as part of their audit. This case had already been highlighted as part of the Adult return. The case had previously been reported to Police and therefore no further report is required.

6.2.5. Northern Health & Social Care Trust

No papers were received from Northern Health & Social Care Trust as part of the Child return. However one case was identified within the Adult return involving a

female aged 17 at the time of the alleged offence. This case could not be progressed as no papers were available and therefore no review can be carried out.

6.2.6. Current Investigations

As of 1 January 2013, there are a further 69 cases which have been reported directly to the police or have been referred by the Historical Institutional Abuse Inquiry. All of these cases involve injured parties who were children at the time of the alleged offence(s). The date range of these complaints is far wider than that of the SMG audit, with complaints ranging from 1953 to 2007.

Police decisions on these matters will take into account the evidence and documentation available at this time; the injured party and the time of the alleged offence. There will also be consultation with the Public Prosecution Service and, prior to recommending any prosecution, consideration will be given as to whether it is in the public interest to pursue some of the alleged cases.

8. CHANGES IN POLICY AND PROCEDURES:

The agreed time period for review was a twenty year period between 1985 and 2005. However, some of the incidents considered in the retrospective sampling exercise occurred as far back as 1971, with others having taken place as recently as 2004.

Over that period there have been significant changes in clinical practice as well as legislation, policy and procedures on how to respond to and investigate allegations of abuse.

There has also been recognition that effective treatment and care for people with mental health problems or learning disabilities can be provided in community settings or in smaller group living arrangements. As a result, fewer people are living in or being admitted to mental health and learning disability in-patient facilities.

These and other developments such as improvements in professional and in-service training have contributed to a positive change in the culture of mental health and learning disability in-patient facilities since the 1970s. Both processes and practice across a range of settings and professional groups have been significantly enhanced so as to afford greater protection to children and vulnerable adults. These developments include but are not restricted to:

- The United Nations Convention on the Rights of the Child 1989
- The Children (Northern Ireland) Order 1995, supplementary legislation and associated volumes of guidance
- Revision of DHSSPS Children 'Sharing to Safeguard (Revised HSCC 3/96)
- The Human Rights Act 1998
- Co-operating to Safeguard Children (DHSSPS 2003) (currently being revised)
- The Bichard Inquiry Report 2004
- Equal Lives (2005)
- Strategic Framework for Adult Mental Health Services (2005)
- UN Convention on the Rights of People with Disabilities (2006)
- SSI Overview Report 'Our Children and Young People - Our Shared Responsibility' (Dec. 2006) ("SSI Overview Report 2006")
- Safeguarding Vulnerable Adults: Regional Adult Protection Policy and Procedural Guidance (2006)

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- Criminal Justice (Northern Ireland) Order 2008 and Guidance on Public Protection Arrangements Northern Ireland (NIO) 2008

- Independent Review Report on Agency Involvement with Mr Arthur McElhill, Ms Lorraine McGovern and their Children - Henry Toner QC (June 2008)
- The Sexual Offences (NI) Order 2008
- Understanding the Needs of Children in Northern Ireland (UNOCINI) DHSSPS 2008
- The Protection of Children in England - A Progress Report - Lord Laming (March 2009)
- Protocol for Joint Investigation of Alleged and Suspected Cases of Abuse of Vulnerable Adults (2009)
- Adult Safeguarding in Northern Ireland: Regional and Local Partnership Arrangements (2010)
- Manual of Practice: Public Protection Arrangements in Northern Ireland (December 2010)
- Reporting and Follow up of Serious Adverse Incidents (HSCB 2010)
- Achieving Best Evidence Guidance on interviewing victims and witnesses, the use of special measures, and the provision of the pre-trial therapy (2011)
- Justice Act (Northern Ireland) 2011
- Records Management: Good Management Good Records (DHSSPS 2011)
- Safeguarding Board for Northern Ireland - Policy Framework Safeguarding Board (Northern Ireland) Act 2011
- RQIA Review of the Effectiveness of the Safeguarding Arrangements in place for Children and Vulnerable Adults in Mental Health and Learning Disability Hospitals in Northern Ireland (2012)

In addition, Trust governance and information management systems now record incidents involving individual service users or staff members and ensure that these are escalated to the appropriate senior managers for action.

9. RECORDS MANAGEMENT

In 2011 the DHSSPS published "Good Records Good Management" as a guide to the required standards of practice in the management of records.

This guidance provides a framework for consistent and effective records management based on advice and publications from the Ministry of Justice and the Public Records Office of Northern Ireland. In establishing this guidance the DHSSPS took account of current practice followed by a wide range of organisations in both the public and private sectors, recommendations emanating from reviews, guidance from professional organisations and bodies, and importantly what the law requires.

"Good Records Good Management" applies to both adult and children's services and to all services, whether delivered in the community or in a hospital, and includes guidance on the retention and destruction of records.

Some of the records from the period of the original retrospective sampling exercise have been destroyed by Trusts in keeping with this guidance. This is particularly relevant in the Northern and South Eastern Trusts.

It also became evident through the work of the SMG that while each service area and specialism maintains its own record of contact with individual service users, these are not routinely cross-referenced. As a result, it is clear that each Trust considered only records from within mental health and learning disability facilities and did not examine individual service user's community-based records. For example, hospital staff were not always aware that a safeguarding investigation was underway in the community, and community staff were not always aware that an allegation of abuse had been made by a hospital in-patient.

Reference has already been made to the lack of formal Terms of Reference for the original retrospective sampling exercise. The SMG acknowledges that, given the time scale for reporting on the original retrospective sampling exercise, it would simply not have been possible for audit teams to examine all records for each individual, even if this had formed part of the original Terms of Reference.

The amount of time that has elapsed and the absence of a central repository of Trust internal operational policies have meant that it has not been possible for the SMG to examine some issues in any detail. For example, issues of ethnicity, race and diversity were not routinely recorded in the 1970's and 80's. It has not, therefore, been possible for the SMG to comment on these areas.

10. SUMMARY OF FINDINGS:

The PSNI and the Adult and Children's Sub-groups reviewed the available information against the Terms of Reference set for the SMG using specially designed audit templates to analyse the information. In relation to each of the Terms of Reference, the Sub-groups would make the following comments:

- Quality assure the retrospective review process and reports in relation to adults

The methodological challenges with the retrospective sampling exercise have already been noted elsewhere and include:

- Inconsistent application of time frames;
- Inconsistent sampling including numbers of cases and records considered;
- Variation in recording of the audit findings; and
- Variation in the analysis of the findings.

A further variation has arisen in relation to the quality assurance of the original sampling exercise and the assessment of whether the actions taken at the time of the original incident were in accordance with best practice. This has varied from a reliance on the knowledge and integrity of the original auditors, through to a complete re-audit of patient files.

The Sub-groups were unable to identify all the policies, procedures, protocols and good practice guidance that regulated practice during the time period considered by the retrospective sampling exercise. A limited list has been compiled, but it is believed to be incomplete. It is therefore difficult to assess whether practice as noted in the contemporaneous notes available to the retrospective sampling exercise, was always in accordance with the policies, procedures and best practice guidance of the time.

- Ensure any issues or concerns in relation to individuals have been actioned appropriately

All issues which have been identified in relation to individuals have been actioned, either:

- At the time of the original incident;
- As a result of the retrospective sampling exercises; or

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- As a result of the SMG review process.

These actions included a review by PSNI of any incidents where it is alleged or suspected that a criminal offence may have taken place and, where appropriate, referral to the relevant Trust Human Resources process or regulatory body.

- Ensure that any criminal concerns or issues have been referred to PSNI

It is clear from the retrospective sampling exercise reports that a number of incidents involving individuals should have been passed to the PSNI for further investigation at the time the incident occurred. Where it has been possible to identify either the victim or the alleged perpetrator, this has now been done. All completed audit templates have been shared with PSNI.

However the PSNI have identified the following challenges in relation to any investigations:

- The criminal law has changed since the timeframe covered by the original sampling exercise and some offences have been de-criminalised;
- Trusts have not been able to identify either the alleged victim or the alleged perpetrators in some cases;
- Due to the lengthy period of time that has elapsed since the alleged incidents took place, it may not be possible to establish if the threshold for criminal activity has been reached;
- A number of the incidents are now statute barred;
- Some of the relevant patient records will have been destroyed in accordance with Records Management: Good Management Good Records (DHSSPS 2011).

- Ensure that any Human Resources and regulatory issues have been taken forward by the appropriate Trust or employer

Adult Sub-group:

A total of 4 incidents within the Adult Sub- group (1 from the Southern Trust and 3 from the Northern Trust) have been identified where it is alleged that abuse took

place and where the alleged perpetrator was a member of Trust staff. These instances of alleged abuse were all identified in patient records at the time of the alleged incident and were highlighted by the retrospective sampling exercise.

In one of these incidents, the staff member concerned was subject to both criminal and employer investigations and was dismissed from Trust employment on conviction.

In one incident, the Trust has determined there are no grounds to take forward an internal disciplinary procedure or for referral to a professional or regulatory body.

However, in 2 incidents (from the Northern Trust), it has not been possible either to identify the alleged perpetrators or victims, or to determine if the conduct warranted referral to a professional or regulatory body. Consequently it has not been possible for the Trust to take forward any HR or regulatory matters in relation to these individual members of staff.

Children's Sub-group:

A total of 4 incidents within the Children's Sub-group have been identified where it is alleged that abuse took place and where the alleged perpetrator was a member of Trust staff.

3 of these were from the Belfast Trust. In one case a referral was made to the relevant regulatory body and Trust HR procedures were implemented. This case is now concluded with no further action required. In two other incidents the allegations were investigated and no further action is required.

1incident from the Southern Trust involved a member of staff who is no longer employed by the Trust.

10. Learning and Next Steps:

The SMG has identified a number of areas of learning through the course of this review.

1) It was difficult to reconcile the processes and methodologies used by the different Trusts in the original retrospective sampling exercise. In any future reviews the following should be considered in order to ensure consistency of reporting:

   - agreed, clear Terms of Reference from the start which set out the required reporting timescales should be available;
   - the establishment of a Monitoring Group (including representation from the PSNI) to oversee the review process and agree the final Report ; and
   - the methodology along with any appropriate audit tools should be based on the Terms of Reference and should be available from the beginning of any investigation.

   The procedures for the establishment of a Strategic Management Group set out in the Protocol for Joint Investigation of Alleged and Suspected Cases of Child Abuse (2004) were particularly helpful for this review, and could be used as a model for any future reviews of this kind.

2) The SMG only considered the findings of the original retrospective sampling exercise which in turn reflected on practice between 1985 and 2005. While there has been significant progress in safeguarding arrangements, processes and practice in the interim period, there is a need for constant vigilance to ensure that the systems in place to protect vulnerable children and adults are as robust as possible. The SMG is aware that the Regulation and Quality Improvement Authority (RQIA) has recently completed an inspection on this theme. The SMG recognises that the HSCB and PHA have a responsibility to ensure that the recommendations contained in the RQIA report "Safeguarding of Children and Vulnerable Adults in Mental Health and Learning Disability Hospitals in Northern Ireland – Overview Report (2013)" are fully implemented. The HSCB and PHA have established a formal reporting process on the implementation of these

recommendations, which includes individual reports from and meetings with Trusts, plus a schedule of reports to the DHSSPS.

3) It was apparent that information relating to allegations of abuse during an admission to an in-patient facility was noted on facility files, but it was not clear if these were subject to proper process, including referral to the PSNI under the Joint Protocol arrangements. Nor was it clear from the records that clinical teams in in-patient facilities were always aware of new or continuing safeguarding investigations in community settings. It is important that in all cases other relevant Trust records, including fieldwork files, Looked After Children records and community services files are cross-referenced so that all relevant information be considered to ensure a more consistent and holistic assessment of a safeguarding concern.

4) The original retrospective sampling exercise considered only 10% of files from the period 1985 to 2005. The SMG recognises that there may be incidents falling outside the audit period or sample size where former patients of mental health or learning disability facilities believe that they were subjected to inappropriate or abusive behaviours during their stay in hospital. The SMG would encourage any former or current patient who feels that they are in this position to contact the PSNI, HSCB or relevant HSC Trust who may then need to consider what actions, if any, may be required. To promote a culture of openness and transparency, it would be necessary to establish a point of contact for individuals and their families or carers who may wish to raise concerns and to have them addressed on an individual level. The promotion of the HIAI will also afford further opportunity for individuals to come forward if they consider that the care afforded to them when in an institution was of an abusive nature and they wish this to be explored further.

5) Throughout this review it has been difficult to access internal legacy Trust and Board policies and procedures which applied at different times throughout the sampling period. A central archive would allow any future inquiry or investigation to access the relevant policies and procedures quickly and easily. This in turn would allow for a clearer and quicker determination as to whether best practice

and policy guidance was adhered to at the time. The HSCB will discuss this with the DHSSPS to consider the value of creating such a regional archive

11. CONCLUSIONS:

The Strategic Management Group (SMG) was set up to take forward a specific piece of work, that is, to consider issues arising out of the retrospective sampling report carried out by the 5 Health and Social Care Trusts and to provide assurance to the DHSSPS that, where incidents of alleged abuse were noted in the retrospective sampling reports, these have been appropriately identified and dealt with.

The retrospective sampling exercise encompassed long stay wards in adult mental health hospitals, learning disability hospitals (excluding Muckamore Abbey Hospital) and regional child and adolescent inpatient mental health services and covered the period 1985 - 2005.

To progress this work, the SMG set up two sub-groups, one in relation to adult services and one in relation to children's services. A number of audit tools were devised and applied to the retrospective sampling exercise reports provided by each Health and Social Care Trust. This work is now complete.

The findings from the audit process were analysed by both sub-groups and shared with colleagues in the PSNI. A total of 77 incidents were referred to the PSNI for consideration and comment. Two incidents led to referral to an appropriate regulatory and/or professional body.

In addition, Belfast and Southern Trusts are reviewing additional files that were not part of the original retrospective sampling exercise, to provide assurances that any contextual issues or concerns have been appropriately followed up.

The SMG is able to provide assurance to the DHSSPS that, with one exception in the NHSCT, 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; either
  - At the time of the original incident;
  - As a result of the retrospective sampling exercise; or
  - As a result of the SMG review process

- Any criminal concerns or issues have been referred to PSNI; and
- Any Human Resources and regulatory issues have been taken forward by the appropriate Trust or employer.

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APPENDIX 1 – SMG TERMS OF REFERENCE

STRATEGIC MANAGEMENT GROUP

TERMS OF REFERENCE

Introduction

The Department of Health, Social Services and Public Safety (DHSSPS) have engaged in a series of discussions with the Health and Social Care Board (HSCB) to set up a Strategic Management Group (SMG) in accordance with the Protocol for Joint Investigation of Alleged and Suspected Cases of Child Abuse in Northern Ireland (2004) (the Protocol).

Although established under the provisions of the Protocol in relation to children, in this case its remit will be extended to include vulnerable adults.

The SMG will conduct a Review of the work undertaken by the 5 Health and Social Care Trusts (HSCTs) which sampled case records of patients in Mental Health and Learning Disability hospitals in the period 1985 to 2005. The purpose of this limited retrospective sampling exercise was to provide assurance to the DHSSPS that. Where incidents of abuse had occurred in the past, these had been appropriately identified and dealt with.

The Review will also include consideration of the conclusions of investigations relating to Lissue and Forster Green Hospitals.

The Regulation and Quality Improvement Agency (RQIA) have been commissioned by the DHSSPS to review the effectiveness of the current safeguarding arrangements for children and vulnerable adults within Mental Health and Learning Disability Hospitals in the Trusts. The SMG will therefore not address current safeguarding arrangements. The SMG will liaise closely with RQIA to address any potential safeguarding issues which may emerge during the course of its review and to follow up issues identified in the Overview Report prepared by RQIA at the conclusion of its process.

Definition of Abuse:

The SMG will use the definition of organised abuse contained in the Protocol, and extend the definition to both children and vulnerable adults.

The Protocol defines organised abuse in three main settings, families, communities and institutions. Section 6.3 of the Protocol refers to institutions where an adult or adults, employed in the public, private or public sector, abuses the children he or she works with. Section 6.8 of the Protocol states that:

"Institutional abuse is abuse by adults working in a position of trust, either in an employed or voluntary capacity, in an organisation or association that has responsibility for or provides activities for children. The organisation or association acts as the organisational base bringing adults and children together which provides the opportunity for exploitation by abusers. Institutional abuse often involves abuse of many children over a long period of time".

Membership:

The SMG will be Co-Chaired by the Police Service of Northern Ireland (PSNI) and Health and Social Care Board (HSCB).

Membership will include:-

Fionnuala McAndrew HSCB	Aidan Murray HSCB
Tony Rodgers HSCB	Philip Moore HSCB
Paula Smyth BSO	Alphy Maginnis BSO
Donald Glass PSNI	Paul Darragh PHA
Lesley Walker BHSCT	Marie Roulston NHSCT
Oscar Donnelly NHSCT	Trevor Millar WHSCT
Brice McMurray SHSCT	Michael Hoy SEHSCT
Mary Hinds PHA	Marian Hall HSCB
Brian Hanna PSNI	Kieran Downey WHSCT

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Paul Morgan SHSCT	Ian Sutherland SEHSCT
Francis Rice SHSCT	Brendan Whittle SEHSCT

In addition the SMG will extend an invitation to one or more recognised experts from outside Northern Ireland who can also act as independent persons to provide professional oversight and ensure greater transparency during the review.

Functions of the Strategic Management Group

The SMG will fulfil the following functions: -

- Develop policy relating to the Review;
- Establish the principles of the conduct of the Review
- Address the issue of resourcing of the Review which will fall into two categories:-
  - Logistical resources - transport, accommodation, staff cover, etc; and
  - Staff resources –which includes administration support
- Act on a consultative basis to professionals involved in the audit of the retrospective sampling exercise
- Ensure co-ordination between the key agencies, which have an interest in the progress of the Review
- Provide regular updates to the DHSSPS on the progression of the Review
- Draw up a communication strategy.

The SMG will **not** be responsible for any Human Resource issues that may be identified within any of the institutions involved but will refer these directly to Senior Management in the respective Trusts for consideration and action as appropriate. It will be a matter for Senior Management in those agencies to actively consider referral to regulatory bodies and/or the professional associations of any staff identified during the course of the review about which concerns have been expressed either in relation to their professional conduct and or ongoing criminal investigations.

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Process

The SMG will meet within agreed timescales and as often as deemed necessary to discuss the progress of the Review and will take forward the following: -

a) Consideration of the retrospective sampling exercise undertaken by all five HSC Trusts and identify any particular gaps/issues which may require a further review of particular cases by developing and applying an audit tool.
   The audit template will consider the following:
   1. Have Trusts complied with the initiating request from DHSSPS to undertake a retrospective sampling exercise? If not, what gaps have been identified and what steps is the Trust taking to address these gaps?
   2. Have individuals identified as victims been referred to the PSNI for further investigation?
   3. Have members of staff in any of the institutions about whom concerns have been expressed been subject to police referral and/or referral to the relevant regulatory and/or professional bodies? If so when and who took lead responsibility for progressing the concerns within the Trusts?
   4. Were investigations completed at the time allegations were made with reference to policy and procedures as they pertained at the time and were they in line with extant legislation, policy and best practice at the time?
   5. Were safeguarding arrangements appropriate in each of the institutions at the time?
   6. What actions if any have Trusts set in place following the retrospective sampling exercise and how are these being progressed?

b) The information technology and administrative support in order to take forward the investigation; and

c) Identify any specialist advice which is required such as legal, medical, psychiatric, cultural or special needs;

Children and adults who may require support and who are identified through the process of this review will be offered support and/ or counseling by an appropriate organization. Any children or adults named by others, regardless of whether they have made statements or not, who may require individual help will be offered support or advice as appropriate. Individuals, both victims and alleged perpetrators, may also

be referred to PSNI who will be responsible for undertaking any criminal investigations

It is recognised that the Review cuts across a number of Trust and PSNI boundaries and the following key points will be considered at all times.

- The continuing safety of children and vulnerable adults;
- Appropriate sharing of information; and
- Lack of contamination of evidence.

The SMG will ensure that lines of communication are well established between the Review Work Groups and the Trusts that have carried out the retrospective sampling exercise and which have responsibility for Lissue and Forster Green Hospitals.

At each meeting the SMG will:

- Review progress
- Review all aspects of the strategy
- Provide advice on the appropriate strategic direction;
- Ensure the continuing active co-operation of all relevant agencies;
- Agree a joint approach to media interest; and
- Produce an accurate record of all meetings held.

In particular, the SMG will consider the following:

- The aims of the investigation: -
  - Protection of Children and vulnerable adults
  - Identification of possible criminal offences
  - Evidence gathering; and
  - Consideration of other possible victims.
- The context of the investigation: -
  - The culture of the institutions
  - Ethnicity, race and diversity issues
  - Consideration of resource implications;
  - Possible community interest and reaction;
  - Media/union/professional association interest; and

- Public profile/status of alleged abuser(s) or victim(s).

- Handling Information: -
  - Arrangements for handling information obtained in the Review
  - Managing confidentiality; and
  - The need to make other organizations aware of abuse allegations concerning their staff in order that they can take steps necessary for child or vulnerable adult protection within their respective organizations and other Human Resource considerations where appropriate.

Work Groups

Two work groups will be established to consider issues relevant to adult and children's services arising from the retrospective sampling exercise and the Lissue and Forster Green Hospital reports, and will make comment on the quality and appropriateness of Trust responses.

Welfare Principle

As with all investigations of abuse of children or vulnerable adults, care must be taken to ensure that the welfare of the child and vulnerable adult remains paramount. Whilst the gathering of criminal evidence is important, it must not be to the detriment of any child or vulnerable adult's welfare. Although investigations to establish the standard of evidence for criminal proceedings are important, the need to protect the child or vulnerable adult, which requires a lesser standard of proof, should not be delayed. Individual/group support to children, vulnerable adults and their families as appropriate should always be considered.

The SMG recognises that whilst some children may have been subjected to abuse or inappropriate treatment, they are now adults and may not wish to have or require ongoing social work involvement. All cases in which abuse is suspected will be referred to PSNI for criminal investigation.

Conclusion

At the conclusion of the Review the SMG will meet to discuss the salient features of the Review and make recommendations for improvements either in policy or in practice.

Recommendations should be communicated to the Chair of the Regional Child Protection Committee (RCPC) or Safeguarding Board for Northern Ireland (SBNI) (if established), the Chair of the Northern Ireland Adult Safeguarding Partnership and the PSNI for further consideration and any necessary action.

A written report will also be sent by the SMG to the DHSSPS to inform future strategic and policy developments.

APPENDIX 2 –SMG MEMBERSHIP:

Fionnuala McAndrew, HSCB Co-Chair
Brian Hanna, PSNI, Co-Chair
Tony Rodgers, HSCB
Paula Smyth, BSO
Donald Glass, PSNI
Lesley Walker, BHSCT (subsequently replaced by Cecil Worthington)
Oscar Donnelly, NHSCT
Bryce McMurray, SHSCT
Aiden Murray, HSCB
Phillip Moore, HSCB
Alphy Maginness, BSO (Legal Department)
Paul Darragh, PHA
Cecil Worthington, NHSCT (subsequently replaced by Marie Roulston)
Trevor Millar, WHSCT
Michael Hoy, SEHSCT
Mary Hinds, PHA
Paul Morgan, SHSCT
Francis Rice, SHSCT (subsequently replaced by Miceal Crilly)
Marian Hall, HSCB
John Doherty, WHSCT (Later replaced by Kieran Downey)
Ian Sutherland, SEHSCT
Don Bradley, SEHSCT

In attendance:

Martin Quinn, HSCB
Joyce McKee, HSCB

APPENDIX 3 – SMG CALENDAR OF MEETINGS:

The SMG met on the following occasions:

- Wednesday 25 April 2012
- Friday 21 September 2012
- Friday 23 November 2012
- Thursday 24 January 2013
- Thursday 21 March 2013

ADULT SUB-GROUP: MEETING DATES

- 9 July 2012
- 14 September 2012
- 9 November 2012
- 7 December 2012
- January 2013
- 1 February 2013
- 29 March 2013

CHILDREN'S SUB-GROUP: MEETING DATES

- 22 August 2012
- 25 September 2012
- 26 October 2012
- 27 November 2012
- 19 December 2012
- 22 January 2013

- 21 February 2013
- 25 March 2013

ADULT AND CHILDREN'S SUB-GROUPS: JOINT MEETING DATES

- 12 October 2012
- 19 December 2012

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APPENDIX 4 – COMMUNICATIONS PLAN

Strategic Management Group – Communications Plan

Introduction

The Department of Health, Social Services and Public Safety (DHSSPS) have engaged in a series of discussions with the Health and Social Care Board (HSCB) to set up a Strategic Management Group (SMG) in accordance with the Protocol for Joint Investigation of Alleged and Suspected Cases of Child Abuse in Northern Ireland (2004) (the Protocol).

Although established under the provisions of the Protocol in relation to children, in this case its remit will be extended to include vulnerable adults.

There is intense public concern surrounding the issue of organised and institutional abuse. It is essential that there is an effective communications strategy in place which ensures that information is released into the public domain in a timely, balanced, victim centred and appropriate way.

This will require a co-ordinated approach with all relevant organisations including the HSCB, Police Service of Northern Ireland (PSNI) and HSC Trusts.

The historical abuse inquiry due to commence in the Autumn and other associated pieces of work may have an impact on this plan, so there will also need to be a close link with OFMDFM, DOJ and DHSSPSNI in relation to a co-ordinated communications approach.

It is important that the communications plan remains fluid and is developed as the work of the Strategic Management Group (SMG) progresses.

The purpose of this brief plan is to provide a very broad template from which to start the communication process; a list of the key stakeholders; communications options and a list of the key information needed in due course.

Objectives

The communications plan aims to:

- Support the overall aims and objectives of the Strategic Management Group

- Provide a co-ordinated communications approach with key partners.

- Ensure that no information is released into the public domain that will compromise or prejudice enquiries.

- Ensure that as far as possible all communications are sensitive to the needs of victims and where appropriate ensure that victims are briefed on any statements being issued into the public domain.

- Provide wider public reassurance that all appropriate steps are being taken by the SMG, within their remit, to effectively address issues relating to children and adults.

- To build confidence in the Strategic Management Group which will be essential for ensuring the review and any investigations are as effective as possible.

- To monitor all media and social media coverage and stakeholder statements, and effectively address any concerns at an early stage; providing necessary information and reassurance; and where the criticism is unfair, inaccurate and unfounded to robustly rebut it.

Partners and Stakeholders

Below is a list of key partners and stakeholders – the list is not exhaustive and can be added to as the work of the SMG progresses.

Key partners

- Health and Social Care Board

- Police Service of Northern Ireland

- HSC Trusts
- DHSSPSNI
- Dept of Justice
- Office of First and Deputy First Minister
- Regulation and Quality Improvement Authority
- Safeguarding Board Northern Ireland
- Public Health Agency

Key Stakeholders

- Victims
- Victim Groups
- Staff
- General public
- Local politicians
- Health Committee
- Justice Committee
- Local and national media
- NI Social Care Council
- Religious organisations
- Statutory organisations
- Charity organisations
- Regional Voluntary and Community Organisations
- Independent Contractors
- Trade Unions
- Care Providers
- BMA

- RCN

Key Communications channels

It is essential that there is effective communication both internally and externally to ensure that staff, stakeholders, and the public are kept fully informed as appropriate.

Whilst not exhaustive communications options include:

Internal

- Intranet
- Email
- Staff Publications
- Face to face briefings

External

- Media Briefings
- Press releases
- Interviews/feature articles
- Lines against enquiry
- E-briefings for stakeholders
- Updates on websites
- Briefings for Health and Justice Committees
- Assembly written and oral statements
- Letters to the editor

Key Communication Principles:

- The PSNI have primacy over all communications in relation to specific investigations. This is essential in ensuring that nothing is issued that could potentially jeopardise an investigation.

- Each organisation should identify a senior representative to approve media statements and lead on interviews as required.

- It is essential that all media enquiries, interview bids and any responses are shared amongst all relevant partner organisations.

Action Points

In order to ensure that we have an effective communications plan in place the following information will be required from the SMG as and when available:

- As appropriate and following close liaison with PSNI, details of alleged offences under investigation, including any protection issues.

- Where appropriate a brief on safeguarding and investigative steps taken at the time the offences occurred.

- Where appropriate a brief on safeguarding arrangements in place now to minimise the risk of this occurring again. There will also be a need to explain how these arrangements compare to protocols and polices in place at the time of any alleged abuse.

- As appropriate and following close liaison with PSNI, details of any progress in the investigation, arrests, charges, court appearances.

Next steps

SMG to advise on timings for communications activity. At this stage a detailed timetable of communications activity will need to be developed and agreed by all the relevant partner organisations.

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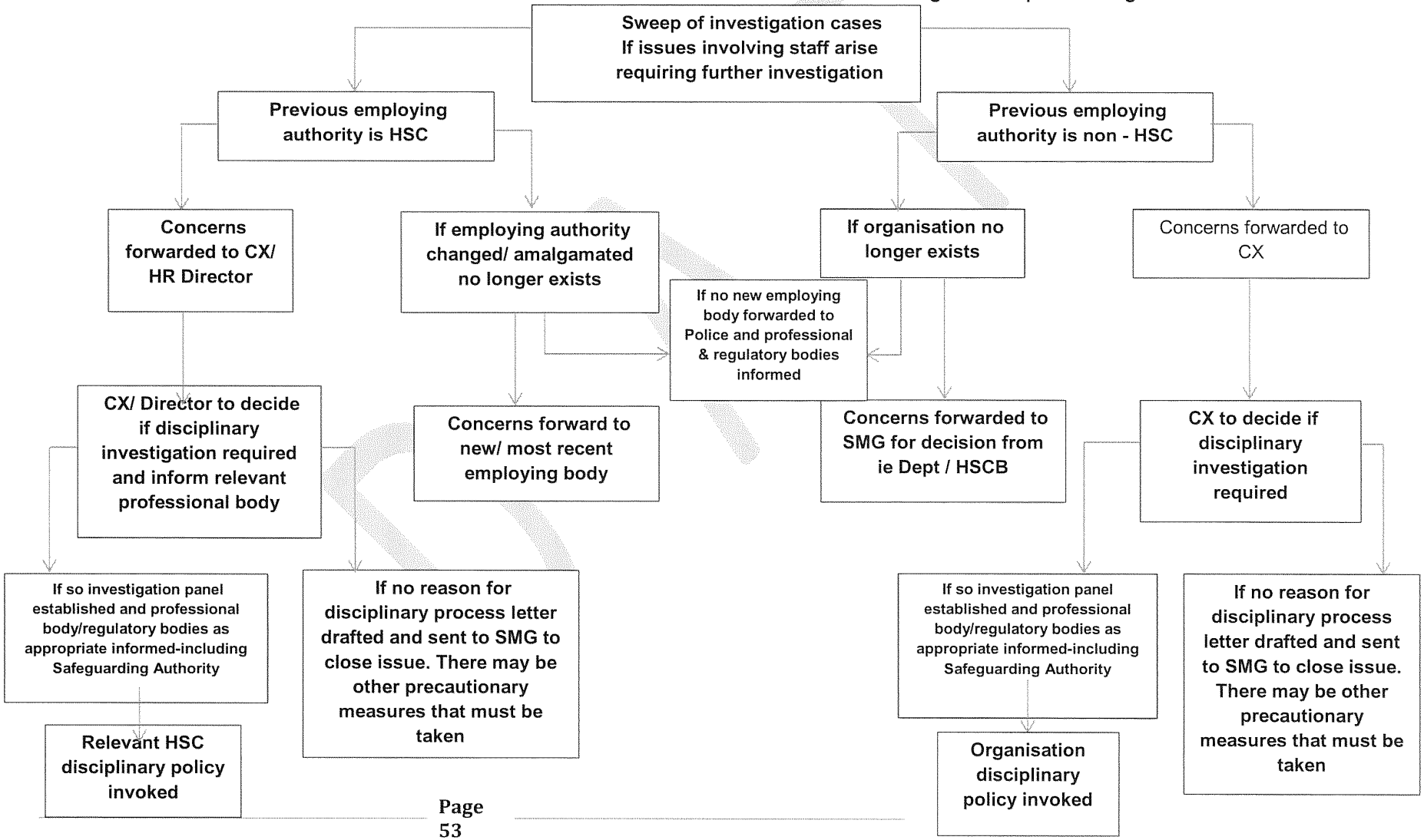
APPENDIX 5 – HR PROTOCOL

HR Protocol for Non – Criminal Actions

This Protocol is established for non -criminal issues for all HSC staff discovered during the sweep of investigation cases.



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APPENDIX 6 – ADULT SUB-GROUP TERMS OF REFERENCE

STRATEGIC MANAGEMENT GROUP

ADULT SUB- GROUP TERMS OF REFERENCE

Background:

- The Department of Health Social Services and Public Safety (DHSSPS) is engaged in on-going discussions with the Health and Social Care Board (HSCB) in relation to the establishment of a Strategic Management Group (SMG) in accordance with the Protocol for Joint Investigation of Alleged and Suspected Cases of Child Abuse in Northern Ireland.
- Although established under the provisions of the Protocol in relation to children, in this instance the SMG's remit extends to consideration of how to proceed with regard to any concerns that may arise in relation to the historic care of vulnerable adults emerging from the recent retrospective sampling work undertaken by each of the 5 Health and Social Care Trusts (HSCT).
- In order to ensure optimal co-ordination at a regional level, Social Services input is from the HSCB and the Police Service for Northern Ireland (PSNI) involvement is provided at a Detective Superintendent level.
- The SMG has established two sub-groups to take forward the work in relation to adults and children. The Sub-groups are chaired by the HSCB Adult Safeguarding Officer and Children's Safeguarding Officer respectively.

Purpose of Adult Sub-group:

The purpose of the Adult Sub-group is to:

- Quality assure the retrospective review processes and reports in relation to adults;
- Ensure any issues or concerns in relation to individual adults have been actioned appropriately;
- Ensure that any criminal concerns or issues have been referred to the PSNI; and

- Ensure that any Human Resources and professional regulatory issues have been taken forward by the appropriate Trust or employer

Regulation and Quality Improvement Agency:

- The Regulation and Quality Improvement Agency (RQIA) have been commissioned by the DHSSPS to carry out a review of the effectiveness of current safeguarding arrangements within Mental Health and Learning Disability Hospitals in the five HSCTs.
- This review will become the baseline to assure HSCB of the effectiveness of current safeguarding arrangements in these facilities, and formal discussions with RQIA are required to clarify this process.

Reporting Arrangements:

The Chair of the Adult Sub-group will report directly to the SMG on the sub-group's deliberations on an on-going basis and will, at a minimum, provide written reports to each SMG meeting.

The Chair of the Adult Sub-group will also contribute to the final report which will be submitted by the SMG to the DHSSPS, PSNI, SBNI and NIASP.

Membership of the Adult Sub-group:

J McKee (HSCB) Chair	
T Millar (WHSCT)	M Ó Maoláin (SHCT)
J Veitch (BHSCT)	T Fleming (NHSCT)
M Mannion (BHSCT)	M Mitchell (BHSCT)
D Bradley (SEHSCT)	D/I Stephen Wilson PSNI

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APPENDIX 7 – CHILDREN'S SUB-GROUP TERMS OF REFERENCE

STRATEGIC MANAGEMENT GROUP

CHILDREN'S SUB- GROUP TERMS OF REFERENCE

Background:

- The Department of Health Social Services and Public Safety (DHSSPS) is engaged in on-going discussions with the Health and Social Care Board (HSCB) in relation to the establishment of a Strategic Management Group (SMG) in accordance with the Protocol for Joint Investigation of Alleged and Suspected Cases of Child Abuse in Northern Ireland.
- Although established under the provisions of the Protocol in relation to children, in this instance the SMG's remit extends to consideration of how to proceed with regard to any concerns that may arise in relation to the historic care of vulnerable adults emerging from the recent retrospective sampling work undertaken by each of the 5 Health and Social Care Trusts (HSCT).
- In order to ensure optimal co-ordination at a regional level, Social Services input is from the HSCB and the Police Service for Northern Ireland (PSNI) involvement is provided at a Detective Superintendent level.
- The SMG is the appropriate vehicle to co-ordinate (a response to)(joint investigations of)any cases of a child protection nature which may emerge from the forthcoming Historical Abuse Inquiry to be set up by the Office of the First and Deputy First Minister.
- The SMG has established two sub-groups to take forward the work in relation to adults and children. The Sub-groups are chaired by the HSCB Adult Safeguarding Officer and Children's Safeguarding Officer respectively.

Purpose of Children's Sub-group:

The purpose of the Children's Sub-group is to:

- Quality assure the retrospective review processes and reports in relation to children;

- Ensure any issues or concerns in relation to individual children have been actioned appropriately;
- Ensure that any criminal concerns or issues have been referred to the PSNI; and
- Ensure that any Human Resources issues have been taken forward by the appropriate Trust or employer

Regulation and Quality Improvement Agency:

- The Regulation and Quality Improvement Agency (RQIA) have been commissioned by the DHSSPS to carry out a review of the effectiveness of current safeguarding arrangements within Mental Health and Learning Disability Hospitals in the five HSCTs.
- This review will become the baseline to assure HSCB of the effectiveness of current safeguarding arrangements in these facilities, and formal discussions with RQIA are required to clarify this process.

Reporting Arrangements:

- The Chair of the Children's Sub-group will report directly to the SMG on the sub-group's deliberations on an on-going basis and will, at a minimum, provide written reports to each SMG meeting.
- The Chair of the Children's Sub-group will also contribute to the final report which will be submitted by the SMG to the DHSSPS, PSNI, SBNI and NIASP.

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APPENDIX 8 – DECLARATION OF INTERESTS PRO FORMA

SMG DECLARATION AND REGISTER OF INTERESTS

QUESTIONNAIRE

Name: _____

Have you had direct professional responsibility (as a practitioner or manager) in any of the following facilities?

	Yes / No	If "Yes" please give dates:
Lissue Hospital		
Forster Green Hospital		
Young People's Centre		
Stradreagh Hospital		
Tyrone and Fermanagh Hospital		
Gransha Hospital		
Knockbracken / Purdysburn Hospital		
Longstone Hospital		
St Luke's Hospital		
Holywell Hospital		
Downshire Hospital		

Have you any connections* with any of the following facilities?

	Yes / No	If "Yes" please give dates:
Lissue Hospital		
Forster Green Hospital		
Young People's Centre		
Stradreagh Hospital		
Tyrone and Fermanagh		

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Hospital		
Gransha Hospital		
Knockbracken / Purdysburn Hospital		
Longstone Hospital		
St Luke's Hospital		
Holywell Hospital		
Downshire Hospital		

*The DHSSPS has no firm definition of "connection"; however it states that you should declare any relationship which could be deemed to influence your views on any matter which may be discussed by the SMG.

Signed: _____ **Date: _____**

Title: ____ **Organisation: _____**

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APPENDIX 9 – AUDIT TEMPLATE 1

Strategic Management Group (SMG) Audit Template

1. Background

A retrospective review of patient files within Muckamore Abbey was completed by the Eastern Health and Social Services Board between2005 and 2009 following a patient complaint.

This led to the Department of Health and Social Services and Public Safety (DHSSPS) instigating a retrospective sampling exercise across all five Health and Social Care Trusts (HSCTs) to identify if there were concerns or significant prevalence of similar findings within any other mental health or learning disability in-patient hospitals within Northern Ireland.

It was agreed in June 2007 that the sampling exercise should focus on those most at risk, especially minors/children admitted to mental health and learning disability hospitals over a 20 year period 1985-2005. A 10% sampling of relevant files was agreed. Each HSCT was asked to follow the methodology applied in the Muckamore Abbey review which categorised the incidents as follows: -

Category 1 -	Sexualised behaviour between Adult/Minor
Category 1 (A) -	Sexualised behaviour between Minor/Minor
Category 2 -	Sexualised behaviour between Adult/Adult (Non-Consenting)
Category 3 -	Sexualised behaviour between Adult/Adult (Consent unclear)
Category 4 -	Sexualised behaviour (Consenting)
Category 5 -	Suspected sexualised activity (General details unknown)
Category 6 -	Physical abuse involving actual bodily harm and above
Category 7 -	Sexualised behaviour – query significance

Category 8 - Issues noted – dealt with thoroughly using recognised procedures

Between April 2008 and August 2009, 8 reports were submitted covering 10 sites. In late 2011 these reports and other reporting documents, 13 in total, were handed over to the PSNI for further investigation.

It was evident from the analytical review of the available information that the scale and scope of the sampling had been interpreted by HSCTs in different ways and this resulted in significant inconsistencies and variances in both methodology and sampling applied within the commissioned reports.

2. Terms of Reference

Fionnuala McAndrew, Director of Social Care, Health and Social Care Board requested a template be developed for the Senior Management Group (SMG) to address the following key areas:-

- What was the expectation at the time of responding to the described scenarios?
- What legislation policy and practice guidance was in place?
- Were the responses in line with expectations of best practice at the time?
- Was there appropriate liaison with police and child or adult protection services?
- Are there any situations that require further investigation by the PSNI?

The PSNI carried out an investigative analysis report to determine if additional information was required for the PSNI to carry out its investigation and noted the following gaps in the submitted reports:

TRUST/HOSPITAL	DATES 1985-2005	SAMPLING	SIZE / %	CHILDREN	ADULTS	CATEGORIES	INCIDENT DETAILS
EASTERN – Lissue, Foster Green	1970-1979 1990-1999	NOT CLEAR	NOT CLEAR	YES	NO	NO	YES

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WESTERN – Stradreagh	YES	YES	10%	YES	YES	YES	YES
WESTERN – Tyrone & Fermanagh, Gransha	YES	YES	37%	NO	YES	YES	YES
BELFAST - Knockbracken	1970-1986	NO	20% + 6	YES	YES	NO	YES
SOUTHERN – Longstone	YES	NOT CLEAR	25% + 10	YES	NO	NO	NO
SOUTHERN - St Luke's, Craigavon	YES	NOT CLEAR	25%	YES	NO	NO	LIMITED
NORTHERN – Holywell	YES	NOT CLEAR	10%	NOT CLEAR	NOT CLEAR	YES	LIMITED
SOUTH EASTERN – Downshire	YES	YES	10%	NO	YES	YES	LIMITED

The PSNI report made the following comments: -

1. It is not possible to put a figure on the number of incidents reported on. This is due to some of the HSCTs reporting a number of incidents and others stating the number of patients affected.
2. It is not always clear where the patients involved are adults or children this means that the assessment of incident if criminal is difficult.
3. The lack of incident detail in some reports has made it difficult to make basic assessments of what has happened, when and where it happened and who was involved.
4. Information including patient names (whether perpetrator or victim), dates of birth, date of incident or whether the incident was reported to the police is not always recorded.
5. It has not been possible to complete the network analysis or analyse whether problems exist in particular wards or under certain staff members.

6. The main focus of many of the reports is on the process and policies that were in place at the time of the incidents and whether these were adhered to. They appear to overlook the vulnerable victims and perpetrators in some cases failed to emphasise the incidents where the police should have been involved and fully investigate why they were not.
7. In some of the reports it has been stated the police have advised on the findings of the report and are of the opinion that nothing further can be done.
8. There is no further information on who was consulted and whether these incidents were formally cleared.
9. Minutes of the reports assume a level of knowledge of the remit and the layout of the institution.

The police go on to identify information which is required in order to progress the analysis. The police indicate that much of the information required would have been captured at the time of completion of the individual reports and may still be readily available if the research has been retained.

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Audit Template

TRUST:	**HOSPITAL SITE:**
REFERENCES: (Source Material, attached copies if possible)	
INCIDENT DATE:	**INCIDENT LOCATION:**
VICTIM:	**ALLEGED PERPETRATOR :**
Name or Unique Reference	Name or Unique Reference
Gender: MALE/FEMALE	Gender: MALE/FEMALE
DOB or Age:	DOB or Age:
Status (e.g. Inpatient, Outpatient, Staff, Other)	Status (e.g. Inpatient, Outpatient, Staff, Other)
RELEVANT LEGISLATION, POLICY AND PRACTICE GUIDANCE AT THE TIME:	
WERE THE RESPONES IN LINE WITH EXPECTATIONS OF BEST PRACTICE AT THAT TIME?	
CATEGORY	**Tick which is appropriate**

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1. Sexualised behaviour between Adult/Minor	
1A. Sexualised behaviour between Minor/Minor	
2. Sexualised behaviour between Adult/Adult (Non-Consenting)	
3. Sexualised behaviour between Adult/Adult (Consent unclear)	
4. Sexualised behaviour (Consenting)	
5. Suspected sexualised activity (General details unknown)	
6. Physical abuse involving actual bodily harm and above	
7. Sexualised behaviour – query significance	
8. Issues noted – dealt with thoroughly using recognised procedures	
POLICE INVOLVEMENT	
Reported to Police	YES/NO
Police Advice	YES/NO
Further Details (e.g. Outcomes if known, Police Contact)	YES/NO
SOCIAL SERVICES INVOLVEMENT:	
Reported to Social Services	YES/NO
Social Services Advice	YES/NO
Further Details (eg Outcomes if known, referral to counselling, support services etc)	YES/NO

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FORM COMPLETED BY:	
Name:	Job Title:
Signature:	Date:

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APPENDIX 10 – AUDIT TEMPLATE 2

Strategic Management Group Audit Template 2

Name of Report	
Trust Name	
Signed off by	

Are the Terms of Reference included in the report?	☐	☐
Does the report address the timescale 1985 – 2005? If not what dates are covered?	☐	☐
Does the report confirm that a 10% sample was reviewed?	☐	☐
How many files were reviewed in total?	☐	
Does the report address children's files?	☐	☐
Are specific incidents referred to which identify either victims or adults? If yes can you complete template 2 for each case/file.	☐	☐
Is an Action Plan referenced in the report? If yes, is it available?	☐ ☐	☐ ☐
Are any actions outstanding? (Please attach a copy of Trust Action Plan)	☐	☐
Does the report fully address the Terms of Reference?	☐	☐
Comments		

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APPENDIX 11 – AUDIT TEMPLATE 3

Strategic Management Group (SMG)

Monitoring Template – Audit Template 3

PSNI [i]					Social Services [ii]				
Initials or Identifying Reference	Nature of Alleged Offence	Statement of Complaint Yes/No	Investigating Officer	Update	Referred to Trust Yes/No *(if No enter N/A below)*		Lead Officer	Update	Criminal / Civil Legal Proceedings Update
					Name of Trust	Date of Referral			

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APPENDIX 12 - SUB-GROUP MEMBERSHIP

Membership of the Adult Sub-group:

J McKee (HSCB) Chair	
T Millar (WHSCT)	M Ó Maoláin (SHCT)
M Mitchell (BHSCT)	T Fleming (NHSCT)
M Mannion (BHSCT)	D/I S Wilson (PSNI)
B Rhodes (SEHSCT)	

Membership of the Children's Sub-group:

M Quinn (HSCB) Chair	M Logan (SHSCT)
T Cassidy (WHSCT)	J Fenton (NHSCT)
T McAllister (BHSCT)	D/I S Wilson (PSNI)
A Garland (SEHSCT)	U Turbett (PHA)

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

20.1 The school at Lissue[34] was established by the South Eastern Education and Library Board and was subject to periodic inspection by the then Northern Ireland Department for Education's Inspectorate.

21. The Inquiry is aware that a television documentary was made in relation to Lissue. Please provide a copy of the same.

21.1 The Department believes that the above request refers to a BBC 2 Horizon production entitled "Breaking in Children", broadcast on 12 October 1981 and featuring the work of a consultant child psychiatrist based at the Royal Victoria Hospital and Lissue Children's Hospital. The Department does not have a copy of the documentary but has referred the HIAI to sources from which it may be obtained.

22. 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 Department on receipt of the same?

22.1 The steps taken by the Department on receipt of the Stinson Review need to be viewed in the context of other major work undertaken by the Department, Boards and Trusts to identify potential cases of historical abuse against children and adults mental health and learning disability hospitals. The Stinson Review contributed to the Department's strategy in taking this forward.

22.2 In 2005, a former patient in Muckamore Abbey Hospital made a complaint alleging sexual abuse some 30 years earlier. That complaint was exhaustively investigated in a process that was commissioned by what was then the EHSSB and which involved the police, including professionally-monitored interviews with patients and the scrutiny of almost 300 files of patients who had been in Muckamore Abbey. There were no prosecutions arising from this investigation.

22.3 Following this exercise, which was largely into the abuse of patients by other patients, the Department asked HSC Trusts to conduct a wider retrospective sampling exercise across adults' and children's files from all Mental Health (MH) and Learning Disability (LD) hospitals across NI (covering the period 1985-2005). This was in order to determine whether there was any evidence

[34] See page 130 of Annex A which provides details of the school.

of historical abuse of patients.

22.4 The aim of the retrospective sampling exercise was to explore a sample from the other LD and MH facilities in order to:

- determine whether there was any evidence that similar incidents were common elsewhere; and

- seek an assurance from the HSC Board and HSC Trusts that appropriate procedures were now in place to prevent abuse of children and vulnerable adults in such facilities, and that any such incidents of abuse identified were dealt with properly and effectively.

22.5 HSC Trusts carried out this exercise, at the request of the Department, during 2008-09. The brief for the retrospective sampling exercise was to focus on those people most at risk, especially minors (children under the age of 18 years) admitted to MH and LD hospitals between 1985 and 2005. A 10% sample of relevant files was agreed.

22.6 The exercise encompassed long stay wards in adult mental health hospitals, learning disability hospitals (excluding Muckamore Abbey Hospital, where a similar exercise had already been carried out) and regional child and adolescent inpatient mental health services.

22.7 When Departmental professional advisers and policy colleagues examined how this exercise had been carried out, they concluded that Trusts' approaches and coverage had not been consistent, and therefore the Department required further assurance regarding the rigour of the exercise. It was suggested that a further investigation or review should be considered, particularly in relation to the findings for certain settings.

22.8 In late 2011, there was extensive media coverage of abuse allegations in Lissue and Forster Green Hospitals resulting from a leaked memo from the HSC Board to the Press. The Health Committee held two evidence sessions in relation to the allegations reported in the media, in October 2011 and January 2012. Former Minister Poots made a statement to the Health Committee on 26 October 2011, and to the Assembly on 7 November 2011, and a further statement to the Health Committee on 18 January 2012. The Health Committee asked to be kept updated on developments.

22.9 A Strategic Management Group (SMG) co-chaired by the HSC Board and the PSNI, was established in March 2012. The remit of the SMG was to review the 2008/09 retrospective sampling exercise, and identify concerns or issues arising from the reports conducted by the EHSSB into Lissue and Forster

Green Hospitals, and consider actions taken at the time. It was agreed that all cases in which abuse was suspected would be referred to PSNI for potential criminal investigation.

22.10 The final SMG report into the review of the retrospective sampling exercise was received by the Department in December 2013. Departmental officials met with the HSC Board in March and August 2014, highlighting a number of queries with the report and seeking further assurances on a number of issues in the SMG report. In addition, the HSC Board held a further meeting with the PSNI in June 2014 to seek clarification on some of the issues raised by the Department.

22.11 The key findings of the SMG report are summarised as follows:

(i) Where it had been possible to identify the victim or the alleged perpetrator, details of potentially criminal activity had been passed to the PSNI for investigation.

(ii) There was inconsistency across Trusts on sample size, timeframes, and recording and analysis of findings.

(iii) It was difficult for SMG to determine whether actions taken at the time were in accordance with extant standards, as all policies and guidance were not available.

(iv) Some records had been destroyed in accordance with record management guidance.

(v) The PSNI had identified a number of challenges including de-criminalisation of some offences since that time *(for example, consensual sex between adults of the same gender);* absence of identifiers, including names, of alleged victims or perpetrators in records; the fact that a number of incidents are statute barred; and the destruction of some patient records.

(vi) There had been no prosecutions to date as a result of the retrospective sampling exercise or the review of the exercise.

22.12 With regard to the destruction of records referred to at point (iv) above, the schedule for the management and destruction of records includes clear timescales for the destruction of records. The HSCB instructed Trusts not to destroy records likely to be required for the Historic Institutional Abuse Inquiry (HIAI) once the HIAI was established. However some relevant records may have been destroyed in accordance with the guidance prior to this instruction

being issued.

22.13 The following information was provided to the Department by the HSC Board in relation to incidents referred to the PSNI with reference to children. This included the information gained from the Stinson Review:

- 35 incidents were referred to the PSNI
- 25 were closed by PSNI following review of papers
- 10 were referred to District Public Protection Units for investigation of which 4 related to one potential victim and were subject to on-going PSNI investigation, which had not yet concluded; and 6 fell outside the scope of the review. The incidents relate to contextual concerns prior to the young people's admission to the facility. The PSNI were following up the issues and social services are no longer involved.

22.14 There have therefore, been no prosecutions to date as a result of the retrospective sampling exercise or the review of the exercise.

22.15 Within the children's sub-group, there were four incidents of alleged abuse by staff. In two cases, the allegations were investigated by HSC Trusts and PSNI under the relevant protocols for the Investigation of cases of Alleged or Suspected Cases of Abuse of Children/Vulnerable Adults, but no further action taken. In one case the staff member was no longer employed by the Trust. At the request of the SMG, the Trust reviewed the relevant documentation and no further action was required. In one case, the staff member was referred to the relevant regulatory body and HSC Trust HR procedures. These further investigations concluded that no further action was required.

22.16 The SMG report gave assurance to the Department that, where incidents of alleged abuse were noted in the retrospective sampling reports:

- any issues or concerns in relation to individuals who were able to be identified through the files have been actioned appropriately, either at the time of the original incident; as a result of the retrospective sampling exercise; or as a result of the SMG review process;

- any criminal concerns or issues have been referred to PSNI; and

- any Human Resources and regulatory issues have been taken forward by the appropriate Trust or employer.

- any issues or concerns identified in relation to individual children have been actioned appropriately; either
  - At the time of the original incident;
  - As a result of the retrospective sampling exercises; or
  - As a result of the SMG review process
- any criminal concerns or issues identified have been referred to PSNI; and
- no Human Resources or regulatory issues were identified.

5.3 Northern HSC Trust

One incident was reviewed under the retrospective sampling exercise. The incident involved a 17 year old female patient in Holywell Hospital and involved sexualised behaviour between an adult and a minor. The Trust is unable to identify the original case file so little information is available about the case, and no further information is available that could assist in identifying the case.

In these circumstances therefore, SMG cannot be completely satisfied that in relation to the retrospective sampling exercise in the Northern Trust:

- any issues or concerns identified in relation to individual children have been actioned appropriately; either
  - At the time of the original incident;
  - As a result of the retrospective sampling exercises; or
  - As a result of the SMG review process
- any criminal concerns or issues identified have been referred to PSNI; and
- any Human Resources and regulatory issues identified have been taken forward by the Trust.

5.4 Belfast HSC Trust

At the time of the original retrospective sampling exercise, Belfast Trust reviewed **30** sample incidents, 10 from Lissue Hospital, 10 from Forster Green Hospital and 10 from the Young People's Centre. The audit was undertaken by 2 senior staff from outside the Child and Adolescent Mental Health Service (CAMHS). The audit did not include the 8 point classification used by the Muckamore Audit Team and it remains unclear why this classification was not used.

5.4.1 *Lissue Hospital*

The review of 10 cases within Lissue did not present with any new concerns. A number of former patients have, however, already made contact with the PSNI in relation to historical allegations of abuse. These are being investigated by the PSNI and sit outside the SMG process.

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

3. HISTORICAL INSTITUTIONAL ABUSE INQUIRY

On 31 May 2012 the First Minister and Deputy First Minister announced an Inquiry into historical institutional abuse in Northern Ireland. The Northern Ireland Executive Inquiry and Investigation into Historical Institutional Abuse Inquiry (HIAI) will examine if there were systematic failings by institutions or the state in their duties towards those children in their care between the years 1922 – 1995.

The Inquiry and Investigation will take the form of

- An Acknowledgement Forum;
- A Research and Investigative Team; and
- An Inquiry and Investigation Panel with a statutory power which will submit a Report to the First Minister and the Deputy First Minister.

A number of cases of interest to the HIAI have already been referred to PSNI for investigation.

As the HIAI has indicated that Lissue and Foster Green will be included in its consideration it is anticipated that the SMG report will be made available to the HIAI to assist where possible.

For Noting

Health and Social Care Board

Report in respect of Historic Review of Children admitted to Lissue and Forster Green Hospitals

Introduction

This report sets out the findings of a review of the care and treatment of children admitted to Lissue and Forster Green Hospitals in the late 1980's.

The review was instigated by the legacy Eastern Health and Social Services Board following receipt of a Serious Adverse Incident report on 2 May 2008.

The report includes a summary of a parallel audit undertaken by the Belfast Health and Social Care Trust to ensure that current safeguarding arrangements within the regional inpatient child and adolescent facility are robust.

Background

Lissue and Forster Green Hospitals were directly managed services within the Eastern Health and Social Services Board with the establishment of Trusts in 1994. The hospitals provided inpatient care for children with a range of mental health difficulties including anorexia, depressive illness, suicidal and self harming behaviours and a range of conduct and behavioural problems.

The service was at that time Consultant led and two Consultant Psychiatrists provided support from the Child Psychiatry Unit based on the Royal Victoria Hospital site. Lissue Hospital ceased operation as a Child Psychiatry Unit in 1991.

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.

In conclusion, each of the three reports indicate concerns about the level of abusive behaviour and bullying by children. There is clear indication of a harsh regime within the facilities. There was a lack of policies, procedures and protocols for dealing with the behaviours and for child protection. There was an absence of multi disciplinary working and the environment within the units presented challenges for the observation and management of the children.

However, it is also noted that the children admitted to Lissue and Forster Green had a range of challenging needs. The standards of professional practice required today has changed significantly with more emphasis on support to practitioners through policies, procedures, guidance and appropriate training.

PSNI Investigations

All matters of a potential criminal nature were referred at various stages to PSNI as they became evident. PSNI has confirmed that they have pursued the issues with the individuals concerned. In all cases, except one, PSNI has advised that they do not propose to proceed further. This is either because the individuals do not wish to speak to the police; co-operate with an investigation or there is a lack of evidence to substantiate that the incident occurred.

One case is being considered by the Public Prosecution Service.

Issues in respect of Named Staff

In the course of the investigation three members of staff were named.

Staff A

Although named in the documents there were no specific allegations against this person. The staff member has continued to work within Health and Social Care Services and is a highly regarded practitioner. There has been no indication of any concerns about their practice in the intervening years.

Staff B

This person was identified in the allegation received by DHSSPS in 1993. PSNI investigated but no evidence was found to corroborate the allegation. The then DPP confirmed that no prosecution would take place.

The staff member returned to work from precautionary suspension and retired from the service in 1996.

Staff C

Following an internal investigation by Belfast Trust the decision was taken to terminate their employment. The Trust will not provide a reference and the staff member was referred under the vetting and barring scheme. He/she is no longer a registered nurse and the Trust has placed a marker so that they are contacted if he/she seeks registration in the future.

PSNI has advised that the allegations currently being considered by PPS relate to this staff member.

Belfast Trust Retrospective Child Protection and Safeguarding Audit

The Trust undertook a retrospective audit of child protection regional arrangements within the required child and adolescent inpatient service. The periods of the audit were 1970-1979 at Lissue Hospital and 1990-1999 at the Young People's Centre. The period 1980-1989 was excluded in view of the EHSSB review highlighted in this report. The findings have been shared with HSCB and DHSSPS.

The findings of this audit raised concerns about communication between professionals, record management systems, recording, and allegations against staff. It is clear that in a number of cases there would have been an expectation of a different response to identified child protection concerns.

As a result the Belfast Trust developed an action plan to ensure that the current child protection arrangements within the Child and Adolescent Service complied with relevant policy and guidance and Trust policies and procedures. The action plan is provided at

Appendix 1 and it should be noted that all but one of the recommendations have been completed.

Recent Developments

It should be noted that the child protection arrangements today are greatly different from the period of the Board's review of children admitted to Lissue and Forster Green in the 1980's;

- New legislation, policy, procedures and associated guidance have all been published in the intervening years
- Child protection training is provided on a multi-disciplinary basis and is mandatory for staff working in children's services. The RCPC monitors the uptake of training by staff working with children.
- Child Protection Nurses and Nursing Teams have been developed to provide safeguarding advice to nursing staff within Trusts.
- The Regional Child Protection Committee has been established to oversee safeguarding arrangements across Northern Ireland, to be replaced in 2011 by the Safeguarding Board for Northern Ireland (SBNI). CAMHS is a formal member of the RCPC.
- Each facility providing care to children is required to have a statement of purpose and appropriate policies and procedures for safeguarding children.
- More robust arrangements are in place for the supervision of social work practitioners and more recently supervision arrangements for nursing staff have been developed on a pilot basis.
- CAMHS inpatient services are now provided in a new building and this regional facility provides a high standard of environment for the care and treatment of children.

- A number of safeguards have been introduced for children to themselves to utilise including independent visitors; advocacy services; representation and complaints procedures under the Children Order and all Trusts have whistle blowing policies to allow staff to comment on poor practice by colleagues.

- There is greater involvement of children and parents or carers in review and decision making processes.

- Service standards have been developed for inpatient CAMHS services (QNIC) and for the past two years CAMHS has been audited against these national standards receiving positive reports in respect of safeguarding.

- The Regulation and Quality Improvement Authority has recently undertaken a review of CAMHS services and the report is imminent.

Recommendations

1. The Board is asked to note this report prior to its submission to DHSSPS.

2. The Board is asked to note that the Regional Child Protection Committee will continue to review safeguarding arrangements in CAMHS services and act on the recommendations from external reviews as required.

Fionnuala McAndrew
Director of Social Care and Children

A. Could I just -- am I allowed to make --

Q. Yes, of course.

A. -- a further comment on that? I mean, I do set out in general terms in paragraph 5 what the purpose was, but there were four objectives that were associated with the review, and they are not in the statement, but they are clear in the minutes and records that I have looked at.

That was very much to deal with concerns that might be of a child protection nature. It was to make sure that anything which may be a criminal offence was appropriately dealt with. It was also to make sure that there was --

CHAIRMAN: A little bit more slowly, please. You have not told us these before.

A. I beg your pardon.

CHAIRMAN: Deal with child protection concerns?

A. Any concerns that may potentially be of a child protection nature. Am I speaking too quickly? My apologies.

CHAIRMAN: Just you haven't set these out in your statement. So it is the first time we have heard them.

A. Yes, I think that's right. That --

Q. So just -- what's the second one?

A. That if there were any concerns that may constitute a criminal offence, that they had been appropriately

dealt with, and that if there were any professional issues, and I took that to mean that any staff that were referenced in the records, if they were still in the employment of the service, then appropriate action was taken, and then, finally, to satisfy themselves that the current care of children in a similar facility was appropriate.

So I acknowledge it is not set out specifically in the statement, but from my reading of records those were the specific objectives of the exercise.

MS SMITH: In that regard you are distinguishing the purpose of these reviews from what might otherwise be seen as a full review of the practices in Lissue.

A. That's correct.

Q. Now there is a document that the Inquiry has looked at and which led you to make this additional statement, Fionnuala. That's 13714. This is what is known as Folio 21. You refer to it in the body of your statement. Now when we were talking earlier, I think you have clarified certainly for me that what you did in this document was simply summarise the contents of those reviews --

A. That's correct.

Q. -- the Stinson, Devlin and Jacobs review.

A. That's correct. I had no independent information to add

HIA REF: [ ]

NAME: [Fionnuala McAndrew]

DATE: [6 May 2016.]

THE INQUIRY INTO HISTORICAL INSTITUTIONAL ABUSE 1922 TO 1995

Supplemental Statement of the Health & Social Care Board

I , Fionnuala McAndrew, will say as follows: -

1. I submitted a statement dated 22 April 2016 to the Inquiry **see LIS1436- 1443** in which I set out the methodology of the reviews undertaken by Stinson, Devlin and Jacobs (the Reviews). I subsequently gave oral evidence on 27 April 2016 [Day 203].

2. During the course of my evidence I made reference to four objectives that were associated with these Reviews and, while they were not included in my statement referred to above, I believed that they were clear from the documentation which I reviewed .

3. I can confirm that these objectives are my summary of issues identified in Minutes of a Board Officers Meeting in respect of Lissue held on 15 January 2009 which I now attach herewith by way of **Exhibit 1**. I can also confirm that these minutes can be found at LIS 10261 – 263.

4. Since I had not included these objectives in my previous statement, I have now set these out below. These were as follows;
   - to deal with concerns of a child protection nature,
   - to make sure that anything which may be of a criminal offence was appropriately dealt with
   - if there any professional issues about staff who were still employed in the system, then appropriate action was taken

- to satisfy themselves that the current care of children in a similar facility was appropriate.

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

Signed _____

Dated 6 May 2016

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.

to those reviews.

Q. So if we can just scroll through this, please, you set the introduction and background. Then you go on to the incident report, the methodology of the review, the independent review reports, and then if we can pause here, please, the next -- just at the top there where it says:

"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."

That is not your personal view. That is your summary of what was in those reports?

A. That's correct.

Q. This report you provided for the benefit of the Board. I was -- those -- it summarised the conclusions of the reports and that was subsequently sent on to Maura Briscoe -- and I will look at that in a moment -- in the Department.

I was wondering what discussion there was on your summary at Board level, because the minutes that you refer to in your statement I have looked at and they're at -- I don't think we need call it up, but it is at

Questions from THE PANEL

CHAIRMAN: Can we have the previous page, please, 11922? 11922. Scroll back, in other words. Scroll down, please. Stop there. When you wrote to the Department, you said:

"It is also clear that children accommodated within these hospitals were subjected to a harsh and punitive regime."

There is no qualification there.

A. I am accepting that with hindsight. When I wrote to the Department, the Department knew the terms of reference. They knew that it was a sampling exercise. It would have been clearer -- it would have been clearer to have said that it was specifically in respect of the children within the context of the sampling exercise and I accept that now.

Q. Because I take it you can see how on one reading of that letter it represents the considered view of the Health & Social Care Board after three separate, albeit limited, reviews that that was the position, but you are saying that's a misreading of the position. You can see how somebody would take a different view, can't you?

A. Yes. I am agreeing with the point you are making, Chair.

Q. Yes.

A. Yes. I would like to take that opportunity, but just make a comment first that my reading of the reviewers' reports that the lack of multi-disciplinary working and care planning was particularly about some of the concerns that they read in the entries, which were really about managing risky behaviour. So again even the comments are in the context of the issues that were raised in the small sample size.

I think that in reading the report now it might have been clearer if I had made that more explicit in my report to the Board at the time. I feel it was understood, but perhaps reading the report with the gap of a number of years that I would have -- could have taken the opportunity to be more explicit about that.

Q. I mean, obviously hindsight is a wonderful trait, but when you were writing that report, the people you were writing it for were aware of the circumstances. Is that the position?

A. I think everybody understood the context within which the report was being presented to them.

Q. Paragraph 20 you go on to say that you are mindful that, given the allegations made, there was a heightened alertness at that time to any staff behaviour that may have been seen as unacceptable, which could have resulted in criticism of staff and other arrangements in

happened here. We need a full review by some suitable person or group of people brought in from outside to see what happened in Lissue"?

A. So the comment I would make in relation to that, Chair, is that this was part of a broader retrospective sampling exercise that was running parallel to this, and I think that this is quite important in terms of the decision that might be taken as to whether there should be a further -- a wider review. So there were a series of sampling exercises being undertaken. This was seen in my mind as part. It contributed to a period of time within the scope of that exercise. It was part of that jigsaw, if you like, in terms of the retrospective sampling.

That's why I was submitting my letter and the report to the Board and the reports of the reviewers to the Department. There were then discussions going on about what the next steps were. I suppose in my head that was not a conclusion, that the report to the Board didn't feel like a conclusion of the exercise, but there was dialogue with the Department about what the exercise might be.

I am very mindful that at the point that that was all taking place the proposal for this Inquiry had been received and it was clear that this Inquiry was going to

be set up and the opportunity to look broadly at facilities where people came forward was going to be afforded. I -- in that context I don't believe that it was my decision about what the next step should look like. It was an iteration between myself and the Department.

Q. Yes. Now you have referred to the four objectives, which you say are not in your statement but were articulated in discussions which are minuted of the entire Board.

A. Yes.

Q. I would be grateful if you would provide us with a statement exhibiting those minutes, because it is not something we have seen, if I understand correctly, until this moment. It may be it is somewhere within the material that we have already been given, but I don't believe we have been able to consider it, because we have not been told about it before today. So if you would let us have a statement as soon as possible just exhibiting the minutes so that we can look at that aspect ourselves.

A. I most certainly will, Chair, and I apologise that you should have had that earlier.

MS SMITH: Chairman, in fairness to the witness she does refer in her statement to a minute of 15th January 2009,

"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 due attention to the conduct of a named member of staff, which is addressed later in this report."

It seems that in this report that the Board is submitting to the Department they are effectively accepting the results of the review and they are saying that it did show a harsh and punitive regime. Would that be your reading of that?

A. Yes.

Q. And that's what they are saying to the Department, "We accept that there was" --

A. Right.

Q. -- "a harsh and punitive" --

A. Exactly.

Q. -- "regime in Lissue", and Forster Green as well by implication.

Now was -- I mean, I know when we were talking, you yourself took issue with the view expressed by the Board about the multi-disciplinary working, saying that your

view was that there was evidence of multi-disciplinary working, and it was wrong for the Board to say there was little multi-disciplinary working.

A. Certainly my experience of working with Lissue and former patients there was that there was very much a multi-disciplinary ethos.

Q. We will ask the Board's representative maybe why they came to that conclusion.

A. Uh-huh.

Q. But certainly the Department then, when they received this report, they accepted the views of the Board?

A. Yes. Well, we certainly didn't challenge those findings, but were obviously very concerned about them and with Lissue in particular having closed, but with other institutions still being up and running the Department established -- its concern was such that we established the Strategic Management Group to advise on the way forward and assure us that things were very different today.

I should also say that I had actually forgotten when we were speaking earlier, but as far as I recall the Department also commissioned the Regulation, Quality and Improvement Authority to do a comprehensive review of learning disability and mental health hospitals and the report of that review also made several recommendations.

Q. Thank you, doctor. There is nothing more I want to ask you about, but I am fairly sure the Panel may have some questions for you, unless there is anything else that you feel you want to say about either of your two statements?

A. I don't think so.

Q. Thank you.

Questions from THE PANEL

MS DOHERTY: Thanks. Can I just ask: the issue about multi-disciplinary approach, could you give some examples of that? You say you did experience that in Lissue.

A. Yes. Well, I'm speaking from -- I think my memory is -- I remember I had a couple of children who were placed in Lissue, and I think Dr McAuley was the consultant and LS80, LS80, the social workers, and I remember being -- there being significant communication between us in terms of how to manage the behaviour of certain children. We also -- I didn't actually work in Tara Lodge, but I had management responsibility for that Adolescent Unit, and we had a couple of patients who were referred to us from Lissue, and again the -- you know, the communication that we had with the consultant psychiatrists and social work team and psychologists, where necessary, was extremely good. We had -- and, you

know, their input to reviews and so on was extreme... -- was very valued.

Q. I mean, one of the issues -- and again this is just from your experience -- one of the issues that has arisen is whether the children that were put into Lissue were children whose behaviour was such it was very hard for them to be placed anywhere else or for them to be contained within a children's homes as opposed to them having a psychiatric illness --

A. Yes.

Q. -- as we would know it. Do you have a view about that?

A. Yes, I saw that in the reports and there was some discussion that it was -- that some of the children were there due to a lack of appropriate facilities within the community.

Now again that wasn't necessarily my experience, but my experience, of course, is very limited to a few children.

Q. Uh-huh.

A. In particular, the girl who reported the alleged abuse to me in '93 was really quite -- had really quite serious mental health needs. She was diagnosed schizophrenic and had -- you know, had several episodes of hospitalisation. So, you know, that was not the sort of problem that children's homes would have been able to

fortunately there were places in England that we could encourage Social Services to try and apply to get them transferred.

Q. Can I ask a couple of other questions about the hierarchy and the issue of -- first of all, before I go on to that may I ask about record keeping?

A. Uh-huh.

Q. You kept your own notes and records?

A. Yes, yes, that's correct.

Q. The nurses kept their own notes and records --

A. Uh-huh.

Q. -- and the consultants kept theirs. You believe that there must at some stage have been a composite file.

A. Yes.

Q. You certainly were able to go and check the nursing records --

A. Yes.

Q. -- if there was something that you wanted to find out about --

A. Uh-huh. Uh-huh.

Q. -- how something had gone, for example, the day before.

A. Yes, yes. Uh-huh.

Q. So there was open access --

A. Yes.

Q. -- to members of the team --

A. Uh-huh.
Q. -- to all of the records that were being kept on the children?
A. Yes. Uh-huh.
Q. In terms of the multi-disciplinary team that we have heard operated in Lissue --
A. Uh-huh.
Q. -- first of all, can I ask about the consultants? How often would they have been in Lissue?
A. They held weekly ward rounds, as they called them, weekly meetings where they discussed all the patients that they had admitted and that were being treated in the unit.
Q. In those ward rounds -- these were meetings of the team --
A. Yes.
Q. -- did they see the children?
A. Probably not. They may have, but probably not, because in a sense they were delegating that work to us in the unit.
Q. In terms of the hierarchy, what was the hierarchy? You were the senior social worker, though you seem to suggest that even though the person -- the other social worker was maybe a grade lower than you --
A. Uh-huh.

Q. -- on the pay scale, as it were --
A. Yes, yes.
Q. -- you very much worked doing the same job.
A. Well, I think the -- on the multi-disciplinary side you had registrars or senior registrars on the medical side, psychologists, social workers and nurses and generally those four disciplines worked together. So there was no sense of well -- apart from the consultants, who we kind of saw as separate, because they weren't usually involved in the work with us in Lissue, there was very much that sense of teams or sort of mini-teams developed between those four professions, if you like. So we saw ourselves as developing our therapeutic skills and our abilities to kind of work in more complex cases with each other as time went on and weren't so worried about our kind of like -- where we were on the pecking order of psychologists are better than social workers or whatever.
Q. Uh-huh.
A. So family therapy work was very much like that. So you had doctors, psychologists, nurse, social worker involved in those sessions with the whole family working as a team of equals and making decisions as a team of equals, which then went back to the ward round to say, "Well, this is what we are doing", you know, and get

some sense of, "Yes, that's good. Keep doing that" or some other advice from the consultant.

Q. The Inquiry has seen a Horizon programme that was made in 199... -- 1981 -- sorry --

A. Uh-huh.

Q. -- when you would have been in Lissue.

A. Uh-huh.

Q. It involved Dr McAuley --

A. Uh-huh.

Q. -- and his work in respect of two different families --

A. Uh-huh.

Q. -- but part of that -- I know you don't recall it or you don't remember having seen it --

A. Uh-huh.

Q. -- but part of that was clear that there was a nurse --

A. Uh-huh.

Q. -- who was acting out as the child --

A. Uh-huh. Uh-huh.

Q. -- and Dr McAuley and someone else in the room was observing the mother's interaction with the child, as it were.

A. Yes, yes.

Q. The other person who then seemed to be in the background having an input, one could have expected that to be a social worker --

A. Yes.
Q. -- for behavioural techniques --
A. Yes.
Q. -- how did you have the opportunity to observe then in the ward? Did you spend time ...?
A. Well, I suppose my office was just beside the ward. So I was in and out of -- on the ward every day, into the nursing office every day to see what had been happening, having chats with people in the nursing office. So the little kind of eating area was just opposite. You could see nurses managing children's behaviour daily --
Q. Uh-huh.
A. -- and also you get a good sense what's working for them? What's not working for them? So what could a parent do? Could a parent use some of those ideas or not?
Q. I mean, we have heard descriptions. Some people have said about, you know, children swinging from the chandeliers or that the mornings were particularly difficult in trying to get them settled. For you being, you know, there on the site did it feel as if behaviour and kind of eruptions of bad behaviour were a common ...?
A. There were some, but I don't recall anybody swinging from a chandelier.

A. Uh-huh.
Q. -- and we have heard about the ward rounds, but were there also meetings where all the staff came together to discuss --
A. Yes.
Q. -- the running of the unit? How often would they have been?
A. Well, there were meetings -- there were different meetings, but there was certainly a -- I think it was called the academic meeting on Tuesday afternoon.
Q. Uh-huh.
A. So myself and others from Lissue would have gone up to The Royal for those meetings, which were very much kind of general meetings about what was happening in the work in our setting. There would have been training experiences there as well, lectures given or videos and this sort of thing. So that would have been a place of kind of meeting to discuss things and also training as well --
Q. Right.
A. -- there.
Q. Were you at all involved in the use of the room where there was video --
A. Yes.
Q. -- cameras --

A. Yes.
Q. -- and there was the one-way window and so on?
A. Yes, yes, there was.
Q. Which side of the window would you have been? Were you an observer or participant?
A. Both, both. In both, because the family therapy approach was very much based on an idea of you have a family who are in the room. There is somebody there, one of the multi-disciplinary team, is in the room with them, one person, who has a kind of earphone --
Q. Uh-huh.
A. -- and then you've got the other three or four behind the screen watching what's going on and at times then saying, "Maybe you could ask them this", or "Ask them that", or "Don't go there", or "Don't go here". So that was kind of like that way of working.

Equally then when we were doing the parent training, sometimes you are in front maybe demonstrating and modelling good parenting and then sometimes you are behind the screen just watching and observing and giving some feedback as well that way.
Q. Did you play back the videos much for training purposes or to analyse the case?
A. Yes, we would with the family -- certainly with the parent training and trying to say, "Look, here's -- you

undertaken --

A. Uh-huh.

Q. -- into Lissue and Forster Green Hospitals. If we can look, please, at page 13716. Just if we go to 13714 just to show the start of the report, you will see that the report sets out the findings of a review of the care and treatment of children admitted to Lissue and Forster Green Hospitals in the late 1980s. It goes on then at that page 13716, where she says that:

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

A. I totally deny that as being present in Lissue. It was not my impression that that was the regime.

Q. And I think you said you would totally disagree with that assessment.

A. Oh, I would indeed.

Q. Even the next line:

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

Again you would say the whole ethos was of multi-disciplinary working.

A. Undoubtedly.

Q. We have heard that older staff maybe were stricter with

Q. It has been accepted by the Health & Social Care Board that what the Stinson report reveals was a harsh regime. Is that your recollection --

A. No.

Q. -- of Lissue?

A. No.

Q. Is there anything you would like to say to the Inquiry about that, LS21?

A. I think it depends on how you define "harsh". It had rules and limits, what we call boundaries, and children were con... -- within those boundaries any incursion which threatened the stability of that regime, that milieu couldn't have been tolerated. We took steps, ongoing, even by instinct to ameliorate, to change, to reduce any potential violence, aggression, tension. That was what it was all about. So I didn't consider that to be harsh.

I have three children of my own at the same age as all these children are talking about, and I got them all to university and they don't feel that they have been restricted, and my behaviour there was the way I managed my family.

There were rules. We had to have rules, and encouragement was used: "Keep within those rules".

Q. Well, did you ever yourself see staff behave

total package, the total care of the child, the fact that staff on duty weren't interviewed, while I understand the emphasis and indeed the previous witness, the context probably has got lost somewhere along the way in these inquiries -- these reports.

If you were to ask me about harsh regime and that term "harsh regime" which comes up, I think I have tried to listen to the applicants who describe it as a harsh regime and we have to hear them. I have listened to the staff, who don't recognise it in the way that the applicants do. I think if you don't understand behaviour modification as a philosophy and as a model of care and you see children getting sanctions as well as rewards and you see one child in one therapeutic regime and another, I could absolutely see how it can become a harsh regime. If you are a nurse in mental health, you will see the care in a different way than I would. If I were to go into Lissue and watch the care, I probably would think it's harsh as an A&E nurse and as a mother. I think if I was to take one of the nurses from Lissue and put them in a busy A&E Department on a Friday night, they would probably think that's a bit harsh and a bit chaotic where that is my bread and butter. So there's something about the context and the eyes that we looked upon -- through in terms of these

in terms of the evidence that you have heard. The reviewers in their reports were very specific about their concerns about entries in the file. Now it may be, if there had been a wider review, that further understanding of some of those actions could be achieved, if you like, because of seeing it in the treatment plan for behaviour modification, but Maura Devlin herself commented that some of the actions went beyond the -- you know, the acceptance of reasonableness. She talked about the lack of dignity and gave some examples of the lack of dignity, and as a professional social worker, whether it was then or now, I think that those examples are difficult to stand over, but -- so I can't second guess the view of the reviewers, but I would have concerns that some of the entries did give rise to concern about individual practice that those children in the sample experienced.

Q. Okay. I think that's very helpful. You know, it clarifies for me that you are not standing away from that, because I think there are issues to do with practice. I think the multi-disciplinary -- there is an issue about were consultants at, you know, meetings and were the -- you can see where maybe more files would give you a consideration, but I think it is important that there was sufficient within the extract that would

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

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

Concluding Remarks

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

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

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

obviously had access to information that I didn't have. I didn't work within the unit itself. That would have been my experience as an outsider to whom children would have been referred.

Q. The other question that's linked with that: you didn't feel that the judgment about it being a harsh regime should be challenged?

A. I think the Department accepted on the basis of the evidence --

Q. Right?

A. -- that it was, and even some of the practice for the day at times appeared to have been very harsh and punitive.

Q. Okay. Thank you very much.

CHAIRMAN: Dr Harrison, if I can just follow up that last question about multi-disciplinary working, your experience with what you have correctly identified as a limited number of children who were there indicated that there was very good multi-disciplinary practices and an ethos to that effect. I suppose the question is well, if you experienced that, no doubt others would have done so as well; in other words, it wasn't just specific to your children, something that was laid on for them. I think it is fair to say that, and I can't put my hand on it now, I think there was criticism of at

sleeping. In [redacted] joint protocol interview records (page 17) on the 3rd of June 2008 she reported that ' when everybody was in bed at night, everyone had to be in bed by I think it was about half nine and lights were out and because I was quite noisy with my Tourettes it would have, the staff would have shouted alot at me and you know things would have been said like if you don't stop making that stupid noise you'll be locked away for the rest of your life'.

In relation to [redacted] knowledge of child protection procedures at that time, he reported that he did not remember any procedures. He described working in this area as 'cold turkey into child psychiatry' 'using common sense','steep learning curve' and with 'no induction'.

When asked if he had any concerns about the care regime provided to the children at the time in question. HL again stated that he felt some of the children were not in an appropriate setting and practice was very different then. There was not a common approach to the use of restraint.
[redacted] reported that each child had care plan but did not elaborate on the details.
[redacted] reported that on occasions he did challenge aspects of the tough regime within the unit but at that time there were a number of powerful individuals who persisted with the established custom and practice.

[redacted] was asked if he wanted to provide the names of any staff members who witnessed his practice at that time and who could corroborate his version of events. He indicated that most people are retired and in their eighties. He felt that he could not make this request of the one staff member who is still working as he felt it would cause her undue distress. In relation to the allegations he stated that 'it will be her word against mine'.
At the end of the interview [redacted] was advised to avail of the support of Staff Care Services and his Professional Association Representative for support at this difficult time.

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.

the last act of the Eastern Health & Social Services Board was to accept Stinson and those reports, and the Health & Social Care Board inherited, but Fionnuala McAndrew or Marion Reynolds certainly overlapped between the two.

A. Uh-huh.

Q. I know that you wanted to say something more to the Inquiry about this apparent acceptance of those reports as disclosing a harsh and punitive regime.

A. Yes. As you say, the Stinson report and the other reports were the last handover from the legacy Eastern Board into the new Health & Social Care Board, and I think the emphasis at that time of all of the work of the Board was to ensure that whatever systems and processes we had in place continued to protect children. So I do not think -- and I was there -- we did not do a reflection on whether the process of the Stinson inquiry -- report and indeed others was fulsome and complete in its work. The focus was ensuring that children were safe.

I think since then and as part of this Inquiry in terms of us looking again at how Stinson was commissioned by the previous Eastern Health & Social Care Board, the fact that extracts alone were used, the fact that Stinson didn't get the opportunity to see the

total package, the total care of the child, the fact that staff on duty weren't interviewed, while I understand the emphasis and indeed the previous witness, the context probably has got lost somewhere along the way in these inquiries -- these reports.

If you were to ask me about harsh regime and that term "harsh regime" which comes up, I think I have tried to listen to the applicants who describe it as a harsh regime and we have to hear them. I have listened to the staff, who don't recognise it in the way that the applicants do. I think if you don't understand behaviour modification as a philosophy and as a model of care and you see children getting sanctions as well as rewards and you see one child in one therapeutic regime and another, I could absolutely see how it can become a harsh regime. If you are a nurse in mental health, you will see the care in a different way than I would. If I were to go into Lissue and watch the care, I probably would think it's harsh as an A&E nurse and as a mother. I think if I was to take one of the nurses from Lissue and put them in a busy A&E Department on a Friday night, they would probably think that's a bit harsh and a bit chaotic where that is my bread and butter. So there's something about the context and the eyes that we looked upon -- through in terms of these

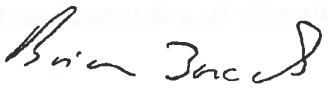
but also have a very clear understanding that they are slightly separate from it in this regard.

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

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

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

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



inspection might have brought forward, if there had been an inspection of files and of the notes that you would have expected, then it could have been issues about restraint or behaviour management could have come to the fore if there had been an inspection?

A. Yes, I would accept that, yes, if children's files had been examined, and I know that that was the case in the 2005 inspection that I was involved in. I was actually involved in doing an inspection in Forster Green and we were concerned about the use, for example, of time out for children and made comments about that, but that came as a result of reviewing patient notes, yes.

Q. So that might have been a possibility. Okay. Thank you.

MR LANE: Just to follow up on the question about alternative places, obviously with the older adolescents they often moved on to training schools if there was difficult behaviour which needed to be managed and so on, but where would you consider children could have gone who were younger other than Lissue?

A. Well, again just off the top of my head and recalling from memory, it wasn't really until the 1990s that -- I'm trying to think -- the Department developed a residential child care strategy, and it really identified the need for differentiated accommodation in

children's homes --

Q. Yes.

A. -- and the need for units that dealt in particular with children who had challenging behavioural needs and, for example, needs of children who had been sexually abused, and so really our thinking wasn't that far advanced during the period that Lissue would have been working.

Q. Yes.

A. The differentiated accommodation amounted to, you know, long-stay, short-stay units, assessment units, but it wasn't until I think the Department produced its "Children Matter" strategy, which was informed by Board and Trust representatives and voluntary homes' representatives, that, you know, there was a strategy in place and units were established to deal with those types of problems.

Q. So that children's homes would have had to cope really?

A. Generally speaking, yes.

Q. Going back to the question of the interdisciplinary question, you gave evidence of how you thought there was good interdisciplinary working.

A. That's right, yes.

Q. If so, why do you think the review thought it wasn't happening?

A. Yes. Well, again I wasn't part of the review. So they

A. Because at that stage they were not able to be coped with within the Social Services' set-up, residential.
Q. And we didn't have the facilities that they had in other parts of the UK.
A. Well, they weren't nearly as well developed as, say, for example, in the London area.
Q. Well, you go on then in paragraph 21 -- you have been provided with Stinson, Devlin and Jacobs reports to update you. Just to confirm, you were never consulted when those reviews were being undertaken --
A. No.
Q. -- to make any comment about it. You say you are very saddened that you were not made aware of the issues therein at the time they were alleged to be occurring. I presume you mean by that at the time the nursing staff were recording the extracts that form part of this Stinson review.
A. Uh-huh.
Q. "As I have previously indicated, I was in Lissue nearly every day at some time. It is unfortunate that staff did not feel able to approach myself."
Paragraph 22:
"It would have been so much easier to have dealt with the difficulties as they were occurring rather than having to consider these issues on the basis of

Miss Robinson here outlined David's claim that he was sexually assaulted by a 16 year old female babysitter when he was only eight years old. Miss Robinson went on to outline David's family history and his involvement with Dr. McAuley (Child Psychiatrist, R.V.H.).

Dr. McEwen presented his analysis of David's social history. He highlighted the rejection David has been faced with from his parents and the child's desperate need to be cared for. As a result of constant rejection by his parents David's emotional development has been impeded. He resents Rathgael because he perceives it as a punitive environment and feels he has done nothing wrong to warrant a Training School placement. His perception is therefore, that he was in Rathgael because no-one has ever loved him.

Mr. Clotworthy asked Dr. McEwen if he felt concerned at David swallowing foreign bodies. Dr. McEwen stated emphatically that this was a grave concern because the child has a "crashingly low self-esteem". Those who should love him (i.e. his parents) do not, therefore the risk of serious harm or even death is very real. Mr. Donnell asked whether David's behaviour could be construed as merely attention seeking. Dr. McEwen stressed that David could kill himself. Mrs. Black informed those present that David's potentially self-destructive behaviour has not been exclusive to Rathgael Centre, that he inflicted superficial wounds to his wrists the previous week in Downshire Hospital and apparently broke a porcelain cup and attempted to eat some of the pieces. Dr. Kernaghan said that although he was unaware of these two incidents, David had displayed verbal and physical aggression towards hospital nursing staff during recent weeks after his initial period there had been relatively settled. Dr. Kernaghan then read aloud the report pertaining to one of David's aggressive outbursts.

Mrs. Black's interpretation of the change in David's behaviour in the Downshire was that on David's admission, he was receiving a lot of attention from the middle-aged male and female patients and this served to have a settling influence on him. Of late, however, the novelty of having a very active, talkative 13 year old about the ward has worn off and the patients have withdrawn their attention from David, consequently he resorts to anti-social type behaviour in an effort to regain some of their attention. Dr. Kernaghan agreed with this and admitted that David was giving rise for concern at present. His recent behaviour could also be an effort to prevent him returning to Rathgael. Mr. Donnell asked if there had been an obvious trigger for David's most recent outburst - had he for example been told he may be returning to Rathgael. Dr. Kernaghan said there had been nothing of that kind.

A discussion then followed about David's familiarity with the Welfare System, Case Reviews, Social Work jargon and so on. Dr. McEwen said that given David's present age and past experiences of the various caring agencies, it is probable that he can conceptualize such things. Dr. McEwen went on to say that David can be viewed as a boy whose emotional development has become stuck. He likened David to a baby crying to manipulate it's mother into giving the response the baby wants. David has a limited set of ideas and cannot conceive the mutuality of any relationship. He takes what he can get but cannot give much in return because he has not experienced reciprocity as a child. In order for David to be able to develop, therefore, he needs to be placed in an environment in which people's tolerance is extremely high and where David can have one-to-one relationships. Mrs. Black, Mr. Murdock and Miss Robinson all acknowledged that David interacts much better on a one-to-one basis. Dr. McEwen

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highlighted the importance of such relationships for David because it was at the one-to-one stage with his mother that his emotional development ceased.

It was realised by everyone present that nowhere in Northern Ireland could provide the unconditional caring David needs. Dr. McEwen recommended trying several places in mainland Britain. Dr. Kernaghan agreed with this opinion and said that Downshire Hospital would provide a place for David until somewhere more appropriate is found. Mr. Orr stressed the importance of acting quickly on this before anymore damage is caused to his emotional development. Mr. Donnell pointed out the need to be wary of placing David in another setting which could prove to be a failure and thus may be seen by David as further rejection. Dr. McEwen underlined the importance of David living amongst staff who share a philosophy that allows them to view David developmentally. In Northern Ireland this is only found in piecemeal fashion, therefore a therapeutic community in England is the only viable option if David's needs are ever to be met. At present, Dr. McEwen said, David is the right age for just such a place. He could remain there until 18 years old and even though he is facing the most chaotic years of life, it is also a time during which a lot of good work can be done with David and a time when he can be given appropriate models - something David has never had. If he were to remain in Downshire, Dr. McEwen argued, there is a risk he could become hypochondriacal and he will certainly miss out on learning to cope with his peer group.

Ms Stewart then informed those present that David's father had telephoned David shortly after his admission to the Downshire. Mrs. Black confirmed this but pointed out that Mr. Simpson's contact with David has always been erratic and that like Mrs. Simpson, he failed to keep any of the many promises made to David. Mr. McConnell said that he knew David's father to be a heavy drinker and a physically aggressive man. He went on to relate a situation in his own home where David amused himself playing with 'Star Wars' figures. This and other evidence of child-like behaviour makes Mr. McConnell wonder whether David needs to be somewhere in which he can regress. Dr. McEwen said David does indeed need the opportunity to regress, but places which provide for regression are few. The Cotswold Community is one such place and Dr. McEwen feels this would be an ideal placement for David.

Mr. Clotworthy then summarised what had been said at the Case Conference and asked about the cost involved in sending David to a therapeutic community in the Cotswolds. Dr. McEwen estimated £27,000 per annum. Miss Robinson, fully aware of the financial committment of such a placement said that Rathgael could possibly contain David and there was a slight chance he would survive in the Centre. However, in light of the professional opinions given today, it was clear David needed a more specialised setting. Mr. Clotworthy said it was apparent from what had been said today that David was not only a risk to himself but to other children. Mr. Buchanan inquired about the legal connotations of transferring David to England since he is the subject of a Training School Order. Mr. Clotworthy said that the legal aspect of the transfer was complicated but could be dealt with. Mr. McConnell pointed out Dr. McAuley's prediction that David would commit suicide and Ms Stewart said that Dr. McAuley had claimed he would support any decision taken by Rathgael upon David's future. Mr. Donnell said the N.I.O. had to be wary of "picking up the tab" for what is essentially a Care boy and therefore the responsibility of the D.H.S.S. Mr. Donnell then had to leave the Case Conference.

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were presenting with very difficult behaviours.

A. Well, when you are having to deal with a very physically violent child, then it may appear that you are acting in a rather rough way or forceful way, but that's because of the degree of roughness and violence that the child is exhibiting.

Q. And you made the point to me too that the difficulties that children were experiencing were not difficulties de novo. They had not arisen de novo within Lissue. These children were coming in with difficulties into the unit in the first place.

A. Well, I think a lot of children from the Social Services' end of things would probably have had experience of other residential situations and exhibited difficult behaviours, which may be one of the reasons why they were being admitted to the Lissue situation.

Q. We have heard that there was an incident book kept in Lissue. Have you any recollection of that?

A. Well, I knew of its existence, but it wasn't something that I consulted. I would have seen this really as a nursing staff responsibility.

Q. And apart from the ward rounds, the treatment of children was carried out by the full-time staff under your direction. You and Dr McAuley devised the treatment plans for the children --

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

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

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

RESTRAINT

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

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

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

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

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

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

[38] LIS 116, paragraph 129