

HIA REF: []

NAME: [HSCB and PHA]

DATE: [29th February 2016]**THE INQUIRY INTO HISTORICAL INSTITUTIONAL ABUSE 1922 TO 1995**

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

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

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

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

2. In responding to this question, the Board has been assisted by “Lissue Hospital, History 1981” which is exhibited hereto at **Exhibit 1**.
3. Lissue House was a private home to Colonel D C Lindsay. Its first link with the Royal Belfast Hospital for Sick Children (“RBHSC”) occurred during the second World War when Colonel Lindsay offered accommodation at his home to give as many children as possible care and safety at the time of the first bombing blitz in Belfast. The links continued after the war, noting: “the location being an ideal settling for long term and convalescent care and treatment”. On 1 May 1947 Lissue House was donated by the Lindsay family to the RBHSC.



The spacious entrance hall and grand staircase of Lissue House

the Belfast Hospital for Sick Children, Professor P.T. Crymble, Ian Fraser, J.S. Loughridge, Dr Rowland Hill, Dr Muriel Frazer and Dr Ivan McCaw were responsible.

Naturally, one of their main concerns was the availability of sufficient beds to cope with a major emergency. Therefore it was with gratitude and alacrity that the Staff accepted the most generous offer by Colonel and Mrs D.C. Lindsay to hand over part of their home, Lissue House, at Ballinderry, near Lisburn, as a convalescent or evacuation hospital, should the need arise. A preliminary inspection by Dr F.M.B. Allen and the honorary secretary of the Medical Staff Committee, Dr Ivan McCaw, reported that Lissue House would be ideal accommodation for up to thirty children. The house was ready to receive evacuation patients on 15 July 1940, and the first batch arrived the following day. This proved to be a timely provision, in view of the air raids which were to devastate Belfast early in 1941.

Dr Patterson, a Lisburn general practitioner, was asked to attend Lissue as a non-resident house surgeon, for which she would receive £75 per annum. In anticipation of their own remuneration for time and travelling

I, Hilary R Harrison will say as follows:

This statement has been provided on behalf of the Department of Health, Social Services and Public Safety (the Department) in response to the Rule 9 request of the Historical Institutional Abuse Inquiry (HIAI) dated 16 December 2015. It has been prepared on the basis of information contained in files currently held by the Department and such evidence received from the HIAI as it has been possible to review within the required timeframe. As further information becomes available, it may be necessary to provide to the HIAI, revised or supplementary statements.

Question1

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

- 1.1 The Department understands that Lissue House, a private home, was opened in May 1947 for the treatment and convalescence of sick children. Following a brief period of closure after the ending of the war in 1945, Lissue House was privately donated to the newly created Northern Ireland Hospitals Authority (the Authority). It re-opened in 1949 as Lissue Hospital, a paediatric medical and surgical hospital and continued as such until May 1971, when it began to provide additional services in the form of psychiatric in-patient and day patient services for children and young people. In later years, prior to its closure, Lissue hospital also provided in-patient respite care for children with complex health needs.
- 1.2 The Health and Social Care Board (HSC Board) in its statement to the HIAI dated 29 February 2016¹ (the HSC Board statement) has set out in detail the history and operation of the hospital with reference to the Child Psychiatry Unit, until the service transferred to the Foster Green Hospital site, Belfast. Attached at Annex A of this statement is a comprehensive history of the hospital and all paediatric services provided on the Lissue site from the hospital's opening to its closure in January 1989 taken from a book written by a former consultant paediatrician at the hospital. entitled: 'A history of the Royal Belfast Hospital for Sick Children: a history 1948-1998'².

2. How many individuals spent time in Lissue?

- 2.1 The HSC Board statement provides the numbers of in-patient and day patient between May 1971 and 29 February 1989³ to the psychiatric unit at Lissue. During these years 1,124 children were admitted as in-patients and 250

¹ LIS 079

² Love, H. The Royal Belfast Hospital for Sick Children: a History 1948-1998. Belfast: Blackstaff Press, 1998

³ LIS 081

to Lissue, Medical Staff decided to place a book at the Hospital recording their visits. Reminder letters regarding payment for such visits, sent to the Ministry of Home Affairs in March and April 1941, were not acknowledged; it was not until May, 1942 that a response to repeated approaches was received. The Ministry conceded that Medical Staff were being put to extra inconvenience and loss of time in travelling to Lissue but offered only to defray travelling expenses at civil service rates. This worked out at 6s 8d per visit. Staff considered this derisory and resolved to bring the matter to the attention of the Parliamentary Medical Subcommittee, then sitting. Co-operation was also sought from the medical staff of the Ulster Hospital for Women and Children, who were in the same plight. This joint approach bore fruit for in September 1942 the Ministry agreed to pay a fee of two guineas for each staff visit to Lissue, to take effect retrospectively from the original date of transfer of patients. This rather tardy offer was accepted by Staff as satisfactory and Lissue continued to play a vital role as a convalescent facility throughout the war years.

With the cessation of hostilities, the Northern Ireland government stopped payment for the upkeep of Lissue, as of 30 September 1945, and ordered that all effects must be removed and the house vacated.¹

The loss of Lissue House was a severe blow and the Medical Staff demanded the provision of a convalescent home to replace it, whether it be located inland or by the sea. The original Queen Victoria convalescent home, situated in the townland of Ballydollahgan on the outskirts of Belfast, had long since closed in 1908. (The house, now privately owned, can still be seen on the corner of the Saintfield Road and Beechhill Road, Newtownbreda.) The Board responded by purchasing Ballynascreen House, at Greenisland, Co. Antrim, for the sum of £4,500. However, by December 1946 Lissue was back on the agenda. Dr Muriel Frazer raised with Medical Staff the possibility of acquiring Lissue House as an ancillary hospital which would relieve the overtaxed accommodation on the Falls Road site. This possibility became a reality when, at its meeting on 12 August 1948, the Temporary Committee was able to announce that, through the great generosity of the Lindsay family, the Hospital was to acquire the whole of Lissue House for conversion to a branch of the Royal Belfast Hospital for Sick Children; no conditions were attached, except that the house must be occupied within nine months. Fortunately, the Board was able to sell the property at Greenisland at the original purchase price, and proceeded at speed with the necessary structural alterations to Lissue.

The first patients were admitted on 1 September 1948, and the official opening was performed by Mrs D.C. Lindsay on 21 January 1949.² A plaque to commemorate this important event was placed in the entrance hall.

In the early days tuberculosis posed a problem. For example, in July 1949 there was a case of open tuberculosis at Lissue, prompting the Medical Staff to adopt a policy stating that no open case of TB should be sent to Lissue or admitted into the main hospital. These words appeared to fall on deaf ears, for in May 1953 the Hospital Committee asked the Northern Ireland Hospitals Authority to take up with the Northern Ireland Tuberculosis Authority (NITA) the problem of the large number of cases of primary TB complex then in Lissue. In May 1955 there were twenty-four of these children at Lissue Hospital, there being no vacancies at the NITA establishment at Crawfordsburn.

Infections other than tuberculosis afflicted the hospital from time to time, and in September 1954 there was what was termed an 'explosive outbreak of enteritis', with no specific organisms found. In the same year, at a more mundane level, the ingestion of laburnum seeds by a few ambulant patients necessitated the felling of the offending tree. There is no record of any harm coming to the children.

There was the occasional brush with management at both local and area level. On 22 June 1964 a message was received from the Group secretary, R.T. Spence, who was proposing to transfer twenty-two orthopaedic cases from Greenisland Hospital to Lissue during the first week of July. This was the first notice that the Staff had of this move. Not surprisingly, they made urgent representations to the senior administrative medical officer of the Hospitals Authority, expressing deep concern at this lack of consultation before such a major step was undertaken. They pointed out the lack of space, the absence of treatment room facilities and poor sluice accommodation which should be upgraded prior to the transfer. Furthermore, the presence of so many adult-sized beds in the upstairs ward, with their necessary beams, pulleys and so on, would make it unreasonably cramped. The Nursing Staff were so perturbed that the matron, Molly Hudson, wrote to the Board in protest. Notwithstanding, by September 1964 the transfer of orthopaedic patients had taken place, with no improved hygiene facilities and no additional bed space.

Undoubtedly, the event which caused most concern and dismay to the Staff was the transfer, in 1973, of the administrative control of Lissue Hospital from the North & West Belfast District to the Lisburn District. In May of that year, the Ministry of Health (soon, with direct rule from Westminster, to become the Department of Health & Social Services) issued a memorandum to members of the EHSSB, the Central Services Agency and the Area Executive teams, concerning the overlap of services between Areas and Districts (Circular R16/73).⁵

In a section dealing with the 'Criteria for Management Arrangements', the document enunciated certain principles, among them:

- 1 The underlying policy in the administration of the Health and Personal Social Services is that the existence of administrative factors (Area or

happened frequently enough to create the suspicion that premature leaks are used by the policy makers to test the water.

Discussions eventually took place between the consultant psychiatrists and members of the EHSSB at which various reasons were given as to the desirability of a move from Lissue. The Board argued that the present unit was too expensive and too remote and that it would be more cost-effective to bring several services together on a new site. In a word, rationalization was its objective and it would not be deterred.

The news of the closure united the people of the Lagan Valley in a campaign to save Lissue. James Molyneaux, the local MP and Ulster Unionist Party leader, described the Board's decision as an appalling blunder, and the Alliance councillor Seamus Close dismissed the three-month consultative period as a 'complete and utter farce'. Albert Brown, chairman of the campaign committee, saw it as the 'old, old story of financial concerns taking precedence over parents' and people's wishes', and spoke for many in the community when he said that Lissue Hospital offered both an expert service and a loving unique environment that would be most difficult to replace.

The Save Lissue Campaign failed, and in mid-1985 the Medical Staff were invited to view various areas of Forster Green Hospital. After inspection, it seemed to them that the old Nurses' Home would be the most suitable in terms of accommodation, provided extensive alteration and refurbishment were carried out. They conceded that Forster Green had some undoubted advantages over Lissue; the site was nearer the outpatient unit at the Royal Belfast Hospital for Sick Children and was also in close proximity to the area of greater Belfast, whence the majority of patients would come.

Forster Green, a Belfast tea merchant, was a Quaker with an acute social conscience. In 1896 he purchased Fortbreda House on the Saintfield Road, Belfast, for adaptation to a sanatorium; the first patients were admitted the following year. In the 1930s TB was the main killer of young adults. It was responsible for 49 per cent of all deaths in the age group fifteen to twenty-five and for 38 per cent of those between twenty-five and thirty-five. The mortality rate was 20 per cent higher in Northern Ireland than in Britain.⁶ Forster Green's own daughter was a victim. It was not until 1941 that the Northern Ireland Tuberculosis Authority was set up to find and treat the victims of what was then a dreaded disease of frightening morbidity and mortality. With the aid of new drugs, such as PAS and Streptomycin, and BCG vaccination, together with advances in surgical and anaesthetic techniques, by 1954 the incidence of the disease had been reduced by 15 per cent to the same level obtaining in England and Wales. NITA's success was such that it was dissolved in 1959.

For two or three years after 1985, consultant staff were involved in further negotiations with the Green Park Unit of Management and the EHSSB,

which would be available in Belvoir Park had been considered with regard to the needs of the Eastern Board children, who would take precedence over children from the other Board areas. In the EHSSB's view, respite care did not require a regional resource and other areas should be encouraged to set up their own units.⁸

The Board's determination was irresistible and on 3 August 1988 Dr Hicks informed the Division of Paediatrics that in January 1989 the paediatric unit at Lissue was to move to refurbished accommodation at Belvoir Park, Pavilion 1 (this having proved more suitable than Pavilion 2, originally offered). The cost of upgrading the accommodation came to £86,000 plus VAT.

The new unit, named Forest Lodge Children's Respite Care Unit, became part of the Green Park Trust, which includes Belvoir Park, Forster Green and Musgrave Park Hospitals. It has a complement of fifteen beds and cares for children up to the age of fourteen. The ward is staffed, as at Lissue, by nurses who have paediatric training and are under the charge of Sister R. Lloyd, who moved with the unit from Lissue Hospital. The medical care is provided by Dr Elaine Hicks (who assumed a regional role in 1992), Dr Nan Hill and Dr Paul Jackson. There are ninety-five to one hundred children on the books at present.

The appointment of Dr Nan Hill in 1986 was another step in the evolution of the neurodevelopmental service at the Royal Belfast Hospital for Sick Children. Eighty per cent of her work was hospital-based – at the Children's Hospital, Musgrave Park Hospital and Lissue House – with the balance involving responsibilities at the two regional schools for children with physical disabilities, Fleming Fulton and Mitchell House, and at schools for children with speech and language problems, namely, Thornfield and Seagal House (Mencap Nursery). (This situation is now reversed as she is almost entirely based in the community.) Dr Hill's work has been built on the labour and dedication of colleagues who preceded her, Dr Chris Green, Dr Maurice Savage and Dr Claude Field.

Dr C.M.B. Field wrote a report in 1948 on the types of illness in children admitted to a typical twenty-six-bed children's ward in that year. There were 94 children with lobar pneumonia, 63 with various strains of tuberculosis, 129 with rheumatic fever or chorea and 29 with heavy infestations with various kinds of worm. Writing in 1982, he noted that these illnesses had almost completely disappeared and that handicapping disorders of children were becoming a large and important part of paediatrics. Furthermore, he observed that children were rarely afflicted by a single handicap, most having several additional problems. Dr Field recognized that a special clinic was required where children with complex problems could be seen at leisure, not only by the paediatrician but by other



Nurses Linda Williamson and Sandi McTrusty consult a patient's notes at Forest Lodge Children's Respite Care Unit, 1997

4. As detailed in the history document, by 1959 Lissue was a busy branch hospital of RBHSC, treating surgical and medical patients.
5. A psychiatric inpatient service for children and young people was first provided on the Lissue site from May 1971. It is this service that the Board understands is the focus of the Inquiry and thus forms the focus of this statement.
6. Prior to the opening of this unit at Lissue Hospital, there was no provision for in-patient child and adolescent psychiatry in Northern Ireland. The first proposal to consider Lissue for such a service was on 21 June 1968, following which a medical staff sub-committee in RBHSC was appointed on 1 July 1968 to:
“Consider the best way Lissue House could be converted into an In-Patient Child Psychiatry Unit and if this was not possible, whether or not a new Unit should be provided”. This subcommittee subsequently produced a report which is at **Exhibit 2** and details the committee's deliberations in relation to the proposed use of the building and staffing needs.
7. In November 1968, the Belfast Hospital Management Committee confirmed to the Northern Ireland Hospital Authority that they had accepted in principle a recommendation from Dr Porter that part of Lissue Hospital should be converted into a 20-bed inpatient child psychiatry unit. See **Exhibit 3**
8. The in-patient unit subsequently opened in May 1971 with the first patients admitted on 17 May 1971 as detailed in the in-patient admission book.
9. The Child Psychiatry unit at Lissue also offered day patient admissions. It is noted that the day patient admission book records the first patients for this service in September 1971.
10. From May 1971, therefore, there were two inpatient services at Lissue Hospital:
 - a. A Paediatric Unit (on the ground floor) comprising of 20 beds providing the full range of services for physically ill children;

In 1959, it was a busy Branch Hospital of R.B.H.S.C. treating surgical and medical patients and providing training and experience under full supervision, for doctors, nurses and physiotherapists. By now the number of patients had swelled to 70 children and these ranged over the many categories of illness in childhood — surgical, medical, orthopaedic and general.

This valuable and industrious service continued through the sixties, and so much had Lissue become part of the fabric and essence of the R.B.H.S.C. that it again became an admirable location for the development of a new area of service in May 1971 — a regional in-patient unit for Child Psychiatry — to this day the only such facility in Northern Ireland.

Thus, as the Lindsay family had opened its doors to the R.B.H.S.C. it came the turn of R.B.H.S.C. and Lissue to adapt and welcome this expansion of its role; now the new facility was established by an internal/reorganization of Lissue — achieving two new units for care and treatment within the Hospital.

1. Paediatric Unit for 20 beds providing the full range of services for physically ill children.
2. Child Psychiatry Unit — 20 beds and 5 day-patients providing specialist help to children and families with emotional and behavioural disturbances.

Therefore — not only because Lissue, by the early seventies had a history of Paediatric care and treatment to look back on, but also because it was continuing to meet new needs in this field, — could this stage be regarded as a watershed; in the interests of setting out the developments and progress of the two units within the hospital, it is proper that they should be dealt with separately in this article, so as the reader can fully appreciate the events, efforts and hopes of the staff at all levels who are concerned with its operation.

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- 2 -

per 500,000 total population. In addition, in each Regional area not less than 25 beds will be required for the "residential" long term patients. For Adolescents they estimated that 20 beds for a total population of 500,000 are necessary.

In 1960 the Royal Medico-Psychological Association in a memorandum on Units for the Long-Term Medical Care of Emotionally Disturbed Children and Adolescents suggested the need of two further kinds of units, (1) Hospital Annex (2) Therapeutic Hostel.

The Ministry of Health (England and Wales) in a document on "In-Patient Accommodation for Mentally Ill and Seriously Malsadjusted Children and Adolescents, H.M. (64) 4, containing advice from the standing Mental Health Advisory Committee and endorsed by the Central Health Services Council, recommended Regional Hospital Boards to provide for Children 20/25 beds per million population for assessment and relatively short term treatment in addition 25 beds per region for Long Stay patients. For Adolescents they recommended 20/25 beds per million population with special units for short and long term treatment. The suggestions contained in this Ministry of Health document are referred to in a Leader on Mental Health Services for Children from the British Medical Journal of the 3rd June 1967.

MHS 3/69

IN-PATIENT CHILD PSYCHIATRYR.B.H.S.C. MEDICAL STAFF SUB-COMMITTEE REPORT

At the Medical Staff Committee meeting held on Monday 1st July 1968, a Sub-Committee consisting of Professor Carre', Dr. Nelson and whoever they wish to co-opt was appointed to "Consider the best way Lissue House could be converted into an In-Patient Child Psychiatric Unit and if this was not possible, whether or not a new Unit should be provided."

The consideration of Lissue House as a possible location for an In-Patient Child Psychiatry Unit at this July Medical Staff Committee followed a Special Meeting on the 21st June 1968 in the R.B.H.S.C. at which the following were present:-

Dr. A.A.H. Gailey (in the chair)
Professor I.J. Carre'
Dr. Wm. McC. Nelson
Miss M.H. Hudson
Mr. W. Harvey
Dr. K.R.D. Porter
Mr. R.T. Spence
Colonel T.E. Field
Mr. G. Johnston

This special meeting concluded with the following proposal for Medical Staff to consider:

- Stage 1. (a) Six beds to be provided initially on the top floor of Lissue for children up to twelve years of age to be increased to a total of twenty child psychiatry beds.
- (b) the remainder of Lissue to remain untouched.
- Stage 2. The possible provision of ten further beds for adolescent psychiatric patients.

The R.B.H.S.C. Medical Staff Sub-committee consisting of Professor Carre', Dr. Nelson and Dr. W.F. McAuley (co-opted) would like to submit the following report for Medical Staff's consideration.

At present there are no special In-Patient Child Psychiatry or Adolescent bed facilities in Northern Ireland: it would appear appropriate at this point to look at the general overall requirements for Child and Adolescent patients.

The Royal Medico-Psychological Association, founded in 1841, has a Child Psychiatry Section which is the representative body of child Psychiatrists.

In December 1956 The Royal Medico-Psychological Association produced a memorandum entitled "In-Patient Accommodation for Child and Adolescent Psychiatric Patients", in which they suggested the requirement of children's beds to be 20

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per 500,000 total population. In addition, in each Regional area not less than 25 beds will be required for the "residential" long term patients. For Adolescents they estimated that 20 beds for a total population of 500,000 are necessary.

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- 3 -

THE ORGANISATION OF A CHILD PSYCHIATRIC IN-PATIENT UNIT

Before considering Lissue House as a possible location for an In-patient psychiatry unit, it would seem appropriate at this stage to consider the organisation of a Child Psychiatric In-Patient unit as suggested by the Royal Medico-Psychological Association and other bodies, including the present sub-committee.

The in-patient child psychiatric unit should be allied to the local child psychiatric or child guidance clinic, so that continuity of treatment is assured and the patient remains throughout under the care of the same psychiatrist. Physical proximity of the In-Patient unit to the out-patient clinic is very desirable, this would save on space and have advantages for Staffing. The In-Patient unit should be under the control of Hospital Management.

The optimum size for an in-patient unit is about 20 - 24 beds, a unit of less than 12 beds would be uneconomic.

A median stay Psychiatric Unit should fulfil the basic requirements of plenty of indoor and outdoor recreational space, educational facilities and adequate staffrooms. These patients are not physically ill and will profit from an environment as near home like as possible, this can be achieved through a suitable decor and by virtue of different age groups. There should be a system of planned activity throughout the day, including Recreation, Occupational Therapy, individual and group Psychotherapy, Nursing in small groups, Schooling, Outdoor exercise, Expeditions and Outings. A radio, television and record player are desirable.

In terms of age and sex, the acceptance of patients in a children's unit up to the age of puberty seems more appropriate than an age cut off point. The greatest demand will be for children in the age group 8 - 12 years. In the age group 0 - 5 years, the number of boys and girls are about equal, whereas in the 5 years and over age range, boys outnumber girls in the ratio of 3:2. It is usually more appropriate to separate the older children say 7 to 8 years and over from the younger children; for many activities, including meals. For sleeping accommodation the sleeping quarters of the children over the age of 7 and 8 years should be separate from those of the younger children and provide for the segregation of boys and girls, although this should be kept flexible; emotionally age separate groups is an important aspect.

The provision of accommodation should include, Outdoor playground with an all weather surface, and if possible Garden, an Indoor play area, Smaller Playrooms, Play Therapy room, Quiet reading room, Diningroom accommodation, separate for older and younger groups, Kitchen facilities, Schoolrooms 3 - 4 required, also with flexibility of use, an Occupational Therapy department and facilities for handicrafts and other constructive activities, such as modelling, painting, cookery and model making: bathroom and lavatories, storage space. Sleeping accommodation should be arranged in wards, 5 - 6 beds, in addition a number of single rooms are required. Facilities for the admission of mothers should be

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- 4 -

provided.

Rooms would also be required for, Sister or charge nurse, Psychiatrists, Psychologists, Psychiatric Social Worker, Clinical investigation room, School Staff room, changing and accommodation space for nurses, also waiting room for parents and visitors. It should be possible to combine the function of a number of these rooms.

The Medical Staffing of a unit should be under the general supervision of Consultant Child Psychiatrists, a 20 - 24 bed unit would require a minimum of 9 consultant sessions per week. In addition supporting medical staff should at least be of Registrar status and preferably include Senior Registrars. In a 20 - 24 bed unit the sessions of two supporting medical staff would be desirable. Experience in the running of a unit would better clarify the exact medical requirements. Consultations should be available from all the hospital medical specialists.

The provision of adequate Nursing Supervision at all times is essential. In order to provide this an overall ratio of at least one nurse to each patient will normally be found to be necessary, this could well be inadequate in some instances and a ratio as high as 3:2 might be necessary. Nurses occupying senior posts should have had a period of some special training in Child Psychiatric nursing. A number of Male nursing Staff is required. The proportion of trained to untrained staff in such a unit should probably be about 1:1 although experience should help in deciding this point. Other than State Registered Nurses may be considered.

Other Staff would include an Occupational Therapist, Psychiatric Social Worker and Psychologist part-time. Teaching Staff in sufficient number to take small groups of patients, would be essential. As it is envisaged that school should run throughout the year, a minimum of 3 teachers would be required for a 20 bed unit.

Security in such a unit would largely depend upon the provision of adequate Staff, in addition the design of the building should be considered.

It should be possible to use the In-Patient unit as a Day Hospital for a number of selected cases provided appropriate staffing is provided, and transport to make the unit accessible to the main centres of population.

In-Patient units offer excellent opportunities for Research and original investigations. The staffing establishment should allow such work to be undertaken.

The Organisation of Adolescent In-Patient Accommodation

Many of the above considerations apply to the organisation of an adolescent In-Patient unit.

However it is not felt desirable to mix child and adolescent patients in the one unit. The attainment of puberty presents special problems. The physical location of such a unit may require to be different.

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- 5 -

A separate unit would be required for adolescents, again such a unit should be under the general supervision of consultant child Psychiatrists.

- 6 -

Accommodation and Staffing requirements for an IN-PATIENT CHILD PSYCHIATRY unit.Accommodation

Outdoor playground and garden
Indoor play area
Smaller play rooms
Play therapy room
Quiet reading room
Diningroom accommodation
Kitchen facilities
Occupational therapy facilities
School rooms
Sleeping wards of 5 - 6 beds
Single rooms for sleeping and isolation
Bathroom and lavatory facilities
Storage space

Rooms Required

Sister or charge nurse
Psychiatrists
Psychologists
Psychiatric Social Workers
Clinical investigation room
School Staff room
Waiting room
Changing space for nurses

StaffingMedical

9 consultant sessions
Registrar and Senior Registrar, with sessions amounting to two full time persons

Nursing

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

Other Professional Staff

Occupational Therapist
Psychiatric Social Worker
Psychologist
Teachers

Other Staff

Clerical and others

- 7 -

Consideration of Lissue House as an In-Patient Child Psychiatry Unit

The proposals on page one of this report, stage 1 (a) and (b) and stage 2, can now be looked at against the suggested "Organisation of a child Psychiatric In-Patient Unit" just outlined.

The proposal contained in Stage 1 (a) "that six beds be provided initially on the top floor of Lissue for children up to twelve years of age" is not a therapeutic or economic suggestion. The physical provision of beds is only a small part of the total facilities required; without these additional facilities the milieu could not be regarded as therapeutic and the provision of these additional facilities for only six beds would appear very uneconomic.

It is therefore suggested that initial planning should be for a twenty bed unit as indicated in the latter part of proposal Stage 1 (a). This 20 bed unit would be mainly situated on the top floor of Lissue House. Facilities should also be available for a number of day patients to attend.

It is important to point out at this stage that the provision of even 20 beds without the additional staff and facilities would be totally impracticable:

The provision of such a 20 bed unit at Lissue House using mainly space on the top floor, with adequate staff and facilities and its suitability in terms of location can now be looked at under the following heads:-

- (1) Location
- (2) Physical aspects of the building
- (3) Staffing

LOCATION:

Lissue House is very unsatisfactorily situated in terms of its separation from the main centre of population and in its separation from the out patient child psychiatry services. This would present difficulties in the areas of recruitment and staffing, day hospital usage, parents travelling to the unit and mothers living in.

Day Hospital usage could be possible through the provision of adequate transport to and from Lissue, from a centre such as the R.B.H.S.C. Transport would have to be additionally available for parents visiting. Nursing staff in Lissue appear isolated and require adequate transport facilities.

- 8 -

Physical Aspects of the building. (See attached Plan of Lissue House and Sketch Plan.)

These require to be looked at against the accommodation requirements set out previously.

The bottom floor and top floor of Lissue House were both considered as a possible location for a child psychiatry in-patient unit, it was readily apparent that the top floor would be much more suitable for this purpose.

Outdoor playground and garden areas, marked G. on the plan, are available, it should also be possible to use the area marked P on the plan as an all weather surface play area.

In considering the top floor of Lissue House as a potential area for an in-patient unit, it is readily apparent that a large proportion of this area is occupied by staff, student nurses, assistant matron, medical staff and ancillary services.

In order to make an In-Patient child psychiatry unit at all feasible using the top floor of Lissue House, it would be necessary to have available on the top floor, areas marked B, Dy and M on the plan. (this assumed that areas W8, Do, W6A, W6B, BB, IR, N, K, SI, and I would be available). The areas B, Dy and M consist of a bathroom, a four nurse bedroom and the Male changing room.

Although the nursing staff total number required for psychiatric patients is an increase, the increased proportion of trained staff should make this nurse's bedroom available.

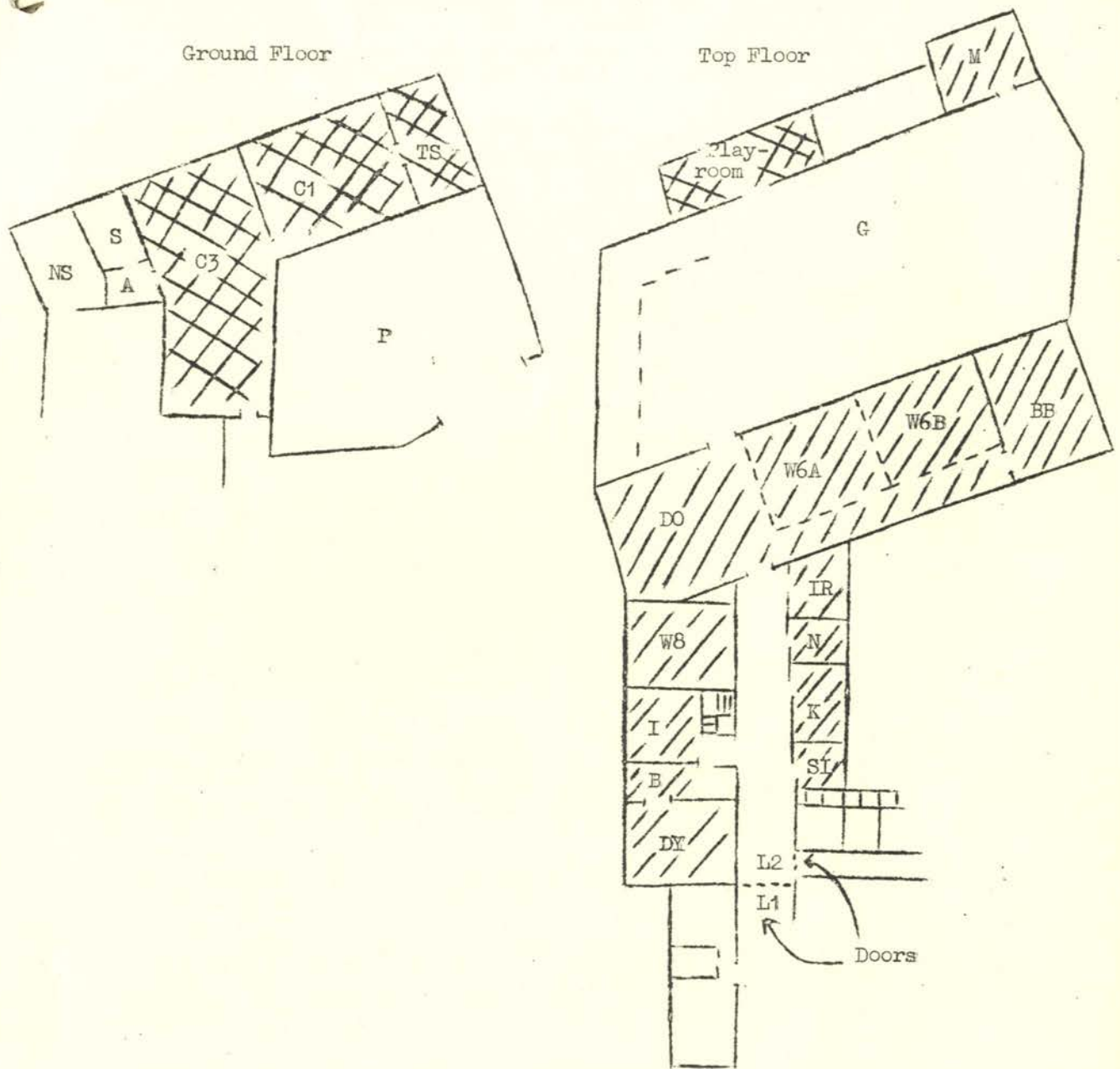
Even with this area available it would not be possible to maintain an in-patient child psychiatry unit without having part time and shared use of the playroom in the old potting shed, the physiotherapy room, C3 on the plan, the classroom CI and the teachers' staffroom TS. Conversion of part of the stable area might be considered for woodwork and other facilities.

The areas outlined above will now be looked at in relation to the accommodation requirements.

(The areas involved are marked on the attached plan, areas for the whole time use of the child psychiatry unit in red and shared or part time use areas being stripped.)

Available for the provision of 20 beds in sleeping wards would be the present small ward marked W8 on the plan, this could accommodate the younger age group, numbering about eight beds. For the older age group part of the large ward would have to be partitioned as indicated on the plan into two areas marked W6A and W6B on the plan with males in one ward and females in the other,

- 8A -

SKETCH PLAN OF THE AREAS INVOLVED IN LISSUE HOUSE

Single hatched areas



For the whole time use of the child Psychiatric unit.

Cross hatched areas

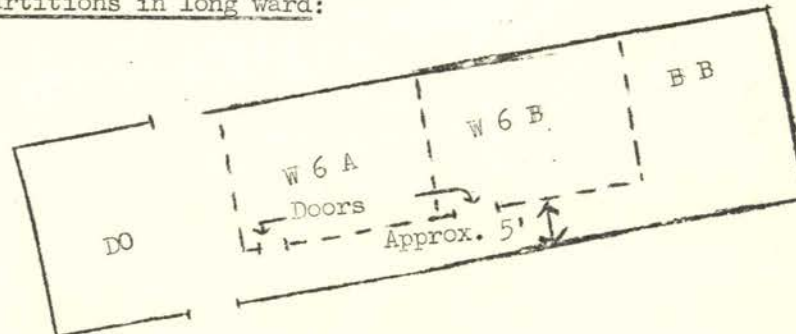


For the part-time and shared use of the child Psychiatric unit.

- 9 -

with approximately six beds in each ward, allowing for some flexibility in numbers of males and females as there would be a tendency to be more males than females in this older age group. Room SI on the plan could serve the dual role of being an occasional single bedroom and also an interview room.

Suggested Partitions in long ward:



Additional structural alterations include the provision of doors L1 which in association with the already present door L2 would provide for separation of the child psychiatry unit from the rest of the top floor. Sluicing equipment could be removed from the sluice room marked IR on the plan, sluicing facilities in the form of the installation of a sink should be put in the room marked BB on the plan. Blackboards to be installed in rooms C3 and M. Other additional structural alterations related to safety factors, especially the windows and stairs may be required.

The bathroom and lavatory facilities BB and B, on the plan should be retained.

Play area and dining room accommodation could be combined for the older children in the area DO on the plan, the area left at one end of the long ward. For the younger children play area and dining room accommodation could be combined using the room DY on the plan.

An indoor play space and facilities for the gymnastic type of activity would be available by having the use on a part time basis of the physiotherapy room on the ground floor, marked C3 on the plan, on a part time basis.

The playroom situated in the old potting shed, marked playroom on the plan, would have to be available for part time use as an occupational therapy department, additional equipment such as pottery and cooking facilities might be required.

School rooms are an important aspect of a child psychiatry unit, it is suggested that shared use could be made of the room marked CI on the ground floor (the present school room), the adjoining teachers' staff room, marked TS on the plan, to continue in this role. The physiotherapy room C3 on the plan

- 10 -

previously mentioned as an indoor play space might serve the dual role of junior classroom if it were provided with appropriate stacking tables and chairs. The room marked M on the plan, on the top floor, would also be a classroom. One of the classrooms might be equiped as a woodwork room.

The Sister or Charge Nurse's office should remain as at present on the top floor in the room marked N on the plan.

A number of interview rooms are required for doctors, psychiatric social workers and psychologists. The room I on the plan, at present a theatre clinical room, could be used for interviewing and ward discussions. Room IR on the plan could also be used as an interview room, and as previously mentioned, room SI on the plan could serve the dual role of occasional single bedroom and interview room. Additional interview rooms would be desirable.

The use of a kitchen at certain times for older children is desirable, the present kitchen, K on the plan should be retained.

Waiting room facilities should be available.

Storage space should be available.

STAFFING:

- (a) Medical
- (b) Nursing
- (c) Other Professional Staff
- (d) Other Staff

(a) Medical:

The general supervision of the unit would be under consultant child psychiatrists; a 20 bed unit would require a minimum of 9 consultant sessions per week. These nine sessions could of course be shared by a number of consultants. It is evident that a third consultant child psychiatrist should be appointed in the Belfast area as the existing child psychiatry services are already working to capacity.

In addition the sessions of two supporting medical staff would be required. One of these should be at least of Registrar and preferably of Senior Registrar status, other grades should be considered. The sessions of the two full time supporting medical staff might be made up by a number of people working part-time in the out-patient clinics. Overall there is a required increase in the supporting medical staff between the out-patient clinics and Lissue House of at least two persons; in addition it is desirable that one of the supporting medical staff have the majority of his sessions in the in-patient unit.

- 11 -

Consultations should be available from all the hospital medical specialists, it would be desirable for one such person to have a close liaison with the child psychiatry unit.

(b) Nursing:

Adequate nursing supervision at all times is essential throughout 24 hours. An overall ratio of at least one nurse to each patient will be necessary, perhaps requiring even 3:2 according to experience, thus for 20 beds, at least 20 nurses are required. A number of male nursing staff is essential. It is suggested that a ratio of one trained to one student nurse is suitable, again experience should be useful in determining this ratio. The employment of other than state registered nurses could be explored, as the personality as well as the training of those working with children is of critical importance.

Nurses occupying senior posts in the unit should have a period of some special training in child psychiatric nursing before opening such a unit. It is desirable that about three nurses should receive such training in a suitable child psychiatric in-patient unit across the water for a period of up to six months.

(c) Other professional staff:

The employment of an Occupational Therapist at Lissie House is essential.

Psychiatric Social Work could probably be initially carried out by the existing psychiatric social work establishment of the two child psychiatric clinics; at a later stage the employment of an additional psychiatric social worker might be required.

Psychological services could be undertaken by the present psychology establishment of the two child psychiatric clinics.

Teachers and teaching facilities form an important aspect of a child psychiatric unit. As these disturbed children require to be taught in small groups of about 5-6 children, a 20 bed unit would require a minimum of three teachers, four being desirable as it is intended that school should run throughout the year. Some special training of teachers would be helpful and a teacher specially interested in woodwork desirable.

(d) Other staff:

Already at Lissie House many facilities and other staff are available. The extent to which some aspects of the voluntary help could be integrated into the child psychiatry unit would have to be explored. Clerical staffing and work could be carried out by the existing clerical establishment in the two out-patient child psychiatry clinics. The services of a ward clerk might be considered.

- 12 -

CONCLUSIONS

Having outlined a proposed 20 bed unit using mainly part of the top floor of Lissue, the proposals contained on the first page can now be looked at again.

In Stage 1 (a) , it is suggested that six beds be provided initially on the top floor of Lissue, the use of six beds as suggested appears totally unsatisfactory.

Under Stage 1 (a) the Sub-committee is suggesting that a 20 bed unit with full facilities, using mainly the top floor of Lissue, as outlined above could be established. Whilst the accommodation and staffing suggested is providing a satisfactory In-Patient unit the location of Lissue is a disadvantage.

Under Stage (b) the remainder of Lissue to remain untouched.

Coming to Stage 2, it is not considered possible or desirable, even using the whole of Lissue to provide for an adolescent unit in the same building. There appears to be virtue in retaining child Psychiatry and Paediatric beds in the same unit.

This report is considered to some degree in isolation from out-patient services. The out-patient services form an integral part of the in-patient facilities. Amalgamation of the out-patient unit would make the working of the in-patient unit much more efficient.

The Sub-committee would recommend that as soon as funds are available a combined in-patient/out-patient unit should be provided in the Belfast area.

- 13 -

APPENDIX

Additional Facilities, Alterations and Staffing for a 20 bed child Psychiatric In-Patient unit, using mainly the top floor of Lissie House.

LOCATION:

Adequate transport facilities for Day Patients, parents travelling to and from unit, medical staff travelling and provision of adequate transport for nurses and others.

PHYSICAL ASPECTS OF THE BUILDING:Rooms in whole time use.

Rooms DO, W6A, W6B, BB, W8, IR, N, K, SI, I, B, DY and M, for the whole time use of the child Psychiatry patients.

ROOMS IN PART-TIME AND SHARED USE:

Rooms C3 and play room in part time use; Rooms C1 and TS in shared use.

MAIN STRUCTURAL ALTERATIONS:

Partitioning in the long ward (to establish ward spaces W6A, W6B and play/dining room space DO).

Provision of doors L1 on the plan.

Removal of sluicing equipment from the sluice room marked IR on the plan.

Installation of sluicing equipment in the form of a sink into the bathroom BB on the plan.

Attention to safety factors, including the windows and stairs.

Blackboards installed in physiotherapy room C3 and the Male changing room M on the plan.

STAFFING - MEDICAL:

9 additional consultant sessions these could be divided between the out-patient clinics and the in-patients. Two full time supporting medical staff, preferably of Registrar/Senior, Registrar status divided between the out-patient clinics and the in-patients. Consultations available from all the hospital medical specialists.

- 14 -

STAFFING:NURSING:

At least 20 nurses required for 20 in-patients.

Three senior nurses to have 6 month child psychiatry training in a unit across the water.

A number of male nurses.

An increase in trained staff to student-nurse staff of 1:1.

The consideration of other than state registered nurses.

OTHER PROFESSIONAL STAFF:PSYCHIATRIC SOCIAL WORKERS:

The number established in the two child psychiatric clinics is probably adequate

PSYCHOLOGISTS:

The number established in the two child psychiatric clinics is probably adequate.

OCCUPATIONAL THERAPIST:

An occupational therapist is essential.

TEACHERS:

A minimum of 3 teachers would be required.

OTHER STAFF:

Clerical work could be carried out by the two psychiatric clinics present clerical establishment.

A ward clerk to be considered.

MISCELLANEOUS:

Woodwork, cookery and potting facilities.

Radio, record player and television.

Tables and chairs for school room (stacking variety) required for physiotherapy room.

Chairs and desks required for interview rooms.

Play and toy equipment.

A number of Parker Knoll type chairs.

The Deputy Secretary reported that the Authority, at their last meeting, had received and noted a letter from Holywell Hospital Management Committee dated 11th December, 1968 in which the Management Committee had expressed disappointment that the Review of the Hospital Plan for Northern Ireland 1968-78 did not contain any provision for the development of psychiatric services in County Antrim, and asking for a deputation to be received by the Authority. It was AGREED to advise the Holywell Hospital Management Committee of action being taken following consideration of a paper on this general subject, and to suggest that it might be more appropriate for the proposed meeting between members of the Authority and of the Hospital Management Committee to take place following consideration by the Authority of the problem in relation to the total amount of money available for development.

- 15/69. Development of the Special Care Service - Londonderry. It was reported that the decision of the Authority to develop the Gransha site for special care purposes had been followed by the appointment of Consultant Architects, Engineers and Quantity Surveyors to survey the site and prepare a plan for examination. The brief was that planning should allow for the ultimate provision of 400 residential places, of which 70 would be in the existing Main Building and 20 in a new experimental unit for which funds had been provided specifically in the 1966 Hospital Plan. In the Report, received a few weeks earlier, it had been stated that the estimated cost of providing 400 residential places, including a school, workshops and administration buildings would exceed £1 million.

The Committee recalled that in 1967 the Working Party on the Development of Special Care Services had recommended that, following the provision of a High Security Villa at Muckamore, available funds should be used for

(a) the provision of 250 beds at Gransha.

(b) the building of two day centres in the South Western area.

Following discussion, it was agreed that the Working Party should be given the information in this survey report, asked to note that only £½ million was available for the development of special care services in the period to 1973, and invited to consider how best to use this money.

- 16/69. Development of Child Psychiatry Services. The Committee was informed that in November, 1968 the Belfast Hospital Management Committee had written to the Authority, accepting in principle a recommendation made earlier by Dr. Porter that part of Lissue Hospital should be converted into a 20-bed in-patient child psychiatry unit. The Management Committee had explained that it must look to the Authority to provide the funds necessary for adaptations to the hospital, for additional staff and for improved transport arrangements. It was reported also that in December, Dr. Porter had discussed with Dr. McAuley and Dr. Nelson the proposal that property at 80 Malone Road - formerly a nurses' home for City Hospital nurses - should be utilised to provide a measure of integration of services for child psychiatric out-patients. This proposal was acceptable to the consultants concerned.

The Committee agreed that, whilst not ideal, these measures would go some way towards meeting the deficiency in the field of child psychiatry, and thanked Dr. Porter for his help. It was RECOMMENDED that the Planning Committee should be advised of the Mental Health Services Committee's support for development of child psychiatry services, as proposed, and that early action should be taken to strengthen the staffing in social worker grades to meet the training requirements of the University. It was AGREED that, when the time was appropriate, steps should be taken to arrange for the administration of this service through one Management Committee.

- 17/69. Early Treatment Beds. The Committee considered Paper M.H.S.5/69, prepared at its request to show the present position in relation to the provision of early treatment beds, and plans for the future. It noted the recommendations in a 1964 Report, following a survey of psychiatric services, to the effect that:-

4. As detailed in the history document, by 1959 Lissue was a busy branch hospital of RBHSC, treating surgical and medical patients.
5. A psychiatric inpatient service for children and young people was first provided on the Lissue site from May 1971. It is this service that the Board understands is the focus of the Inquiry and thus forms the focus of this statement.
6. Prior to the opening of this unit at Lissue Hospital, there was no provision for in-patient child and adolescent psychiatry in Northern Ireland. The first proposal to consider Lissue for such a service was on 21 June 1968, following which a medical staff sub-committee in RBHSC was appointed on 1 July 1968 to:
“Consider the best way Lissue House could be converted into an In-Patient Child Psychiatry Unit and if this was not possible, whether or not a new Unit should be provided”. This subcommittee subsequently produced a report which is at **Exhibit 2** and details the committee's deliberations in relation to the proposed use of the building and staffing needs.
7. In November 1968, the Belfast Hospital Management Committee confirmed to the Northern Ireland Hospital Authority that they had accepted in principle a recommendation from Dr Porter that part of Lissue Hospital should be converted into a 20-bed inpatient child psychiatry unit. See **Exhibit 3**
8. The in-patient unit subsequently opened in May 1971 with the first patients admitted on 17 May 1971 as detailed in the in-patient admission book.
9. The Child Psychiatry unit at Lissue also offered day patient admissions. It is noted that the day patient admission book records the first patients for this service in September 1971.
10. From May 1971, therefore, there were two inpatient services at Lissue Hospital:
 - a. A Paediatric Unit (on the ground floor) comprising of 20 beds providing the full range of services for physically ill children;

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LINDSAY FAMILY
TO THE ROYAL BELFAST HOSPITAL FOR SICK CHILDREN
IN MEMORY OF
DAVID CECIL LINDSAY, D.L.
HIS SON
EDWARD WORKMAN LINDSAY
AND HIS GRAND-DAUGHTER
DEBORAH DAWN LINDSAY



William McClure Nelson, consultant psychiatrist and first director of the Child Psychiatry Unit, 1971-92

For almost forty years Lissue House was to play a very significant role in the affairs of the Royal Belfast Hospital for Sick Children. Initially, it functioned as a convalescent hospital but by 1959 it had become a busy branch facility capable of caring for a wide variety of surgical and medical patients in seventy beds. However, the following ten years saw further change. There had been a slow but steady infiltration of psychiatric patients, and by the middle of 1966 the need for an in-patient child psychiatric unit was becoming a matter of urgency. For example, at the level of practical nursing, mobile psychiatric patients were interfering with other children confined to bed, and with numbers continually rising they became increasingly difficult to control. In response to this concern, a subcommittee of Medical Staff was appointed to decide how part of the Lissue accommodation could be converted to a psychiatric unit. In June 1969 the Ministry approved in principle a proposal to adapt the first floor of the house for this purpose, and in September 1970 a tender of £14,050 for the necessary building works was recommended and accepted.

The new unit opened in May 1971, and consisted of twenty in-patient beds providing residential care for children with emotional and behavioural difficulties. There were an additional five places for children attending daily. The unit was staffed by a multidisciplinary

team comprising doctors, social workers, psychologists and Nursing Staff provided by the parent hospital in Belfast.³

The first director of the Child Psychiatry Unit was consultant psychiatrist Dr William McClure Nelson, under whom the treatment philosophy and general ethos was largely eclectic. The influence of Dr John Barcroft led to the inclusion of a psychotherapeutic approach, and with the appointment of Dr Roger McAuley in 1975 the philosophy changed to a new perspective of behavioural modification strategies. In 1976 this particular focus of treatment became the principal direction of care, with staff from all the disciplines adopting a behavioural philosophy in their work. At this time, the unit developed further with the advent of family admissions, providing a more accurate emphasis on family dynamic and the child management skills of the parents. To meet these criteria, it expanded in 1977 to provide parent accommodation

DR JOHN BARCROFT, son of Professor Henry Barcroft, past Professor of Physiology, QUB, was appointed as a consultant child psychiatrist at BCH in 1973. This service transferred to the Children's Hospital in 1974. Henceforth his remit covered the RBHSC, Ulster Hospital and Lissue Hospital. In 1978 Dr Barcroft took up a similar appointment in Cambridge.

and in in-patients worked with Professor Michael Rutter. After my experience at the Maudsley Hospital, I took up my post as Consultant Child Psychiatrist at the RBHSC.

3. I was, at that time, the only Consultant Child Psychiatrist working in Northern Ireland. Engaged then in only out-patient work at the RBHSC. I also had to cover child psychiatric emergencies coming into the RBHSC, RVH Accident and Emergency Department, BCH Accident and Emergency Department and the Ulster Hospital with attempted suicide and overdoses taken for various reasons. Liaising with paediatricians regarding ward patients was also an important part of the work. At any time over any 24 hour period these emergencies had to be seen quickly.
4. The Child Psychiatric in-patient unit opened by myself in 1971 with 20 in-patients and 5 day-patients. I continued to work at both out-patients at the RBHSC and also cover the new in-patient, unit as Consultant Child Psychiatrist. I retired in 1992.
5. I felt Northern Ireland required in-patient facilities as we were seeing numbers of patients which could not be satisfactorily treated on an exclusively out-patient basis. Many with behaviour disorders out of control, also emotional difficulties such as Anorexia Nervosa, Depressive Illness, Psychotic Diagnoses. These conditions posed serious risks to the child and family.
6. Lissue House at this time was a paediatric unit both on the ground floor and first floor. It was fortunate that Orthopaedics were moving out of the first floor. Some structural work was required, such as a 2-way screen in the old bothy at the back of the day and sleeping area in the main building. A playroom was also organised.
7. Both outpatients at the RBHSC and Lissue were set up as multidisciplinary units. In Lissue we had a trainee Psychiatric Registrar / Senior Registrar full time in inpatients. Other professional personnel were a Social Worker and Clinical Psychologist. For some years we had an Occupational Therapist who was later withdrawn despite our objections. Nursing staff made up one of the most important professionals, being full time 24 hours a day caring for and

treating children, with a Senior Sister / Charge Nurse at their head. There was also a school attached to the unit.

8. In 1976 Dr R McAuley organised an area within the unit where whole families could be admitted for 2-3 weeks.
9. This in-patient, day patient unit, 20 in-patients and 4/5 day patients was the first general Child Psychiatry inpatient unit in Ireland when it was set up. There was an inpatient unit in Dublin, but this was only for Autistic children.
10. Each consultant carried out a half day multidisciplinary ward round each week. All consultants also carried full out-patient assessments and treatment clinics at the RBHSC and later at other places.
11. Outside professionals involved with children being discussed at ward rounds were invited to attend such rounds and also, if appropriate, to attend some treatment sessions. Parents and family members were also encouraged to attend relevant treatment sessions. The Social Worker attached to the unit would be having regular contact with them. Individual children in the unit would be seen by our Clinical Psychologists and trained Doctor.
12. I myself used to visit Lissue every day at different times of the day and also during night hours, with unannounced visits, talking to staff / children and walking around the unit.
13. Most treatments and interventions were carried out by staff full time attached to the in-patient / day patient unit.
14. Dr Barcroft worked as a Consultant Child Psychiatrist, both at the RBHSC and had patients in Lissue. He only worked in Belfast for a limited number of years.
15. Some years after the opening of Lissue, I started using a Family Therapy model of assessment and treatment based largely on the teaching of Salvador Minuchin from Philadelphia, USA, where I visited. This approach included all or

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several causes, among them the development of the nursing service in the community, with its emphasis on care and support in the home situation where possible, a trend continuing and growing today. Ironically enough, together with the greater demands of child psychiatry, another change was appearing: the paediatric beds were being occupied more and more by chronically sick and handicapped children. Furthermore, there was increasing recognition of the need to provide care for the carers, so that in 1977 an arrangement was made for the short-term admission of handicapped patients, with the object of giving their families periods of respite. In that year, only twenty-nine of the thirty-eight 'convalescent' beds were operational and seven of these were occupied by special care patients. This need to accommodate patients with multiple handicap went unacknowledged by the Eastern Health & Social Services Board, and throughout 1977 there was sustained pressure to remove all general patients from the ground floor of Lissue House and to use the vacated accommodation for psychiatric patients. This pressure was resisted, and by December 1979 the admission of special care patients to Lissue was a commonplace occurrence, largely at Campbell's instigation. Until Christmas 1988 the branch hospital at Lissue continued to serve the children of Northern Ireland through its paediatric and psychiatric units, and the new role of the paediatric unit as a facility for the care of the child with multiple handicap was emphasized further by the appointment, in November 1983, of Dr Elaine Hicks as consultant in paediatric neurology and, in June 1986, of Dr Agnes Elizabeth (Nan) Hill, as consultant with an interest in complex handicap.

Michael Swallow, consultant neurologist at the RVH, was encouraged by Ivo Carré and Claude Field to provide a service at the RBHSC in the years before Elaine Hicks was appointed. He established a weekly clinic and also took part on an ad hoc basis in a Genetic Clinic with Norman Nevin. Swallow was a strong supporter of the appointment of a full-time neurologist at the Hospital. He retired in 1989 to pursue his great interest in music, and in 1995 he was awarded an OBE for services to music therapy, art and disability.

The excellent work carried on at Lissue over so many years deserves particular credit given the difficulties which from time to time hindered the smooth functioning of the hospital. The house itself, while ideal for the care of short-term convalescent patients, was not architecturally suited to the ever-changing needs of an increasingly varied patient population, and its deficiencies as a major institutional facility were often exposed. Staff, planners and builders spent many hours making minor and sometimes major alterations to rooms, verandas, plumbing facilities and so on, in order to accommodate the demands of a wide spectrum of patients: infants, children – mobile and immobile – and those requiring education and behaviour control. This led the Nursing Staff to dub the house 'Legoland'. Some of the children called it 'The Zoo'.

PRIVATE

7. The other thing I remember about the boy and the girl is that they had a big meccano set and they used to build cars and motorbikes out of them. They loved it. I remember on one day this same member of staff was walking down the corridor and he kicked the motorbike to smithereens when we were playing with it. I was very upset and they took me back to my room and strapped me to my bed again. After about twenty minutes, my next memory was waking up in bed the next morning.
8. That same member of staff hit me on several occasions also. He would ask me if I wanted a cigarette and when he gave me one he would say "Do you want a light", and when I said yes, he would hit me on the face or head. It was like he was playing mind games with me.
9. I also recall a man who came to the window in my room in the evenings. I think there was a fire escape outside my room. The window hatch was opened slightly and he use to knock and slip cigarettes under the hatch. I don't know who the man was. He was an older man with a bald head. The staff at Lissue thought I made this man up. I know I didn't because I remember looking forward to getting a cigarette in the evening and a bit of conversation.
10. I don't recall any particular routine at Lissue. I have no memory of attending school during my time there or being taught school lessons. There was a cookery class and we used to make buns during it. I also remember a teacher taking our photographs with instant cameras.
11. I remember that as a punishment the staff would put me in a room with children who were severely disabled. I know I had behavioural issues but I was not disabled. The staff would make me sit with these children for hours and I could not understand why. I thought that they were playing mind-games with me and were punishing me in some way. These children had special red chairs with sheepskin padding and I remember these chairs very clearly. My mother came to see me regularly when I was at Lissue and when she saw I was sitting with these children she couldn't understand why. I think it upset

unrest and there were sectarian issues. I banned all things like Ulster badges or tri colour badges. I began a morning meeting after breakfast to prevent them "killing" each other before going to school. There would be a big circle where everyone would sit around and they would bring up their particular difficulties. We quietly managed to get these things sorted out before the children actually went for the first period of school. It was very successful and meant that the child was not left with a conflict unresolved for the whole day. The children were escorted to school at 9.00am. They had a break at 10.45am for 15 minutes. They then went back to school until about 12 noon. They had their lunch between 12 noon and 12.45pm. They would go back to school to 3.00pm. They would then come back to the unit. Organised activities would be arranged and some may have had ongoing treatment. The evening meal would be at 5.00pm. On occasions I would be present after 5.00pm if I did a shift between 1.00pm and 8.00pm. Sometimes I also worked to 6.00pm from 8.00am. Once a month I may work on a Saturday between 8.00am and 5.00pm depending on the need for cover. Most of the children went home on Friday afternoon for the weekend. There would have been 3 or 4 children staying at the weekend.

29. The police asked me again about **HIA 220** aged 9 or 10 in or about 1975/1976. I do not remember anyone of that name. Given the age and sex put to me I believe that such a person may have been there because of conduct behaviour disorders or school difficulties.

30. Each of the allegations made in his statement to the police was put to me and I deny and continue to deny each and every allegation about **HIA 220** Having those allegations put to me made me very upset.

31. If anyone had been held for longer than 13 weeks I believe I would have remembered him. The suggestion that he was there continually between 1975 and 1976 does not make any sense to me. I believe such an assertion is improbable.

32. There are records of staff which are available and accessible. There was no one called **LS 26** at Lissue at the time I was working there.

33. I do not believe there was any nurse working there called **LS 27**

34. I deny that there would have been dormitories shared between boys and girls. The only exception would be dormitories for babies.

35. I do not believe there was a teacher called **LS 20** The teaching staff were there before I joined and were still there when I left.

36. I would state that Lissue did not have any animals in particular a pony. However the house was set in a rural setting and there may have been animals in the neighbouring fields.

37. The specific allegation of sexual abuse carried out by me against **HIA 220** in the dormitory is completely denied by me. The threats and intimidation alleged against me by **HIA 220** is again completely denied by me. All these allegations are completely false.

With the appointment of Dr. R. McAuley in 1976 the previously eclectic milieu changed to absorb a more behaviourist approach which incorporated intensive behaviour modification programmes. Another major change was the advent of family admissions in 1976, focusing on the child management skills of the parent. To meet this demand, the unit necessarily needed to expand, and in 1977 parent accommodation was achieved by the conversion of additional rooms adjacent to the unit. In the development of this extension of the milieu, greater demands were created on the therapeutic team, both in staff hours and in the additional skills required to facilitate the treatment programme.

More emphasis consequently had to be on an ongoing development of academic and practical instruction, aimed at maintaining treatments in line with contemporary knowledge. This consolidation of practical and theoretical study helped to serve the immediate and continuing need for "on the job" training of staff in post.

In December 1979 recognition of the speciality became more manifest in the placement of nursing students from the Central School of Psychiatric and Special Care Nursing, Purdysburn Hospital, for periods of 4-5 weeks. (Prior to this date, students, often graduate nurses, were seconded for experience of the speciality from the large Psychiatric Hospital Schools in the province). This development provided the stimulation and incentive for a reassessment of training needs in Child Psychiatry, leading to the development of a training manual for nurse learners and more systematised approach to teaching.

In January 1980 following a global recognition of the significance of Family Psychopathology in the aetiology of psychological disturbances, the repertoire of treatments extended to include a study of Family Therapy and the development of this alternative approach to psychiatric illness, the main emphasis here being on seeing every member of the child or young person's family. This particular approach also makes additional high demands on the treatment skills of the large number of staff involved.

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

- Part 1: [REDACTED]
- Part 2: [REDACTED]
- Part 3: [REDACTED]
- Part 4: [REDACTED]

128. This Horizon documentary was produced by the the BBC and was broadcast nationally. It focused on the work of Dr McAuley in relation to behaviour modification. [REDACTED].

129. The documentary closes with the following narration:

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

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

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

LS 71

Marmion Children's Home,
Church Road,
Holywood

March 1st 1983

Accompanied **LS 109** to Police Station after we collected **LS 71** from Marmion. We were at the station for a number of hours. **LS 98** and **LS 110** talked to **LS 109** and myself. **LS 110** 'phoned the information through to Lisburn Station, and said written confirmation and copy of statement would follow in due course. **LS 110** took **LS 109**, **LS 71** and I to Bangor Station where **LS 71** was examined by police doctor. The doctor stated that in his opinion (despite the time elapsed since alleged incident) that sexual interference may have taken place. We returned **LS 71** to Marmion late that night.

March 2nd

I accompanied **LS 71** to police station at 10 a.m. **LS 110** took **LS 71** statement. It was a long ordeal for **LS 71**. **LS 110** was very thorough but sympathetic. **LS 71** and I signed his statement. The whole process lasted until 2.45 p.m.

March 2nd 1983

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

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

March 3rd

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

4th March

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

Leave - March 4-21st.

24th March 1983

Called with **LS 111** and left note re Easter plans.

25th March

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

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

Off ill 5th-25th April, 1983.

Mr. R.J. Bunting,
Assistant Director of Social Services

Mr. J.E. Fulton, A.D.S.S.
North Down & Ards Unit of Management.

RJB/KL

CONFIDENTIAL

Re: **LS 71** - Allegation of Homosexual Assault *at home Hospital*

Thank you for the information regarding the above matter which you enclosed with your memo of 22nd April, 1985.

I would advise that you obtain written confirmation from the Police as to the outcome of their investigation and also whether they were able to identify the boy who assaulted **LS 71**

This latter aspect I would consider to be of importance in regard to possible risk to other boys. I feel that we should ask the Police for the name and address of this boy.

RJB Bunting

Mr. R.J. Bunting,
Assistant Director of Social Services (H/O)

23rd April, 1985



1973 1013

The Royal Belfast Hospital
for Sick Children

CHILD PSYCHIATRY DEPARTMENT

Belfast BT12 6BE Northern Ireland. telephone 240503

Ext 3550/2100

To DANO, for information

no issue
3c-3-

To: All Members of Staff

Date: 29 March 1983

From: Dr W McC Nelson

LISSUE HOUSE

It has been decided by Senior Medical Staff to operate a strict age limit of 13th birthday for admission to Lissue either as In-patient or Day-Patient. All future admissions should be under the age of 13 years.

W McC Nelson
Dr W McC Nelson
Child Psychiatry, RBHSC and Lissue House.

DATE	6/4/83
BY	DANO
RECEIVED	✓
FILED	✓

LS-31655

CRIME BRANCH
ROYAL ULSTER CONSTABULARY

10/1/72

10/1/72

10/1/72

LS 71

LS 72

Child Protection

10/1/72

Page No. 44

Action: Permanent Retention

10/1/72

10/1/72

10/1/72

10/1/72

10/1/72

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Prosecution File: <u>R482/105C</u>		Whether now	
C 64/13/83		In Custody	On Bail
Name(s) and Address(es) of accused: — LS 72 			
TRANSIT CHART (To be completed by each forwarding member or office)		Date of Original Arrest: —	
To whom file forwarded	Date	To whom file forwarded	Date
DUNSC LISBURN P.C.	20/5/1983 22-7-83		
S.P.P. Sgt. Laidon S. Grogan C.R.	10-8-83 25/11/83 29-11-83 8-12-83		
Whether any offence alleged requires the consent of the Attorney General or Director of Public Prosecutions. YES/NO <i>Delete as appropriate</i>		Date next in Court: —	
Consent of Attorney General or Director of Public Prosecutions GIVEN/REFUSED		Court and Place	
Copy Directions to <u>SUPERINTENDENT LISBURN</u>		Officer in charge of case: — <u>R. G. SPENCE D/CONST</u>	
Form No. 38/35 (c)		Sub-Division in which offence committed: — <u>R</u>	



Making Northern Ireland Safer For Everyone Through Professional, Progressive Policing

NOT PROTECTIVELY MARKED

CLOSURE SHEET
(To be attached to every file closed)

RECORDS RETENTION POLICY

THIS FILE IS CLOSED

NO FURTHER PAPERS ARE TO BE ADDED

A new file has been opened: Ref
(if appropriate)

Disposal Schedule Ref: Vo.1 46.2

Recommended Action: PR

Year of first paper: 1983 Reviewed by: C Nicholl

Year of last paper: 1983 On: 30.6.10

H.Q. REF. NO:

DIVISIONAL REF. NO:

ROYAL ULSTER CONSTABULARY

J Division LISBURN Sub-Division/Department

SUB DIVISIONAL OFFICE

Station/Branch 7 December 1983 Date

SUBJECT: ALLEGED OFFENCES OF BUGGERY AT LISSUE HOSPITAL, BALLINDERRY ROAD,

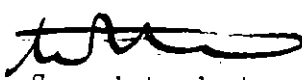
LISBURN, BETWEEN 19 AUGUST 1982 AND 24 SEPTEMBER 1982

R -v-

LS 72

TO: CHIEF CONSTABLE
CRIME BRANCH

Complied with.


Superintendent

H.Q. REF. No.

C 64/12/83

S/DIVISIONAL Ref. No.

DIVISIONAL Ref. No.

LIS-31659

83/1056

ROYAL ULSTER CONSTABULARY

J.

Division

LISBURN

Sub-Division/Department

C.I.D.

Station/Branch

22nd November 1983

Date

SUBJECT: ALLEGED OFFENCES OF BUGGERY AT LISSUE HOSPITAL, BALLINDERRY ROAD,
LISBURN BETWEEN 19th AUGUST 1982 and the 24th SEPTEMBER 1982.

R - v -

LS 72

To: D/Inspector, Lisburn.

I am now in possession of a report in respect of **LS 72**
from Dr Nelson. I respectfully request that this report be
forwarded to the D.P.P. for his information.

R. G. Spence
R.G. SPENCE

D/Const. 9006

Superintendent,
Lisburn.

For information.

ROYAL ULSTER CONSTABULARY
DIVISION

22 NOV 1983

Criminal Investigation Dept.
LISBURN

M. J. Spence

D/Sergt. for D/Insp.

Chief Constable
Crime Branch

Forwarded in compliance with your minute of 1.9.83.

Superintendent

Superintendent

Form 51/1



1873 - 1973

The Royal Belfast Hospital for Sick Children

CHILD PSYCHIATRY DEPARTMENT

Belfast BT12 6BE Northern Ireland telephone 240503
EXTENSIONS 2100/3550

16 November 1983

MEDICAL REPORT

Re:

LS 72

This boy was first seen at our Child Psychiatry Outpatient Department in October 1973. The problems at that time mainly arose from his extreme overactivity. From an early age he had been a difficult child, especially because he slept very little and wandered about the house. He was also generally very active during the day and very difficult to settle.

He has been tried on a variety of drugs while attending Child Psychiatry. In addition, he has had more than 10 admissions to our Child Psychiatry Inpatient Unit between 1975 and 1980. These have ranged in lengths of 7 months to one month. The staff at Lissue, our Inpatient Unit, have at times found him difficult to manage and his parents have continued to find him particularly difficult, especially his mother. During the summer of 1981, he was found to be especially difficult and was admitted to De La Salle Boys' home at Kircubbin.

There have also been problems in finding a satisfactory school placement for LS 72. He started at an orphanary school, then attended Cedar Lodge and then Jaffa Day Maladjusted school. However, we feel we were extremely fortunate in obtaining a residential place for LS 72 at Fallowfield Maladjusted school in February 1982. Unfortunately when the recent investigations came to light, LS 72 was suspended from that situation. In discussions with the present Headmaster, they felt that LS 72 was doing extremely well at Fallowfield and were planning a future programme for him in the coming year and ~~we~~ were very surprised to hear of the difficulties that he was having.

He then spent a period out of Fallowfield and at home which created a considerable difficulty for the family. Part of this time we re-admitted him to our Inpatient Unit at Lissue. We were then very fortunate in the Educational Psychology Service agreeing that LS 72 might attend Fallowfield on a day basis, travelling to and from home to Fallowfield on a daily basis. This is presently happening and seems to be working very well.

LS 72 himself now seems to be in a much more settled period than he has been for a number of years and appears to be benefiting greatly from his attendance at Fallowfield. The family are not finding him as difficult as he has been in the past. LS 72 also seems to be a boy who can find odd jobs for himself and is now intending to keep himself better occupied.

I feel it would be a serious setback for LS 72 if the present investigations were pursued in the court. LS 72 seems to have settled into Fallowfield school in a very constructive way. He appears to be organising his leisure time activities in a more constructive way and his parents are finding him less of a problem.

2.

Re:

LS 72

I think LS 72 realises the seriousness of the situation which has occurred, but I don't feel that court action itself would greatly alter the situation for him, nor can I see it being specially beneficial for him. He is a boy who is fairly easily led and I think there would be a great danger if he were put in close contact with other delinquent boys, that he might adopt a number of very undesirable activities.

Yours sincerely



Dr W McC Nelson
Consultant Psychiatrist.

W McCN/RW

SUBJECT: ALLEGED OFFENCES OF BUGGERY AT LISSUE HOSPITAL, BALLINDERRY ROAD
LISBURN, BETWEEN 19 AUGUST 1982 AND 24 SEPTEMBER 1982

R -v- LS 72

REF.NO: C64/13/83

HEADQUARTERS
ROYAL ULSTER CONSTABULARY
"BROOKLYN"
KNOCK ROAD
BELFAST BT5 6LE

23 November 1983

Superintendent

LISBURN

- 1 The copy directions of the Director of Public Prosecutions are forwarded here-with for information and compliance.
- 2 Please inform interested parties accordingly and return the main file to this office for filing.

ROYAL ULSTER CONSTABULARY
HEADQUARTERS
25 NOV 1983
CRIME DEPARTMENT
C2 BRANCH

Carroll
for CHIEF CONSTABLE

SUPERINTENDENT

664/13/83

S/DIVISIONAL REF. NO:

H.Q. REF. NO:

DIVISIONAL REF. NO:

ROYAL ULSTER CONSTABULARY

'S'

Division Headquarters

Sub-Division/Department

Crime

Station/ Branch

29 November 1983

Date

SUBJECT: ALLEGED OFFENCES OF BUGGERY AT LISSUE HOSPITAL, BALLINDERRY ROAD, LISBURN

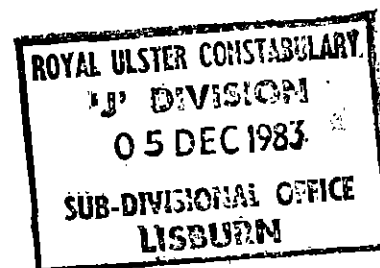
BETWEEN 19 AUGUST AND 24 SEPTEMBER 1982 R v

LS 72

TO: Superintendent Lisburn

Directions in the above case were communicated to you on 23rd inst. The DPP has issued a further directive after considering a report furnished by the Consultant Psychiatrist but has decided that no further direction is necessary. Please perfect records and return main file in due course.

Carroll
Superintendent for
Chief Constable



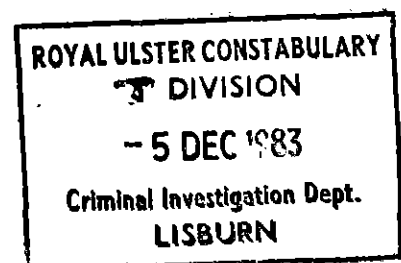
D/Inspector
LISBURN

For information, compliance and report.

William J. Spence
Superintendent

D/Const. Spence.

For information and report.



N. J. Spence
D/Sergt. for D/Insp.

LIS-31664



Belfast, 235111

DEPARTMENT OF THE DIRECTOR
OF PUBLIC PROSECUTIONS
ROYAL COURTS OF JUSTICE
BELFAST BT1 3NX

RUC Ref.: C64/13/83

DPP Ref.: 3400/83


Chief Constable

ALLEGED OFFENCES OF BUGGERY AT LISSUE HOSPITAL,
BALLINDERRY ROAD, LISBURN, BETWEEN 19 AUGUST AND
24 SEPTEMBER 1982 - R -v- **LS 72**

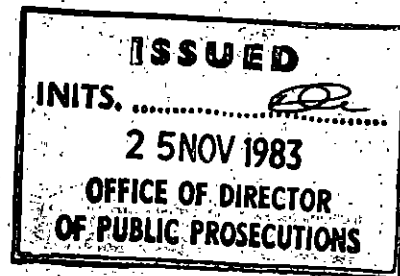
I acknowledge receipt of your C64/13/83 dated
21 November 1983, with attached medical report.

File passed to professional officer concerned for
information and any further action considered necessary.
DPP registry file note states "I am satisfied that no
further direction is required Signed E Rosen".

Original papers returned herewith and copy filed
(DPP 3400/83).


For Registrar

25th November 1983



RJM/MU

The Royal Belfast Hospital
for Sick Children

DEPARTMENT OF CHILD PSYCHIATRY

Belfast BT12 6BE Northern Ireland. telephone 240503

EXT 3550/2100

1275-1973

28 October 1983

CONFIDENTIAL REPORT

RE: **LS 71**
C/O MARMION CHILDRENS HOME
HOLYWOOD

Date of Birth **[REDACTED]**

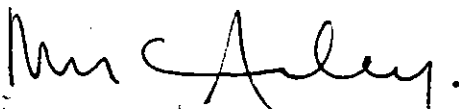
I have had contact with this child over approximately the last two years. The initial contacts resulted from requests made by Marmion Childrens Home with regard to help with **LS 71** difficult behaviour in that setting. Later the child was admitted to Lissue Hospital on 19 August 1982 because his behaviour problems in the Childrens Home had intensified considerably.

Following a period of assessment and treatment he was discharged on 24 September 1982. At this stage he returned to Marmion Childrens Home. Subsequently he was seen on an out patient basis for approximately a further five week period and then since that time there have been various consultations with Marmion Childrens Home and the child himself.

This child was admitted to Marmion Childrens Home on 20 February 1981. Since that time he has presented with a range of behavioural difficulties and these included problems in the Childrens Home setting and in the School setting. In the Childrens Home the sorts of behaviours which he presented with included disobedience, running away, general non-cooperation and some episodes of stealing from outside shops and in the Childrens Home. In School there were rather similar problems with the additional difficulty that he was achieving poorly. Generally in both settings he related rather poorly to adults and to other children. Thus over the years this child who comes from a particularly difficult home background has exhibited a wide range of behavioural problems which have required intensive work. I should also point out in view of the allegations being made by this child that there has never in the past been any indication that he was sexually maladjusted (or that he had problems with sexual identity).

26 October 1981

Prior to **LS 71** admission to Lissue for quite some time it was possible to contain his behaviour by consultation with Marmion Childrens Home staff. A great deal of enthusiasm from then was required. However in the late summer of last year his behaviour deteriorated considerably and he was admitted to Lissue Hospital. During the time he was in Lissue Hospital he settled extremely well; his behaviour became rapidly under good control and he made good progress in the classroom setting. In fact at that time we were extremely pleased with the progress achieved. In fact during the admission to Lissue Hospital there appeared to be a gradual improvement and during his time there the staff did not notice any particular signs of stress in the child. Further a careful review of his notes did not reveal any hints of the fact that he may have been sexually assaulted or molested. Following his discharge from Lissue he remained reasonably well settled in Marmion Childrens Home for a couple of months. At this stage his behaviour again deteriorated and in particular he was involved in several stealing and delinquent type activities in and outside the Childrens Home. A further series of detailed consultations with the Childrens Home staff resulted in a further management treatment programme and fortunately over the spring and summer period his behaviour has again settled down extremely well and at a last consultation roughly one month ago he was continuing to progress satisfactorily. The staff in Marmion Childrens Home have worked extremely hard with this child and certainly I would hope that the progress achieved recently will continue and persist.



R McAuley MD MRCPsych
Consultant Psychiatrist

RMCA/SMCK

LIS-31667



Belfast 235111

DEPARTMENT OF THE DIRECTOR
OF PUBLIC PROSECUTIONS
ROYAL COURTS OF JUSTICE
BELFAST BT1 3NX

RUC Ref: C64/13/83

DPP Ref: 3400/83

Subject: ALLEGED OFFENCES OF BUGGERY AT LISSUE
HOSPITAL, BALLINDERRY ROAD, LISBURN,
BETWEEN 19 AUGUST 1982 AND 24 SEPTEMBER
1982

R -v-

LS 72Chief ConstableDirection

I direct no prosecution.

The information requested in the interim direction of 26 August 1983 has not yet been received. It is considered that the time which has elapsed since the incidents occurred is such that proceedings would now be inappropriate.

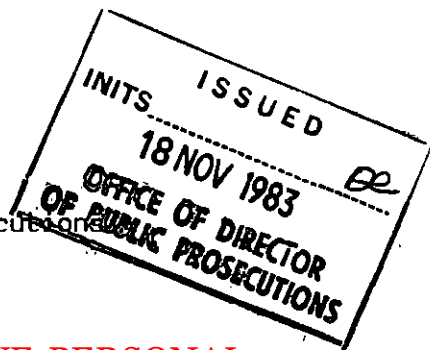
Police investigation file is returned herewith.

E ROSEN

for Director of Public Prosecutions

18 November 1983

ER/KD



STATEMENT OF: Dr. Richard Bryans

AGE OF WITNESS (if over 21 enter "over 21"): over 21

OCCUPATION OF WITNESS: General Practitioner

ADDRESS: Bangor Health Centre, Newtownards Road, Bangor.

I declare that this statement consisting of _____ 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 24th day of October 19 83

SIGNATURE OF MEMBER by whom
statement was recorded or received.

SIGNATURE OF WITNESS

Medical Report - LS 71 - Marmion Childrens Home,
126 Church Road, Holywood, Co. Down.

I am a registered Medical Practitioner with the qualifications MB., BCh. BaO., DRCOG. I was called to Bangor RUC station at 10.15 pm on the 1st March 1983 to examine LS 71 in connection with police enquiries into alleged indecent assault which was stated to have taken place in Lissue Hospital, Lisburn between the 19th August 1982 and the 24th September 1982. LS 71 stated that a 14 year old boy who was also in hospital as a patient, attempted to have anal intercourse on two separate occasions and that he succeeded on one of these occasions. LS 109 and _____ attended on behalf of the Authorities and consented to the examination on LS 71 behalf.

On examination the lad was quiet and co-operative and seemed to understand as I explained the nature and purpose of the examination.

There were no general physical signs of any injury. On specific examination the anal margin was intact but the orifice was gaping. On rectal examination the sphincter had a fair degree of tone, there were no anal warts present nor were there any signs of recent injury to the anal area. The remainder of the genital area was unremarkable.

Generally impressions following examination were that this lad had indeed been subjected to anal intercourse at some time in the past and that no significant damage had been caused to the surrounding area.

SIGNATURE OF WITNESS:

Subject:- OFFENCES OF BUGGERY

R -v- **LS 72**

PART I

COVERING REPORTS

CONTENTS

PAGE NO.

Covering Report of Detective Constable R G Spence ..	1 - 6
Forwarding Report of D/Inspector Gilleece	7
Forwarding report of Superintendent, Lisburn	8
Covering report by D/Divisional Commander 'R'	9



H.Q. REF. NO:

ROYAL ULSTER CONSTABULARY

'R' Division LISBURN Sub-Division/Department

C.I.D. Station/Branch 19 JULY 1983 Date

SUBJECT: ALLEGED OFFENCES OF BUGGERY AT LISSUE HOSPITAL BETWEEN 19 AUGUST 1982
AND 24 SEPTEMBER 1982 : R -v- LS 72

TO: D/INSPECTOR, LISBURN

INTRODUCTION

1. This file relates to offences of buggery which took place at Lissue Hospital, Ballinderry Road, Lisburn between 19 August 1982 and 24 September 1982. The offences were committed against a LS 71 of Marmion Children's Home, 126 Church Road, Holywood and the person committing the offences was a LS 72

2. No charges have been preferred.

THE EVIDENCE

3. LS 71 has been residing at Marmion Children's Home, 126 Church Road, Holywood since February 1981. About August 1982 he was transferred to Lissue Hospital, Lisburn and on arrival was allocated a bedroom of his own upstairs.
4. About a week after he arrived, he retired to bed about 10 pm and he was wearing pyjamas. His bedroom door was not locked (it is the policy at Lissue that bedroom doors are left unlocked). Some time later he was awakened from his sleep by someone getting into bed beside him. He was not aware of the time and he did not know who the person was.
5. When this person got into bed beside LS 71 he got out and stood by the bedroom door. The person in the bed called LS 71 over to him and he went and stood at the side of the bed where this person was lying.

PART II

LS 71

PAGE 1-2

6. The person on the bed told **LS 71** to take off his trousers and get into bed beside him. **LS 71** refused. The person on the bed then took out **LS 71** penis and commenced to masturbate him until he had orgasm. At this time the other person was sitting on the bed and he asked **LS 71** to masturbate him. **LS 71** then started to cry and refused to touch this person. He then got up from the bed, punched **LS 71** on the right shoulder, and left the room.
7. The next morning when **LS 71** got up he saw this person returning from the washroom and recognised him as the person who had been in his bedroom the previous evening (it has now been ascertained that the person in the bedroom was **LS 72** and that he had a bedroom opposite **LS 71** Adair's). **LS 71** never reported the incident to any of the staff at Lissue Hospital.
8. Approximately one week later **LS 71** was lying in his bed when **LS 72** came into his bedroom again and got into bed beside him. **LS 71** tried to get out but **LS 72** caught him, pulled him back into bed and tried to pull down his pyjama trousers. **LS 71** endeavoured to pull his pyjamas trousers back up again but it would appear that **LS 72** was too strong and eventually removed his trousers and left them lying on the floor.
9. **LS 72** then told **LS 71** that if he screamed or shouted that he would kick him. He pushed **LS 71** onto his front and tried to insert his penis into his anus. At this stage **LS 71** was crying as what **LS 72** was doing was painful. He asked him to stop but **LS 72** just told him to 'fuck off' and again tried to insert his penis into **LS 71** anus.
10. **LS 71** asked **LS 72** a second time to stop as what he was doing was painful. **LS 72** then slapped **LS 71** on the back and got out of bed saying 'fuck up.' When **LS 72** got out of bed **LS 71** observed that he was not wearing any pyjamas. Before this had taken place, **LS 72** had held onto **LS 71** around the waist to try and commit the offence but he was unable to insert his penis into the anus of **LS 71**.

11. The last week of **LS 71** stay at Lissue Hospital, **LS 72** returned to his bedroom about 10.30 pm and he thought that it was a Wednesday night. **LS 71** was lying in bed with his pyjamas on and was awake. **LS 72** told **LS 71** that if he ever said anything that he would kill him. He had no clothes on and came over and got into bed beside **LS 71**.
12. **LS 71** was afraid and **LS 72** then pulled his pyjamas down. He **LS 71** tried to pull them up again but **LS 72** managed to remove them completely and throw them at the bottom of the bed. **LS 71** tried to retrieve his pyjamas to put them on, but **LS 72** pulled him back and turned him onto his stomach.
13. At this stage, **LS 72** got behind **LS 71** and lifted his buttocks up with his hands and tried to insert his penis into his anus. Again it was painful and **LS 71** started to cry and asked **LS 72** to stop. **LS 72** refused to stop and continued to insert his penis into **LS 71** anus. He commenced to move and moved a number of times. **LS 71** was still crying and he asked **LS 72** to stop. This time he did stop and got up from bed and went back to his own bedroom.
14. **LS 71** then put on his pyjamas and lay awake all night as he could not sleep. The next morning when he met **LS 72** he asked him if he had squealed yet. **LS 71** told him "no." **LS 72** came to **LS 71** bedroom on his own and only came in on three occasions.
15. These offences only came to light when it was ascertained that **LS 71** was reluctant to return to Lissue Hospital. When he was interviewed by **LS 114** a Social Worker, it was found that these offences had occurred.
16. On Tuesday 7 June 1983 accompanied by WOMAN DETECTIVE CONSTABLE McKITTRICK, we saw **LS 72** at Castlereagh RUC Station. **LS 72** was accompanied by his parents. He was informed of our identities and he was told that we were making enquiries into sexual offences which had taken place at Lissue Hospital.

PART II
PAGE 3
LS 114

PART II
PAGE 4
McKITTRICK 4-6
SPENCE 7-9

Lisburn between 19 August 1982 and 24 September 1982.

LS 72 was also informed that these offences had taken place against a **LS 71** who had been at the Hospital at this time.

17. At the outset, **LS 72** denied committing any of these offences, but after a short period he did admit, in the presence of his parents that he did commit the offences as stated by **LS 71**.
18. **LS 72** refused to make any written statement after caution. He was released pending further enquiries.

19. SUMMARY OF EVIDENCE AGAINST **LS 72**

(a) The only evidence against **LS 72** is the verbal admission that he made to W/D/Const McKittrick and myself in the presence of his parents.

(b) A Medical Report is not available as DOCTOR BRYANS is presently out of the country and will not be returning until the end of July 1983.

OBSERVATIONS

20. Although **LS 72** is presently attending a Special Care School at Fallowfield, Lurgan, he is not educationally sub-normal. From speaking to a member of staff, the only thing which would appear to be wrong with **LS 72** that he is hyperactive.
21. [REDACTED] at Lissue Hospital could not understand how these offences could take place as there was always someone on duty when the children retired at night time, and this was at intervals of fifteen minutes and charts had to be completed to monitor their sleeping patterns.
22. Both **LS 72** parents were present during the interview of their son. They assisted the Police in every way possible and were very perturbed at what had taken place at Lissue.

Both parents are concerned as to **LS 72** future at **[REDACTED]** if convicted of any offence.

23. **LS 72** comes from a decent family. His father has been employed as a **[REDACTED]** for some time. The reason for **LS 72** being in care was that his mother had a heart operation and as **LS 72** was hyperactive, the rest of the family could not cope with him, and he had to be taken into care.
24. **LS 71** has been spoken to a second time and I do believe that he was a bit afraid of **LS 72** although he never reported any of the incidents until six months later and then it was only after he had been told that he was going back to Lissue Hospital.
25. No information has been made available to the Police investigating this matter as to **LS 71** background or family. He still remains in care at Marmion House, Holywood.
26. **LS 72** was moved from Lissue Hospital to Fallowfield, Lurgan. While speaking to the Headmaster at Fallowfield he was unaware that these allegations had been made against **LS 72** and he subsequently got in contact with his superiors and suspended **LS 72** until the matters were fully investigated. He also told us that **LS 72** was the best boy in the school.
27. I respectfully request that **LS 72** be prosecuted as follows -

No 1. THAT YOU between the 19th day of August 1982 and the 24th day of September 1982 at Lisburn in the County Court Division of Ards did indecently assault one **LS 71** a male person contrary to Section 52 of the Offences Against the Person Act 1861 and Common Law.

No 2. THAT YOU between the 19th day of August 1982 and the 24th day of September 1982 at Lisburn in the County Court Division of Ards committed buggery with **LS 71** a boy of the age of 13 years **[REDACTED]** contrary to Section 61 of the Offences Against the Person Act 1861.

No 3 THAT YOU on the 22nd day of September 1982 at Lisburn
in the County Court Division of Ards committed
buggery with **LS 71** a boy of the age of
[REDACTED] contrary to Section 61
of the Offences Against the Person Act 1861.

I submit this report for the information and directions of my
Authorities.

R. G. Spence D/Constable 9006
R G SPENCE

RUC STATION
LISBURN

LISBURN: 77421
EXT. 58

*Examined
20/1/83*

H. G. Spence Sgt

H.Q. REF. No.

DIVISIONAL Ref. No.

ROYAL ULSTER CONSTABULARY

'R'

Division

LISBURN

Sub-Division

C.I.D.

Station/Branch

21 July 1983

Date

SUBJECT: ALLEGED OFFENCES OF BUGGERY AT LISSUE HOSPITAL BETWEEN 19 AUGUST 1982
AND 24 SEPTEMBER 1982 - R - v [REDACTED] LS 72 [REDACTED]

To: Superintendent, Lisburn.

These incidents were not reported at the time and only came to light some six months later as a result of [REDACTED] LS 71 being reluctant to return to Lissue Hospital.

The accused has made verbal admissions to the police and I recommend that he be prosecuted for the offences enumerated by D/Con. Spence on pages 5 & 6 of his report.

A Medical Report has not yet been received but will be available in due course, if required.

F.T. GILLECE.

D/Inspector.

LIS-31677

S/DIVISIONAL REF. NO: *RL/83/1052*

H.Q. REF. NO:

DIVISIONAL REF. NO:

ROYAL ULSTER CONSTABULARY

'R' Division LISBURN Sub-Division/Department

SUB-DIVISIONAL OFFICE Station/Branch 22 July 1983 Date

SUBJECT: OFFENCES OF BUGGERY : R -v- **LS 72**

TO: Divisional Commander 'R' Div.

Prosecutions as suggested by D/Const Spence are recommended.

W McMASTER
Superintendent

LIS-31678

S/DIVISIONAL REF.NO:

H.Q. REF. NO:

DIVISIONAL REF. NO:

ROYAL ULSTER CONSTABULARY

R

Division

Sub-Division/Department

Station/Branch

Date

SUBJECT: OFFENCES OF BUGGERY

R V LS 72

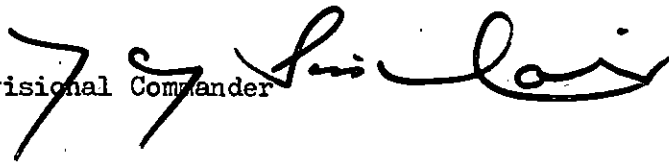
CHIEF SUPERINTENDENT'S
OFFICE, R.U.C.

28 JUL 1983

Ref. No. R/83/1764
ANTRIM, CO. ANTRIMTO: CHIEF CONSTABLE
(Crime)

I concur with foregoing recommendations as to criminal proceedings.

D/Divisional Commander



Subject:- OFFENCES OF BUGGERY

R -v- **LS 72**

PART II

WITNESSES

CONTENTS

PAGE NO.

LS 71	Schoolboy	1- 2
LS 114	Social Worker	3
McKittrick, [REDACTED]	Woman Detective Constable	4- 6
Spence, [REDACTED]	Detective Constable	7- 9

STATEMENT OF

LS 71

AGE OF WITNESS (if over 21 enter "over 21")

OCCUPATION OF WITNESS: Schoolboy

ADDRESS: 126 Church Road, Holywood "Marmion House"

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 2 day of March 19 83

R. Liffence Jc
SIGNATURE OF MEMBER by whom
statement was recorded or received.

LS 71

SIGNATURE OF WITNESS
LS 114

Since February 1981 I was living at Marmion Home on the Church Road, Holywood. About August 1982 I was sent over to Lissue Hospital at Lisburn. I was given a bedroom upstairs at the hospital and I think it was bedroom number 3. I had only two friends at this hospital, [redacted] and another boy called [redacted] who was [redacted]. One night about a week after I had arrived I went to bed at about 10 pm and I was wearing my pyjamas. My bedroom door wasn't locked, because we're not supposed to lock them. I can remember being wakened up out of my sleep with someone getting into my bed. I don't know what time it was. I got out of bed and went and stood beside the door as I didn't know who this person was. This person then told me to go over to him, which I did and stood beside the bed where he was lying. My bedroom light was off. He told me to take my trousers off and to get into bed, but I said "no." This boy then took my dick out of my pyjamas and started to rub it up and down wanking me. He wanked me off and I came all over the floor and felt funny. He was sitting up on the bed and he asked me to wank him off but I said "no." I then started to cry. He then got up out of my bed and with his right hand hit me a punch on my right shoulder. He then left my room. The next morning when I got up I saw this boy coming back from getting washed with his pyjamas on. I think they were green, blue and white coloured stripes on the bottom part and the jacket part was blue and white stripe. I am about 4'9½" tall and this boy was bigger than me, I think he was about 5'5" or 5'6" tall. He didn't have anything on his feet and I noticed that he had big feet. I think he had short l/brown hair but I don't remember what colour his eyes were. I think he was about 14 or 15 years old. I can remember the staff calling him LS 72. The next week I was lying in bed and the same fellow came into my bedroom and got into my bed again. I tried to get out but he pulled me back into bed and started to

SIGNATURE OF WITNESS:

LS 71

LS 114

STATEMENT OF:

LS 71

CONTINUATION PAGE NO: 2

pull down my pyjamas. I tried to pull them back up again but he was too strong and pulled them right off me and left them on the floor. He then said "if you scream or shout, I'll kick you in." He then pushed me over onto my front and tried to put his dick up my bum. I was crying. It was very sore and I said to him "stop." He said to me "fuck off" and tried to put his dick up my bum again. I said "stop, it's too sore" and he then slapped me on the back, got up out of bed and said "fuck up." This time he didn't have his pyjamas on at all and was naked. Before he had tried to put his dick up my bum he got behind me and lifted my bum up from behind and held onto me round my waist before trying to do it. He didn't get in. I know that this boy's room was straight across from my room, only down a wee bit. The last week I was there, I think it was a Wednesday night, I was lying in bed with my pyjamas on at about 10.30 pm when this same boy came back into my bedroom, only this time I was awake. He said to me "if you ever say anything I'll kill you." He had no clothes on this time either and he came over to my bed and came into my bed. He then pulled my pyjamas down. I was afraid every time. I tried to pull them back up and he pulled them right off and flung them down at the bottom of the bed. I tried to go and get them but he pulled me back and turned me onto my front. He then went behind me and lifted my bum up with his hands and tried to stick his dick up my bum again. It was very sore again and I started to cry and asked him to stop but he wouldn't and just kept trying to get his dick into me. I think he got the most of his dick in and he started to push his dick in and out of my bum a number of times. I don't know how many times. I was still crying and told him it was too sore and he then stopped. He then got out of my bed and ran into his own room. I then got my pyjamas bottoms and put them on and lay on top of my bed all night but I couldn't sleep. The next day this same boy said to me "have you squealed yet?" and I told him "no." This boy always came into my room by himself and he only bothered me on the three occasions. The next day I think he was wearing a brown jumper and I think he had training shoes on. I don't know anything else about what he was wearing. I would know this boy again if I saw him.

Signed - LS 71
LS 114

 Certified a true copy of the original Adlene McKintish 1/1/9

STATEMENT OF

LS 114

AGE OF WITNESS (if over 21 enter "over 21") over 21

OCCUPATION OF WITNESS Social Worker

ADDRESS

I declare that this statement consisting of 1 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 2 day of March 19 83

S J Skelly

Ann Adams, S.W.

SIGNATURE OF MEMBER by whom
statement was recorded or received.

SIGNATURE OF WITNESS

On Friday 25 February I was interviewing LS 71 at Marmion Children's Home. The purpose of the interview was to find out why he was so reluctant to return to Lissue. He stated that he did not want to stay there overnight. When I questioned him further as to the reason he stated that he had been sexually assaulted by another boy in-patient.

SIGNATURE OF WITNESS:

LS 114

Certified a true copy of the original

Anlene McKenna

TO BE COMPLETED
WHEN THE
STATEMENT HAS
BEEN WRITTEN

STATEMENT OF Arlene McKittrickAGE OF WITNESS (if over 21 enter "over 21") over 21OCCUPATION OF WITNESS Woman Detective ConstableADDRESS RUC Station, Lisburn

I declare that this statement consisting of 3 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 19th day of July 1983SIGNATURE OF MEMBER by whom
statement was recorded or received.

SIGNATURE OF WITNESS

I am a Detective Constable of the Royal Ulster Constabulary at present stationed at Lisburn, County Antrim. On Tuesday 7 June 1983 at 7.30 pm I accompanied D/Const Spence during an interview of LS 72 of LS 72. This interview took place at Castlereagh RUC Station and LS 72 parents were present. We introduced ourselves to LS 72 and informed him that we were making enquiries into an alleged indecent assault on a boy called LS 71. We told him that this had allegedly taken place at Lissue House some time in August or September 1982. We asked LS 72 if he knew the boy we were referring to and he said that he did, but had not slept on the same floor as him. We pointed out to him that we had checked the records and it appeared that they had both slept on the same floor. D/Const Spence drew a rough sketch of the area of the sleeping rooms and this was shown to LS 72. He then agreed that they had slept on the same floor, but said that never at any time had he gone into LS 71 bedroom. We asked him about the supervision at night in Lissue House. LS 72 said that the staff only checked the rooms once per night. The lights were kept on in the rooms sometimes and the curtain on the window in his door was pulled halfway across. We asked him about his friendship with LS 71 and he said that they had never had any fights and had been on friendly terms when LS 71 left Lissue House. We asked LS 72 what type of pyjamas he had worn while in Lissue. He said he had worn hospital issue pyjamas which were either green or blue. Mrs LS 72 then said that LS 72 had been able to phone her some nights from the night staff office when the staff were not present. We put it to LS 72 that it would have been possible for him to go into LS 71 room when the staff were not there to supervise. He said that he had been in LS 71 room on some occasions but only to look at books and comics and that LS 71 had been in his room on

SIGNATURE OF WITNESS: Arlene McKittrick

STATEMENT OF: Arlene McKittrickCONTINUATION PAGE NO: 2

some occasions. It was pointed out to **LS 72** that earlier in the interview he had said that he had never been in **LS 71** bedroom nor **LS 71** in his. We told him that we did not believe that he was telling us the truth about the matter. At this point both Mr and Mrs **LS 72** spoke to their son and urged him to tell the truth. Mrs **LS 72** told him that she knew when he was telling lies and she knew that he was not telling the truth now. **LS 72** said that there had been a fight with talcum powder. Mr **LS 72** then said to his son that if he would be happier to speak to D/Const Spence alone that he and his wife and I would leave the room for a time. **LS 72** said that he would like to speak to D/Const Spence alone. Mr and Mrs **LS 72** and I left the room at 8.25 pm and waited in the corridor outside. We returned to the interview room at 8.45 pm. I then read D/Const Spence's notes of that period of the interview. D/Const Spence informed Mr and Mrs **LS 72** of what their son had said in their absence. The parents spoke to their son again and told them that they wanted to know everything that had happened. Mrs **LS 72** said that she knew **LS 72** was not telling the truth about all that had happened. **LS 72** then pointed to **LS 71** statement and said that what **LS 71** had said was true. I asked him again if all that **LS 71** had said was true and he replied that most of it was. D/Const Spence then read out the typed statement of **LS 71** and asked **LS 72** to say if it was true. At line 7 on page 1 **LS 72** said that **LS 71** was already wakened when he went into the room. He also said he had not punched **LS 71** and that he had never put his dick into **LS 71** bum. He said that he had pulled **LS 71** pyjamas off about twice, only for a laugh. He said he had never gone into **LS 71** bedroom with no pyjamas on. He said that **LS 71** mother must have told him to say that. We told him that **LS 71** mother had not been present when the statement was made. **LS 72** insisted that he had not put his dick into **LS 71** bum. Mr and Mrs **LS 72** told their son to tell the truth about the matter because the Police would be investigating the matter and would find out the truth eventually and he would be better to tell all about it now. His mother asked him if all **LS 71** statement was true. He said "yes," except that he had never punched him nor never got him down on the ground. We asked him if **LS 71** had ever entered him. He said no that **LS 71** had asked him twice to let him do it but he would not let him. He said that he had put his dick into **LS 71** bum about three times and when **LS 71** wanted to do it to him he had said that it was getting too dirty and he went back to his own bed. D/Const Spence reminded **LS 72** that he was still under caution and asked him if he wished to make a written statement about these matters. He declined. Mr **LS 72** then asked his son if what he had

STATEMENT OF: Arlene McKittrickCONTINUATION PAGE NO: 3

said was the whole truth. [LS 72] nodded affirmative. Mr [REDACTED] asked him if it had ever happened in his own bedroom. [LS 72] said that once [LS 71] had come into his room and said he had a hard on and he said "are you going to do it again tonight?" He said that they had just played with each other that night. We asked him if he had ever done this or anything else like it with any other boys. He said "no." There was then a further conversation with [LS 72] and his parents about his background at home and at school and the interview ended at 9.35 pm.

STATEMENT OF Robert George Spence

AGE OF WITNESS (if over 21 enter "over 21") Over 21

OCCUPATION OF WITNESS Detective Constable

ADDRESS: RUC Station, Lisburn

I declare that this statement consisting of 3 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 20th day of July 1983.

SIGNATURE OF MEMBER by whom
statement was recorded or received.

R. G. Spence
SIGNATURE OF WITNESS

I am a Detective Constable of the Royal Ulster Constabulary at present stationed at Lisburn, County Antrim. On Tuesday 7 June 1983 at 7.30 pm I accompanied W/D/Constable McKittrick during an interview of LS 72

LS 72 This interview took place at Castlereagh RUC Station and both LS 72 parents were present. We introduced ourselves to LS 72 and informed him that we were making enquiries into an alleged indecent assault on a boy called LS 71. We told him that this had allegedly taken place at Lissue House some time in August or September 1982. We asked LS 72 if he knew the boy we were referring to and he said that he did, but had not slept on the same floor as him. We pointed out to him that we had checked the records and it appeared that they had both slept on the same floor. I drew a rough sketch of the area of the sleeping rooms and this was shown to LS 72. He then agreed that they had slept on the same floor, but said that never at any time had he gone into LS 71 bedroom. We asked him about the supervision at night in Lissue House. LS 72 said that the staff only checked the rooms once per night. The lights were kept on in the rooms sometimes and the curtain on the window in his door was pulled halfway across. We asked him about his friendship with LS 71 and he said that they had never had any fights and had been on friendly terms when LS 71 left Lissue House. We asked LS 72 what type of pyjamas he had worn while in Lissue. He said he had worn hospital issue pyjamas which were either green or blue. Mrs LS 72 then said that LS 72 had been able to phone her some nights from the night staff office when the staff were not present. We put it to LS 72 that it would have been possible for him to go into LS 71 room when the staff were not there to supervise. He said that he had been in LS 71 room on some occasions but only to look at books and comics and that LS 71 had been in his room on some occasions. It was pointed

SIGNATURE OF WITNESS: R. G. Spence

STATEMENT OF: Robert George Spence

CONTINUATION PAGE NO: 2

out to **LS 72** that earlier in the interview he had said that he had never been in **LS 71** bedroom no **LS 71** in his. We told him that we did not believe that he was telling us the truth about the matter. At this point both Mr and Mrs **LS 72** spoke to their son and urged him to tell the truth. Mrs **LS 72** told him that she knew when he was telling lies and she knew that he was not telling the truth now. **LS 72** said that there had been a fight with talcum powder. Mr **LS 72** then said to his son that if he would be happier to speak to me alone that he and his wife and W/D/Constable McKittrick would leave the room for a time. **LS 72** said that he would like to speak to me alone. Mr and Mrs **LS 72** and W/D/Constable McKittrick left the room at 8.25 pm and waited in the corridor outside. After Mr and Mrs **LS 72** and W/D/Constable McKittrick had left the room I asked **LS 72** what he wanted to tell me about these incidents. **LS 72** told me that on the first day that **LS 71** arrived he came into his bedroom and wanted to make friends with him. The next day when they were out they smoked cigarettes which **LS 71** had brought with him. The next night **LS 72** asked **LS 71** if he knew how to wank. **LS 71** said no. **LS 72** then asked **LS 71** if he wanted to know how to wank. **LS 71** agreed. **LS 72** told me that he then showed **LS 71** how to wank. He then asked **LS 71** to do the same to him and **LS 71** did. I then asked **LS 72** where this had taken place and he told me in **LS 71** room. He was asked if he went into **LS 71** room often. **LS 72** told me that from then onwards they went into each others bedroom. About a couple of weeks after this they had a fight in **LS 71** bedroom. He **LS 72** had hit and kicked **LS 71**. **LS 71** shouted for the staff but there was no staff about. After this fight **LS 72** took comics and went back into his own bedroom. **LS 71** then followed **LS 72** into his bedroom and he had talcum powder with him which **LS 72** alleged that **LS 71** had got downstairs. **LS 71** sprayed this talc over **LS 72** and his bed. **LS 72** went on to say that he got the talcum powder from **LS 71** and sprayed it over **LS 71**. Both of them started to carry on and were jumping in and out of each others beds. I asked **LS 72** if anything else had taken place. He informed me that before **LS 71** left his room that he **LS 72** kicked him. I cautioned **LS 72** and asked him if he had anything further to add to what he had already told me. **LS 72** replied, "No". I then recalled Mr and Mrs **LS 72** and W/D/Constable McKittrick into the room. They returned to the interview room at 8.45 pm. I then read my notes of that period of the interview. I informed Mr and Mrs **LS 72** of what their son had said in their absence. The parents spoke to their son again and told him that they wanted to know everything that had happened. Mrs **LS 72** said that she knew **LS 72** was not telling the truth about all that had happened. **LS 72** then pointed to **LS 71** statement and said that what **LS 71** had said was true. W/D/Constable McKittrick asked him again

STATEMENT OF: Robert George Spence

CONTINUATION PAGE NO: 3

if all that LS 71 had said was true and he replied that most of it was. I then read out the typed statement of LS 71 and asked LS 72 to say if it was true. At line 7 on page 1 LS 72 said that LS 71 was already awakened when he went into the room. He also said he had not punched LS 71 and that he had never put his dick into LS 71 bum. He said that he had pulled LS 71 pyjamas off about twice, only for a laugh. He said he had never gone into LS 71 bedroom with no pyjamas on. He said that LS 71 mother must have told him to say that. We told him that LS 71 mother had not been present when the statement was made. LS 72 insisted that he had not put his dick into LS 71 bum. Mr and Mrs [REDACTED] told their son to tell the truth about the matter because the police would be investigating the matter and would find out the truth eventually and he would be better to tell all about it now. His mother asked him if all LS 71 statement was true. He said, "Yes", except that he had never punched him nor never got him down on the ground. We asked him if LS 71 had ever entered him. He said no that LS 71 had asked him twice to let him do it but he would not let him. He said that he had put his dick into [REDACTED] bum about three times and when [REDACTED] wanted to do it to him he had said that it was getting too dirty and he went back to his own bed. I reminded LS 72 that he was still under caution and asked him if he wished to make a written statement about these matters. He declined. Mr [REDACTED] then asked his son if what he had said was the whole truth. LS 72 nodded affirmative. Mr [REDACTED] asked him if it had ever happened in his own bedroom. LS 72 said that once LS 71 had come into his room and said he had a hard on and he said, "Are you going to do it again tonight?" He said that they had just played with each other that night. We asked him if he had ever done this or anything else like it with any other boys. He said, "No". There was then a further conversation with LS 72 and his parents about his background at home and at school and the interview ended at 9.35 pm.

R. G. Spence

Subject:- OFFENCES OF BUGGERY

R -v- **LS 72**

PART III

	<u>PAGE</u>
Previous convictions of LS 72	/.

RULE 23

COUNTY COURT DIVISION OF ARDS

Form 38/27
Print 4/80

1 institutions that the Inquiry has looked at, in respect
2 of Lissue the role played by the Department was somewhat
3 different in that here the role was largely to provide
4 funds to initially the Northern Ireland Hospital
5 Authority and then subsequently the Health & Social
6 Services Board, the Eastern Health & Social Services
7 Board, from which they allocated monies to run Lissue
8 and employed staff and really had overall governance for
9 that institution. Would that be correct?

10 A. Yes. That's correct.

11 Q. Now I'm just going to look at a couple of things. We
12 see from the work that the Inquiry has done that there
13 was an allegation of peer abuse in 1983 and the
14 Department complained they weren't informed about that.
15 The joint statement that the Inquiry has received on
16 behalf of the Health & Social Care Board, which I am
17 sure you have seen --

18 A. Yes, I have.

19 Q. -- talks about the 1973 circular and you attach that to
20 your addendum statement at 1414. Maybe if we just
21 briefly look at that. I am pulling this up because
22 although it was talked about, we have not actually
23 looked at it before. It is noted -- it is a letter
24 essentially from Dundonald House, Ministry of Health and
25 Social Services, to the Chief Administrative Officer of

1 each Health & Social Services Board. It says:

2 "I am writing to draw your attention to
3 a long-standing administrative arrangement whereby the
4 Northern Ireland Hospitals Authority undertook to notify
5 the Ministry of the details of all untoward events
6 involving patients in psychiatric or special care
7 hospitals. Untoward events include:

8 (a) unauthorised absences

9 (b) accidents, and

10 (c) sudden, unexpected or unnatural deaths.

11 2. It is essential that this practice be
12 continued."

13 Then it sets out how those untoward events should be
14 reported.

15 "The Health & Social Services Boards should ask
16 psychiatric and special care hospitals to notify the
17 Board by telephone in the first place of details of
18 an untoward event immediately its occurrence becomes
19 known."

20 Now on one view of that it could be argued that,
21 well, an incident of peer abuse might not fall into
22 those three categories outlined, although it quite
23 clearly says "includes the following".

24 A. Yes.

25 Q. Yet equally on another view when we are looking at -- we

1 are looking at -- it is addressing incidents where harm
2 occurs, injury or unexplained absences or death. So,
3 therefore, an incident of peer abuse would fall into
4 that broader umbrella of harm that ought to have been
5 reported.

6 A. Yes, I would agree.

7 Q. I mean, when we were talking, you were explaining to me
8 that certainly it was part of the general consciousness
9 in the '70s and '80s that if there was anything that
10 might cause concern to the public, then that ought to be
11 reported to the Department so that they were aware,
12 particularly in light of matters coming to press
13 attention, which is exactly what happened in 1983. The
14 first the Department seemed to know about it was when it
15 did come into -- there was a report in local press about
16 it.

17 A. Yes.

18 Q. Isn't that right?

19 A. Yes.

20 Q. You were saying that there was no equivalent to this
21 1973 circular sent on the social care side to children's
22 homes or to the boards about children's homes. Is that
23 correct?

24 A. Yes. I can't find any trace of that, but I'm certainly
25 aware from my own practice in the 1970s and early '80s

1 that where any event happened that was likely to be
2 a matter of concern, public concern in relation to the
3 care of children, whether those children were in
4 institutional care or in foster care, or indeed on the
5 child protection register, that the Department was to be
6 immediately notified. That was part, as you say, of our
7 consciousness in working in Social Services during those
8 decades.

9 Q. The 1983 incident of peer abuse had a further
10 significance, might I suggest, in that we are aware from
11 Module 5 when we looked at Harberton House and Fort
12 James about the whole incident of peer abuse that
13 occurred in that -- those institutions and the response
14 that there was, but that was in the '80s that that came
15 to light, early '90s. This was 1983, some -- not quite
16 a decade but certainly a good half decade before that.
17 This was an incident of it being in the public
18 consciousness at that time that children could behave in
19 this way. Isn't that right?

20 A. Yes, that's right, yes.

21 Q. And certainly was known to the Board and was known to
22 the Department, belatedly perhaps, but certainly was
23 known. So is it -- might -- was this, do you think --
24 and I know we are speculating, because we don't have any
25 documentation -- but was this, do you think, seen as

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

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

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

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

82. The Board is aware that in March 1983, **LS 71** alleged buggery by another patient in the Child Psychiatry Unit. The following chronology summarises the steps taken:

- a. **LS 71** was an inpatient in Lissie from 19 August 1982 to 24 September 1982;
- b. **LS 71** was subsequently placed in Marmion Children's Home. In February 1983 consideration was being given to a further admission to Lissie, which upset **LS 71**. Over the course of discussion with his Social Worker, **LS 114**, on 25 and 28 February 1983, he disclosed sexual abuse by a peer (whose name he did not know) within the unit during his previous admission;
- c. This matter was immediately reported to police. The Social Worker accompanied **LS 71** to the police station on 1 March 1983. On that date he

was medically examined. It is recorded that: "the doctor stated that in his opinion (despite the time elapsed since alleged incident) that sexual interference may have taken place". The Social Worker returned to the police station with **LS 71** on 2 March 1983 when a statement of complaint was taken. The Assistant Director of Social Services, EHSSB, Mr Bunting, was also advised of the complaint by telephone on 2 March 1983;

- d. The allegation was also reported to the Child Administrative Nursing Officer ("CANO") at EHSSB. On 3 March 1983 the CANO made contact with the District Administrative Nursing Officer ("DANO"). The DANO undertook an investigation and provided a written report dated 16 March 1983. The conclusion was, in summary, that policies were sound and there was adequate provision for the nursing care of all children brought into the Unit; that an element of risk did exist within the philosophy which had to be accepted; that the recent tendency to admit children over 14 years was stretching the Unit beyond that with which it could cope; and that in completing the investigations, DANO had sought to ensure that nursing staff fully understood their role and responsibilities. The investigation concluded that staff were fully aware of all procedures and there was no indication of any staff negligence. It was held that, given the risk element and the large number of children over 14 years, it was difficult for staff to manage and supervise them and manage their care because of the many difficult needs of the various groups.
- e. This report was provided to the CANO. Following discussion with Consultant Medical Staff, it was agreed to institute a change in admission policy so as to ensure that children over 13 would not be admitted from 29 March 1983. Additionally, measures were taken to restate all policies and procedures and discussion sessions were held with staff to reinforce their awareness of their roles and responsibilities.
- f. By 8 March 1983 the fact of the police investigation had been reported in the press (Irish News).
- g. On 21 July 1983 the Child Administrative Officer advised the Department in writing of the untoward incident. This followed correspondence from the Department commencing 26 March 1983 in light of the press report. The Department sought information as to which the incident had not been dealt

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

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

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

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

- a. Complaints of sexual abuse by peers (see internal pages 22 to 24 of the report):
 - i. Child A **LS 67** an 8 year old girl admitted between June and August 1986, complained that a male child had kissed her in the private parts. She later said that this was all lies;
 - ii. Child **LS 68**, a 13 year old girl admitted between April 1979 and March 1980 (with a further period as a day patient from November 1980 to



OFFICIAL-SENSITIVE-PERSONAL
MINISTRY OF HEALTH AND SOCIAL SERVICES

LIS-1414

HSS4(OS) Branch

Dundonald House Upper Newtownards Road Belfast BT4 3SF

Telex 74578

Telephone 0232 (Belfast) 650111 ext

Please reply to The Secretary
Your reference

The Chief Administrative Officer of
each Health and Social Services Board

Our reference A1034/73
Circular Ref No HSS4(OS) 1/7
Date 30 October 1973

Dear Sir

NOTIFICATION OF UNTOWARD EVENTS IN PSYCHIATRIC AND SPECIAL
CARE HOSPITALS

1. I am writing to draw your attention to a long-standing administrative arrangement whereby the Northern Ireland Hospitals Authority undertook to notify the Ministry of the details of all untoward events involving patients in psychiatric or special care hospitals. Untoward events include:

- a) unauthorised absences;
- b) accidents; and
- c) sudden, unexpected or unnatural deaths.

2. It is essential that this practice be continued. Each Health and Social Services Board should therefore arrange for a telephone message to be sent HSS4(OS) Branch, Dundonald House, Upper Newtownards Road, Belfast BT4 3SF, (telephone Belfast 650111 extension 397) as soon as possible after the occurrence of any such untoward event, with the following information:

- a) the nature of the occurrence (ie whether an unauthorised absence, an accident or a sudden, unexpected or unnatural death);
- b) a brief description of the circumstances of the event;
- c) the name of the patient involved and his hospital status;
- d) the name of the hospital of which he was an in-patient and if the incident occurred in any place other than that hospital, the location of the event;
- e) the date and time of the occurrence; and
- f) whether the patient's relatives, the RUC and the Ministry of Home Affairs, as appropriate, have been informed of the event.

3. To enable the necessary information to be furnished to the Ministry, each Health and Social Services Board should ask the psychiatric and special care hospitals within its area to notify the Board by telephone, in the first place, of the details of an untoward event immediately its occurrence becomes known. Immediate notification is particularly important where a death has occurred.

Yours faithfully

L. L. Gillin

11/10/73 (HSS4)

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

15.1 Please see paragraph 19.1 below.

16. Is the Department aware of any contemporaneous complaints made of abuse in Lissue?

16.1 The Department does not have any information to hand which suggests that the MHLG or subsequently the DHSS were aware of any contemporaneous complaints in relation to the Lissue Hospital.

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

17.1 The Department was aware of the following complaints in relation to alleged sexual abuse by staff at Lissue:

The ^{LS 68} complaint made in November 1986 relating to the mid 1970s

17.2 To the Department's knowledge this was the first complaint brought to the attention of the DHSS in relation to Lissue. It was made in November 1986 by a young woman, ^{LS 68} then aged 17 years and resident in Coulter's Hill Children's Home, a home run by the Northern Health and Social Services Board (NHSSB).

17.3 The Chief Social Work Adviser (CSWA) was notified by letter dated 22 December 1986¹⁰ from the Northern Health and Social Services Board (NHSSB), that a girl then aged 17 years who was in the care of the Board had alleged she had been sexually assaulted by a male member of staff at Lissue when she was a patient in the hospital some 10 years previously. The NHSSB had notified the EHSSB who in turn had referred the matter to Lisburn RUC. The EHSSB appears to have ascertained that the person against whom the allegation had been made was a nurse who had left the service a year previously on the grounds of ill-health. The DHSS made a written request dated 8 January 1987¹¹ to the NHSSB to be kept informed and requested a further update from the NHSSB on 24 March 1987¹². By letter dated 14 April 1987¹³ the NHSSB responded indicating that ^{LS 68} refused to make a formal statement of complaint to the police but that the EHSSB was inquiring further

¹⁰ LIS10050

¹¹ LIS10051

¹² LIS 10055

¹³ LIS 10057

into the matter.

- 17.4 On the advice of the EHSSB by letter dated 27 October 1987¹⁴, the NHSSB challenged a police decision communicated to Lisburn Social Services on 8 April 1987¹⁵, not to pursue the matter any further as [REDACTED] had made a written statement in January 1987 withdrawing the original complaint. As a consequence, the police confirmed to the NHSSB in November 1987 that the investigations were being reopened and that the findings would be submitted to the Director of Public prosecutions¹⁶. The CSWA (now the Chief Inspector, SSI) was copied into correspondence between the NHSSB, the EHSSB and the police in relation to these events and requested by letter dated 7 December 1987 to be kept informed of any further developments¹⁷. The Department does not hold any additional information in relation to this case.
- 17.5 The Department holds no further information regarding the [REDACTED] complaint.
- 17.6 The following information regarding the [REDACTED] and [REDACTED] complaints has been drawn from documentation which was shared with the EHSSB by the DHSS, which was retained by the Board and submitted in its evidence to the HIAI. The DHSS's own file in relation to these complaints is not available, having most likely been disposed of in accordance with the Departmental file management systems.

The [REDACTED] complaint made in 1993 relating to the 1970s

- 17.7 In May 1993 during my tenure as a DHSS Social Services Inspector, [REDACTED] then a 27 year old woman and a former resident of Barnardo's Tara Lodge Adolescent Unit which I had previously managed, alleged to me that while she had been a patient in Lissue some 14 years previously, she had been sexually assaulted by a male nurse whom she named. I provided a report on the matter to Dr K McCoy, the then Chief Inspector (CI) and [REDACTED] SND 509, an [REDACTED]¹⁸. I recall that the contents of the report were discussed with me at a meeting between the CI, the [REDACTED], the then Assistant Secretary within the DHSS's Child Care Policy Branch, [REDACTED]
- 17.8 Following the meeting, I contacted Sergeant W McAuley of the RUC Care Unit on behalf of [REDACTED]. I understand Mr P Simpson, a senior official within the DHSS Management Executive contacted the EHSSB and the Green Park

¹⁴ LIS 10063

¹⁵ LIS 10056

¹⁶ LIS 10065

¹⁷ LIS 10067

¹⁸ LIS 10076

Prosecution File ○ JN 88 / 41 (C)		Whether now	
		In Custody	On Bail
Name(s) and Address(es) of accused:— LS 144 		N/A	N/A.
TRANSIT CHART (To be completed by each forwarding member or office)		Date of Original Arrest:— NOT ARRESTED	
To whom file forwarded	Date	To whom file forwarded	Date
NSP. JN.	8.3.88		
UMP	14.3.88		
DPP	18/3/88		
Wsburn	2/4/88		
		Nature of Offence(s) ALLEGED INNOCENT ASSAULT ON LS 68 C/O COUNTER HILL CHILDRENS HOM BARNCLARE.	
Whether any offence alleged requires the consent of the Attorney General or Director of Public Prosecutions. (Delete as appropriate)		Date next in Court:— N/A	
		Court and Place	
		Officer in charge of case:— DET. SERGT. G. P. LYCHE	



Department of the Director of Public Prosecutions
Royal Courts of Justice Belfast BT1 3NX
Belfast 235111

RUC REF: CM78/249/87

DPP REF: 1249/88

Subject: ALLEGED INDECENT ASSAULT AT LISSUE HOSPITAL
LISBURN

Chief Constable

Direction - Part I

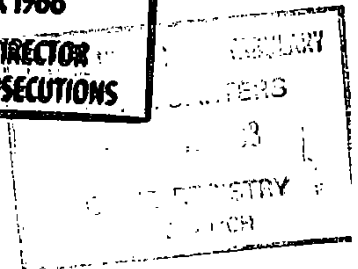
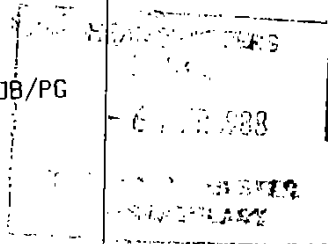
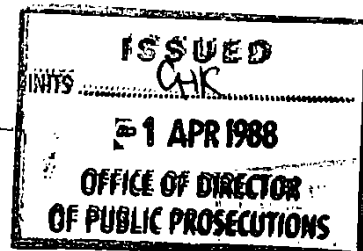
I direct 'no prosecution'.

Police investigation file returned herewith.

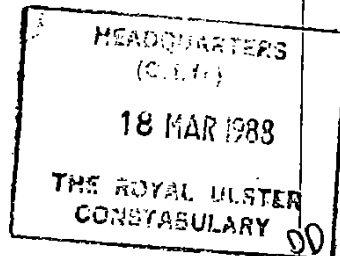
R A KITSON
South Eastern Circuit
for Director of Public Prosecutions

31st March 1988

GJB/PG



Reference CM78/249/87

SUBJECT: ALLEGED CHILD ABUSE BY **LS 144**

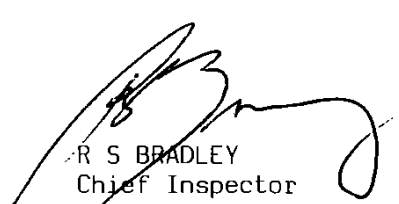
Headquarters
The Royal Ulster Constabulary
Brooklyn
Knock Road
BELFAST
BT5 6LE

18 March 1988

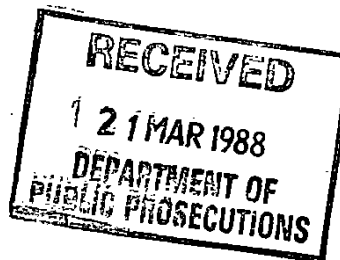
The Legal Registrar

Forwarded for directions, please in view of the concern expressed by the Department of Health and Social Services.

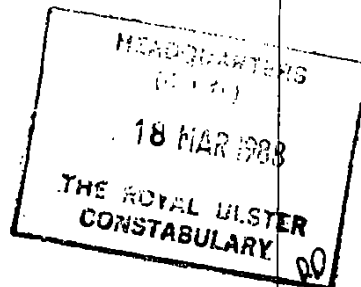
There can be no prosecution in this case. **LS 68**
declines to prosecute a complaint with a proper statement and
LS 144 strenuously denies the allegations.



R S BRADLEY
Chief Inspector
for Chief Constable



Reference CM78/249/87

SUBJECT: ALLEGED CHILD ABUSE BY **LS 144**

Headquarters
The Royal Ulster Constabulary
Brooklyn
Knock Road
BELFAST
BT5 6LE

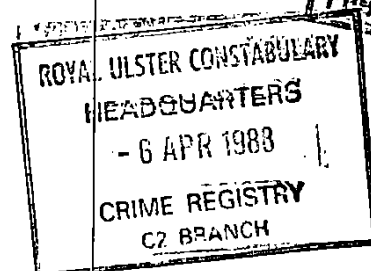
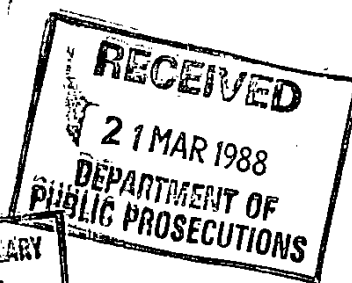
18 March 1988

The Legal Registrar

Forwarded for directions, please in view of the concern expressed by the Department of Health and Social Services.

There can be no prosecution in this case. **LS 68**
declines to prosecute a complaint with a proper statement and
LS 144 strenuously denies the allegations.


R S BRADLEY
Chief Inspector
for Chief Constable



SUBJECT: ALLEGED INDECENT ASSAULT ON [REDACTED] LS 68 C/O COULTER HILL CHILDREN'S HOME
BALLYCLARE

PART I

INDEX TO POLICE REPORTS

CONTENTS

Covering Report of Detective Sergeant G P Lyttle
Forwarding Report of Detective Inspector, Lisburn
Forwarding Report of SDC, Lisburn

PAGE NO

1 - 5
6

ROYAL ULSTER CONSTABULARY

RUC REFERENCES

To: The Director of Public Prosecutions

SUB-DIVISION:

Per: The Legal Registrar
Royal Courts of Justice
Belfast

DIVISION:

H.Q.:

or: The Circuit Assistant Director

..... Circuit

(Delete as
appropriate)

NB: In "Fast Stream" cases only the Sections marked * should be completed.

SUBJECT*(nature of offences,
venue, persons
involved)ALLEGED INDECENT ASSAULT ON **LS 68**

FORMERLY OF COULTER HILL CHILDRENS HOME

BALLYCLARE

DATE OF
OFFENCE*

BETWEEN 1 4 79 - 30 8 79

DATE REPORT
SUBMITTED*

8/3/88

REPORTING*
OFFICER

NAME	George Paul LYTTLE
RANK AND NUMBER	Detective Sergeant 9391
STATION	Lisburn
SUB-DIVISION	Lisburn
DIVISION	'J'
TELEPHONE NUMBER FOR CONTACT	Lisburn 5121 Ext 232

2.

PERSONS REPORTED*

(Separate page 2 for each person reported. Number pages 2, 2a, 2b etc.)

(Delete as appropriate)

SURNAME	LS 144		
FORENAMES	LS 144		
DATE OF BIRTH			
ADDRESS			
CHARGED	XX YES	NO	COPY CHARGE SHEET ATTACHED AT PART IV
SUMMONS ISSUED	XX YES	NO	COPY SUMMONS ATTACHED AT PART IV
INFORMATION LAID	XX YES	NO	COPY INFORMATIONS ATTACHED AT PART IV
DATE OF FIRST COURT APPEARANCE	N/A		
AT DATE OF THIS REPORT IS	XX MOUTED	XX 2A	

NATURE OF EVIDENCE*
AGAINST PERSON
REPORTED

(Tick as appropriate)

WRITTEN CONFESSION	
ORAL CONFESSION ONLY	
VISUAL IDENTIFICATION	
MEDICAL EVIDENCE	
FORENSIC EVIDENCE	
DOCUMENTARY EVIDENCE	
OTHER (SPECIFY)	

ANTECEDENT HISTORY*
OF PERSON REPORTED

(Summarise relevant information eg. marital status, employment, associates, mental or physical abnormalities. Give physical description where appropriate)

PREVIOUS CONVICTIONS	YES NO	COPY CRO 22 ATTACHED AT PART IV
<p>LS 144 is a married man in his retirement. He resides in an owner/occupied house with his wife. He was formerly employed at Lissue Children's Hospital, Lisburn, during the period of the alleged assault.</p>		COPY CRO 14 ATTACHED AT PART IV

3.

OUTLINE OF CASE*

(Give salient facts in chronological order with clarity and brevity. Do not merely repeat witness statements. Where more than one person reported summarise case against each)

- 1 [REDACTED] **LS 144** was employed at Lissue Hospital, Lisburn, between [REDACTED] and was known as [REDACTED]. He has a clear criminal record.
- 2 [REDACTED] **LS 68** was a patient at Lissue between [REDACTED] to [REDACTED]. She has a minor conviction for common assault.
- 3 On 29 10 86 [REDACTED] **LS 68** made a written statement of complaint to a social worker in which she alleged that during her stay at Lissue [REDACTED] **LS 144** had sexually abused her.
- 4 [REDACTED] **LS 68** was subsequently interviewed by Woman Constable Craig, Lisburn. She confirmed her earlier written complaint as made to Social Services and stated that this arose following a TV programme on child abuse. She refused to make a formal written statement because she did not want to go to court and was afraid of her father's reaction if he found out. She agreed to give the matter some thought and to make contact later on. [REDACTED] **LS 68** failed to do so and on 2 1 87 at the request of Woman Constable Craig, Constable Wright, Ballyclare, called with [REDACTED] **LS 68** who requested no further action in relation to her complaint and made a written statement of withdrawal.
- 5 On 23 2 88 I again spoke with [REDACTED] **LS 68**. She told me that she had no complaint to make. She had set up home with her boyfriend and was happy and did not want any trouble. I asked her to reconsider but she did not appear to be interested. In any event she agreed to contact me if she changed her mind.

I certify that all witness statements taken by police in connection with this investigation are included in this file.

3(a)

but to date she has not done so.

OUTLINE OF CASE
CONTINUED

6 On 1 3 88

LS 144

was interviewed at Lisburn RUC Station. He totally denied the allegation and could offer no explanation as to why he should have been the subject of the complaint.

4

RECOMMENDATIONS
AS TO CHARGES
AND PROCEEDINGS

This matter was originally reported on by Woman Constable Craig.
File Reference Number CM78/249/87 refers. Copy at Part 4.

LS 68 has requested no further police action in this matter and refuses to make a statement of complaint.

The suspect, LS 144 is now fully retired and totally denies the allegation.

The Social Services have expressed concern that (a) the suspect may still have access to children and (b) there may have been a pattern of abuse over the years. Their concerns may be somewhat allayed by the fact that LS 144 has now no contact with children and that over the years there has been no evidence or allegations of a similar nature in relation to Lissue Hospital.

If the allegations as alleged by LS 68 are true they are very serious. However, due to her reluctance to make a formal complaint, the passage of time and the absence of corroboration of any kind I cannot see how this matter can be progressed to a satisfactory conclusion. I feel that the only way in which this could be achieved is by the interview of all in-patients at Lissue during LS 144 employment and to say the least would be impracticable, suggestive and highly likely to cause unwarranted distress to some of those interviewed.

In all the circumstances I would respectfully suggest that the matter has been sufficiently aired and that the public interest, in the absence of any other information, would be best served by marking the file, "no prosecution".

5

RECOMMENDATIONS
AS TO CHARGES
AND PROCEEDINGS
CONTINUED

Forwarded for information and directions please.

G P LYTTLE
Detective Sergeant 9391

VIEWS AND
RECOMMENDATIONS
OF SUPERVISING
OFFICER*

(In fast stream cases, the recommendation must be from an officer not below the rank of Inspector)

Having regard to all the facts concerning this matter
I agree that this file should be marked "No Prosecution"
and I recommend accordingly.

Signed: N. Carlisle D/Inspector
Date: 8.3.88

VIEWS AND
RECOMMENDATIONS
OF SUB-DIVISIONAL
COMMANDER

Chief Constable
Crime

- 1 I recommend no prosecution in this case.
- 2 Copy papers at Part IV of the file explain the background and reason for submission of DPP file at this stage.

Signed: J Willis
J WILLIS Superintendent
Date: 10 March 1988

SUBJECT: ALLEGED INDECENT ASSAULT ON [REDACTED] LS 68 C/O COULTER HILL CHILDREN'S HOME
BALLYCLARE

PART II

INDEX TO WITNESS STATEMENTS

CONTENTS

PAGE NOS

[REDACTED] LS 68 (Injured Party)

1

[REDACTED] LS 68 (withdrawal)

2

Laura Candida Craig (Woman Constable)

3 - 4

George Paul Lyttle (Detective Sergeant)

5

COPY OF STATEMENT MADE BY [LS 68] TO NORTHERN HEALTH AND SOCIAL SERVICES BOARD LARNE CARRICKFERGUS AND NEWTOWNABBEY UNIT OF MANAGEMENT

29 10 86

STATEMENT - [LS 68] - RE SEXUAL ABUSE ALLEGATIONS WHILE IN LISSUE HOSPITAL.

His name is [LS 144] I think. I was about seven or eight, at night he had to get me up to go to the toilet because I used to wet the bed. He used to give me sweets when we weren't allowed to get them. It started off from that. He would get up, I think around midnight, take me to the toilet, then take me back to bed again. He at first would sit at the edge of the bed, start kissing me on the cheek, then he would touch me between my legs and my "tush" (vagina). Then he would start pulling himself off. When this was done I used to ask what the sticky stuff was, he just said it was cream for sores. He used to say to me don't tell any of the other kids about me doing this because they would be wanting it too. It's only special kids who get this. He also said don't tell your mummy or daddy. I was in Lissue I think about one year, I was there about a month I think before this started happening. I think he is still employed there because the other staff [REDACTED] and [REDACTED] I think are still there.

[REDACTED]

[REDACTED]

LS 68

STATEMENT OF WITNESS

STATEMENT OF:

LS 68

AGE OF WITNESS [if over 21 enter "over 21"]:

17 Years

OCCUPATION OF WITNESS:

Unemployed School Leaver

ADDRESS:

TO BE COMPLETED
WHEN THE
STATEMENT HAS
BEEN WRITTEN

I declare that this statement consisting of one 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

2nd

day of

January

19 87

L C Craig.

LS 68

SIGNATURE OF MEMBER by whom
statement was recorded or received

SIGNATURE OF WITNESS

I wish to withdraw my complaint against the Lissue Hospital, Lisburn, Co. Antrim. This complaint refers to the term I was a patient in the Hospital when I was seven years old.

LS 68

Certified a true copy of the original

STATEMENT OF WITNESS

STATEMENT OF:

LAURA CANDIDA CRAIG

AGE OF WITNESS (if over 21 enter "over 21")

OVER 21

OCCUPATION OF WITNESS:

POLICE CONSTABLE

ADDRESS:

LISBURN RUC STATION

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

4TH

day of

MARCH

19 88

SIGNATURE OF MEMBER by whom
statement was recorded or received

SIGNATURE OF WITNESS

I am a Police Constable attached to Lisburn RUC Station. On 27 November 1986

I received a complaint from the Social Services, Lisburn. The complaint was

in the form of a statement made by [REDACTED] LS 68 DOB [REDACTED]

c/o Coulter Hill Childrens Home, Ballyclare and referred to her being

sexually abused while a patient at Lissue Hospital, Lisburn between [REDACTED]

[REDACTED] She alleged that she was abused by a male member

of staff named [REDACTED] LS 144 and described the form the abuse allegedly took.

On 28 November 1986 I spoke to [REDACTED] LS 68 at Coulter Hill Home, Ballyclare.

She confirmed to me that the contents of the statement were true and that

the reason for her making the complaint was as the result of watching a

television programme on child abuse. I asked her had anyone else said

anything to her while in hospital about being abused. She said no, explainin

that [REDACTED] LS 144 had picked her because he liked her. I asked her to make a formal

written statement of complaint but she refused. She said that she didn't

fancy going to court and also that if her dad found out he would shoot [REDACTED] LS 144

I tried to reassure her but she insisted that she didn't want to make a

statement. I asked her to consider what we had discussed and she agreed to

ring me the next day to give me an answer. [REDACTED] LS 68 did not make any further

contact with me. I tried to establish contact with her but without success

as she had by now left the home. On 2 January 1987 I spoke with Constable

Wright, Ballyclare RUC and asked him to call with [REDACTED] LS 68 in order that

STATEMENT CONTINUATION PAGE

STATEMENT OF: LAURA CANDIDA CRAIG

CONTINUATION PAGE NO. 1

arrangements could be made to see her again. I later received a statement taken by Constable Wright from **LS 68** withdrawing her complaint.

STATEMENT OF WITNESS

STATEMENT OF: GEORGE PAUL LYTLE

AGE OF WITNESS [if over 21 enter "over 21"] OVER 21

OCCUPATION OF WITNESS: DETECTIVE SERGEANT

ADDRESS: RUC STATION, LISBURN

TO BE COMPLETED
WHEN THE
STATEMENT HAS
BEEN WRITTEN

I declare that this statement consisting of one 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 3 day of March 19 88

James Templeton

PK

SIGNATURE OF MEMBER by whom
statement was recorded or received

SIGNATURE OF WITNESS

I am a Detective Sergeant presently stationed at Lisburn RUC Station. On 29 February 1988 at 2 35 pm I saw LS 144 DOB ,

 , at Lisburn RUC Station.

I introduced myself to him and told him I was making enquiries into alleged sexual abuse by him on one, LS 68 I cautioned LS 144 I then read to him the full content of a statement made by LS 68 to a social worker in Ballyclare. LS 144 emphatically denied the allegation. He told me that he remembered LS 68 being a patient at Lissue Hospital where he previously was employed as a between and He recalled that she had a behaviour problem of which bed wetting was a problem and part of his duties would have been to take her to the toilet as and when required. He went on to say that when on night duty there was always a female member of staff on duty as well and that it would have been nearly impossible for him to have committed the acts as alleged, without being discovered. He continued to deny the allegation and could offer no reason why LS 68 would make the allegations against him. I invited him to make a written statement after caution regarding what he had told me. He declined. I then read notes of the interview over to him. LS 144 did not read over the notes as he did not have his spectacles with him. He signed the notes. The interview terminate at 3 20 pm and he was then conveyed to his home.

5
SIGNATURE OF WITNESS: PK

SUBJECT: ALLEGED INDECENT ASSAULT ON **LS 68** C/O COULTER HILL CHILDREN'S HOME
BALLYCLARE

PART III

INDEX TO DOCUMENTARY EXHIBITS

ITEM IDENTIFICATION MARK	DESCRIPTION	PRODUCED BY	PAGE NO
GPL1	Caution Interview Notes signed by LS 144	George Paul Lyttle Detective Sergeant	1 - 2

ROYAL ULSTER CONSTABULARY

INTERVIEW NOTES

SUSPECTS NAME **LS 144** D.O.B. **[REDACTED]**
ADDRESS **[REDACTED]**
INTERVIEW AT LISBURN RUC SIN DATE 29 2 88
TIME COMMENCED 2 35 AM/PM. TIME CONCLUDED 3 20 AM/PM.
INTERVIEWING POLICE OFFICERS D/SGT LYTILE
.....
.....

PARTICULARS OF INTERVIEW:

Introduced self to **LS 144** and informed him of the nature of my enquiries
ie allegation of sexual abuse by **LS 68** **LS 144** cautioned by me.
Read over to him the full content of statement of complaint by **LS 68**
made to social worker in Ballyclare. **LS 144** and self discussed same.
LS 144 totally denied any of the allegations. Stated that he remembered
LS 68 at Lissue Hospital. He had been employed there as a **[REDACTED]**
[REDACTED] for **[REDACTED]** years between **[REDACTED]** He recalled that she had
a behaviour problem and that as far as he could remember bed-wetting was a
side effect of this. Part of his **[REDACTED]** duties would have entailed him
taking Andrea to the toilet as and when required. He further pointed out
that when he performed night duty he was always on duty with a female member
of staff. He was never on duty alone and as such it would have been nearly
impossible for him to have committed the acts as alleged without being
discovered. **LS 144** continued to deny the allegations. He could offer
no explanation as to why **LS 68** would alleged the acts committed, against him
Stated that in all his service at Lissue he had a good relationship with
both patients and staff. Then invited **LS 144** to make written statement
after caution to me outlining our discussion. Refused by **LS 144** who
stated that anything he could say was already written down by self. I then

INITIALS OF INTERVIEWER(S) **LS 144**
/

CONTINUATION - INTERVIEW NOTES -- SUSPECT: **LS 144** PAGE NO: 2

[illegible]

.....

.....

SUBJECT: ALLEGED INDECENT ASSAULT ON [REDACTED] LS 68 C/O COULTER HILL CHILDREN'S HOME
BALLYCLARE

PART IV

MISCELLANEOUS

CONTENTS

PAGE NOS

Copy file re complaint originally submitted by
Woman Constable Craig

Criminal Record - [REDACTED] LS 68

H.O. REF. NO.

S/DIVISIONAL REF. NO.

DIVISIONAL REF. NO.

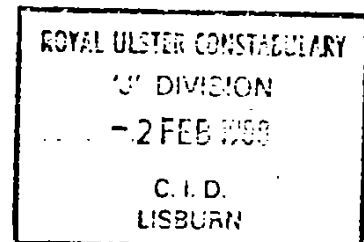
ROYAL ULSTER CONSTABULARY

'J' Division Lisburn Sub-Division/Department
 Sub-Divisional Office Station/Branch 7 December 1987 Date
 SUBJECT: ALLEGED INDECENT ASSAULT ON **LS 68** C/O COULTER HILL
 CHILDRENS HOME, BALLYCLARE

TO: Detective Inspector
 CID, Lisburn

- 1 To see attached directive from ACC Crime. The papers have been raised again in response to Director of Social Services letter dated 29 October 1987 (on file).
- 2 Detail a member to commence enquiry with a view to completing a DPP file as soon as possible.
- 3 This matter will have to be dealt with very tactfully in view of **LS 144** state of health and the fact that [REDACTED]
- 4 Closely monitor the progress of the investigation and let me have a progress report by 15 February 1988.

J Willis
 J WILLIS
 Superintendent



D/Sergeant Lyttle.

- 1 For urgent investigation and report please, as requested by Supt. Willis.
- 2 Liaise with those Police Officers, already involved in this enquiry, and if need be, have **LS 68** re-interviewed.
- 3 Endeavour to establish the identity of some others, who may have been resident in the Home, around this time, in an effort to substantiate or discredit, the original complaint.
- 4 Discuss the case with me, prior to interviewing the suspect.
- 5 In any event, this matter should be submitted via a DPP file for decision.

D/Inspector, Lisburn.

Reference the within, I have commenced discreet enquiries with a view to fully resolving this matter.

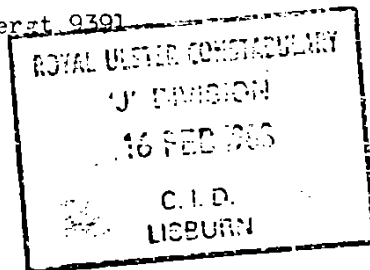
I am unable to report on the matter at present as further enquiries have to be made and I would therefore request extra time to enable me to do so.

Forwarded for information and favour of request.

P. Lytle

P. LYTTLE

D/Serst. 9391



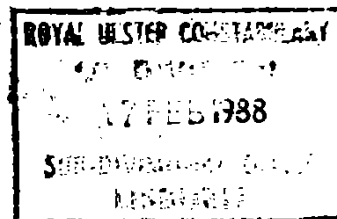
Sub Divisional Commander, Lisburn.

Forwarded with reference to the above report of D/Sergeant Lyttle.

N. Carlisle

N. CARLISLE

D/Inspector



D/Insp. CIO. LISBURN.

I note progress and appreciate present difficulties. F.R. not later than. 1.3.88.

Forwards on CZ. 16/2/88.

CM78/249/87

Reference

ALLEGED INDECENT ASSAULT ON **LS 68** C/O COULTER HILL CHILDRENS
HOME BALLYCLARE

Sub-Divisional Commander
Lisburn

Thank you for your report dated 17 November 1987, concerning the above matter which has been very helpful.

However, in view of the letter from the Director of Social Services, Northern Health and Social Services Board, I feel that at this time, the investigation should recommence and the full papers be placed before the Director of Public Prosecutions for direction.

This decision is not intended to diminish your authority as Sub Divisional Commander, the reasons indicated at 2a - e in your report are sound and will, no doubt, be expressed in your submission to the DPP. It is taken in view of the National and Local attention currently being focused on such matters.

Forwarded for compliance.



W G MONAHAN
Assistant Chief Constable Crime

25 11 87

H.O. REF. NO.

CM 78/249/87

S/DIVISIONAL REF. NO.

DIVISIONAL REF. NO.

ROYAL ULSTER CONSTABULARY

'J'

Division

Lisburn

Sub-Division/Department

Sub-Divisional Office

Station/Branch

17 November 1987

Date

SUBJECT:

ALLEGED INDECENT ASSAULT ON

LS 68

C/O COULTER HILL CHILDRENS

HOME, BALLYCLARE

TO: Assistant Chief Constable
Crime

- 1 Sub-Divisional papers in relation to this matter are attached.
- 2 The decision not to pursue the investigation any further was based upon:-
 - (a) The withdrawal of complaint by LS 68 on 2 January 1987.
 - (b) The fact that the alleged incidents occurred 10 years ago.
 - (c) The suspect was identified as LS 144 who retired from Social Services some years ago for health reasons, is years old and in bad health.
 - (d) Local DHSS staff were aware of the complaint and in a position to know if there were any other complaints involving any other children.
 - (e) No feed-back of disagreement with my decision from local DHSS staff. If they had disagreed the matter would have been remitted to Headquarters for decision.
- 3 In the circumstances I am still of the opinion that there should be no further investigation in respect of the case of LS 68

J Willis
J WILLIS
Superintendent

23 NOV 1987

LS 129

Department of Social Services
Health Services
Lisbon

3087/103

12 / 11 / 1987

Date: LS 129

LS 68 C/O COULTER HILL CHILDRENS HOME, BALLYCLARE

I refer to your communication with Woman Constable Craig
(Lisburn RUC) in November 1986 and subsequent telephone
contact in relation to the above-named.

This is to confirm that on 12 January 1987 LS 68 made
a written statement withdrawing the original complaint. That,
combined with the fact that the alleged incidents occurred 7
years ago, have led me to the decision not to pursue the
investigation any further.

Yours faithfully

J WILLIS
Superintendent

H.O. REF. NO.

S/DIVISIONAL REF. NO.

DIVISIONAL REF. NO.

ROYAL ULSTER CONSTABULARY

'J' Division LISBURN Sub-Division/Department
LISBURN Station/Branch 12 March 1987 Date
SUBJECT: ALLEGED INDECENT ASSAULT ON [REDACTED] LS 68 C/O COULTER HILL CHILDRENS
HOME, BALLYCLARE.

TO: Superintendent
Lisburn

I discussed this matter with a [REDACTED] LS 129 [REDACTED]
[REDACTED] Lisburn Health Centre, on 11.3.87.

The following information was ascertained:-

1. The person named [REDACTED] LS 21 [REDACTED] is a [REDACTED] at Lissue Hospital. He is still employed there. (See [REDACTED] LS 68 statement of complaint).
2. The person named [REDACTED] LS 78 [REDACTED] left Lissue Hospital on [REDACTED]. He is presently employed by the [REDACTED] as a [REDACTED] allocated to Lisburn. (See [REDACTED] LS 68 statement of complaint).
3. There is no suggestion [REDACTED] LS 21 [REDACTED] or [REDACTED] LS 78 [REDACTED] were involved with [REDACTED] LS 68 [REDACTED].
4. [REDACTED] LS 129 [REDACTED] was unable to assist me regarding complainant's background, in relation to her level of intelligence, and honesty. It was suggested to me that the following person would be able to assist in this direction:-

Doctor Billy Nelson
Royal Belfast Hospital for Sick Children
Falls Road
Belfast BT12 6BE

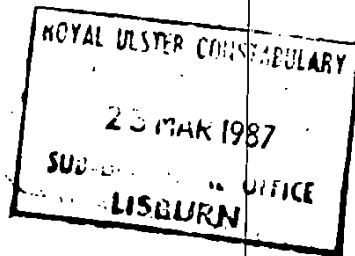
If it is decided to contact Doctor Nelson, this can be by way of letter, in usual way.

5. [REDACTED] LS 129 [REDACTED] is unaware of any other Staff-Patient type complaints
6. Suspect [REDACTED] LS 144 [REDACTED] wife [REDACTED]

I cannot now see the point in pursuing this investigation, in view of the attitude adopted by [REDACTED] LS 68 [REDACTED] on 2.1.87.

For information.

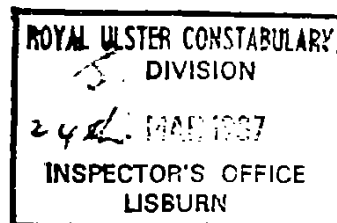
J. R. Wilson
J R WILSON



Inspector Wilson

Please attach a copy of **LS 68** complaint statement, the one on file does not contain any mention of **LS 78**, **LS 21** etc.

J. Willis
J. WILLIS
Superintendent



Supt.
Lisburn

Photocopy of **LS 68** statement of
complaint dated 21-10-86 in file refers.

J. H. Wilson. Jp.

S/DIVISIONAL REF. NO. 770 891 183

H.Q. REF. NO. _____

DIVISIONAL REF. NO. _____

ROYAL ULSTER CONSTABULARY

Division LISBURN Sub-Division/Department _____
SUB-DIVISIONAL OFFICE _____ Station/Branch 12 February 1987 Date _____
SUBJECT: ALLEGED INDECENT ASSAULT ON **LS 68** C/O COULTER HILL CHILDRENS
HOME, BALLYCLARE.

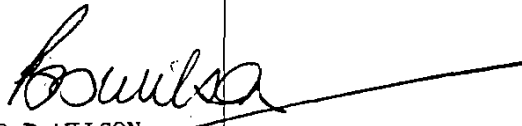
TO: Inspector Wilson
Lisburn

I am inclined to agree with Inspector Wilkinson that we should take this matter a little further although, after some ten years, a considerable amount of fact is required.

Please approach your opposite number in the Social Services and see if the following can be established:-

- (1) A more detailed background to the complainant, particularly in relation to her level of intelligence and honesty.
- (2) Can a suspect be more definitely identified and if so, is he still employed?
- (3) Is there any record of previous complaints, of this nature, having been made at Lissue or emanating from Lissue over this period.

Anything further would also be helpful in trying to determine appropriate action to take.


B D WILSON
Chief Inspector
Deputy Sub-Divisional Commander

HQ. REF. NO.

CM 78/249/87

S/DIVISIONAL REF. NO.

70 SA/183

DIVISIONAL REF. NO.

ROYAL ULSTER CONSTABULARY

Division LISBURN Sub-Division/Department
SUB-DIVISIONAL OFFICE Station/Branch 7 December 1987 Date
SUBJECT: ALLEGED INDECENT ASSAULT ON **LS 68** C/O COULTER HILL CHILDRENS
HOME BALLYCLARE

TO: ACC.
CRIME

I acknowledge receipt of your directive dated 25.11.87 ref no CM78/249/87. Investigations will commence immediately and file will be submitted to HQs for DPP in due course.

J Willis
J WILLIS
Superintendent

10 DEC 1987

S/DIVISIONAL REF. NO.

H.O. REF. NO.

DIVISIONAL REF. NO.

ROYAL ULSTER CONSTABULARY

J Division LISBURN Sub-Division/Department
LISBURN Station/Branch 3 FEBRUARY 1987 Date
SUBJECT: ALLEGED INDECENT ASSAULT ON [REDACTED] LS 68 C/O COULTER HILL CHILDRENS
HOME-BALLYCLARE

TO: The Superintendent
Lisburn

1. Owing to the nature of the original complaint in this matter I am submitting the papers for favour of direction.
2. The allegations, while they relate to some ten years ago, are nevertheless disturbing and one wonders, if true, how many more children at the hospital were involved.
3. I feel that further enquiries should be pursued at Lissue from staff to establish whether or not they were aware of the matter or if any complaint had been made to them by any other child. Inspector Wilson may be able to assist in relation to the views of the Social Services.
4. Suspects, [REDACTED] LS 144 and [REDACTED] LS 144 are mentioned but in the absence of any form of complaint little further can be done as respects him.
5. I would suggest further enquiries and report by 20.2.1987.

J C Wilkinson
J C WILKINSON
Inspector 8883

H.Q. REF. NO:

S/DIVISIONAL REF. NO:

DIVISIONAL REF. NO:

ROYAL ULSTER CONSTABULARY

.....J..... Division LISBURN Sub-Division/Department
..... LISBURN Station/Branch 20TH JANUARY 1987 Date
SUBJECT: ALLEGED INDECENT ASSAULT ON [LS 68] C/O COULTER HILL CHILDRENS
HOME, BALLYCLARE.

TO: Sergeant Jones

On the 27th November 1986 I was contacted by [LS 129] [REDACTED]
[REDACTED] Lisburn reference a letter received by
herself from the Director of Social Services. (Copy of letter
attached).

On the 28th November 1986 at 11am I spoke to [LS 68]
[REDACTED] DOB [REDACTED] at Coulter Hill Childrens Home, Ballyclare.
She refused to make a written statement until after she had told
her father. [LS 68] father has an unbalanced mind and she was
concerned about his reaction to this allegation.

On the 12th January 1987 I received a statement from [LS 68]
withdrawing her complaint.

[LS 68] is now 17 years and alleged that while she was at Lissue
Hospital Ballinderry Road, Lisburn, 10 years ago a male employee
indecently assaulted her. She was unable to name the man involved
but from the description [LS 129] of the Social Services had
located a possible suspect. [LS 144] [REDACTED]

This man has retired some years ago for health reasons and is now
about [REDACTED] of age and in bad health. No contact was made with
[LS 144]

I respectfully request that a letter be forwarded to [LS 129]
[REDACTED] explaining the result of
this investigation. (Contact has already been made by telephone).

L.C. Craig

W/Const 672

Inspector Williams

This alleged offense occurred some 10 years ago
the complainant has now made a statement of
withdrawal.

forwarded.



30/1/82

CONFIDENTIAL

Reference CM78/249/87.....

SUBJECT : LETTER FROM THE DIRECTOR,
NORTHERN HEALTH & SOCIAL SERVICES RE
LS 68

Sub Divisional Commander
Newtownabbey

Please see the attached communication from
the Northern Health & Social Services Board.

I should be grateful if you would forward,
as a matter of urgency, copies of any papers
held at your location, concerning this matter.

W G Monahan

W G MONAHAN
Assistant Chief Constable Crime

3 11 87

CODE 18-78

CONFIDENTIAL



Northern Health and Social Services Board

LARNE, CARRICKFERGUS AND NEWTOWNABBEY UNIT OF MANAGEMENT

WHITEABBEY HOSPITAL, DOAGH ROAD, NEWTOWNABBEY BT37 9RH — Telephone: Whiteabbey 65181

98 / 53031

OUR REF.: BAS/DK

YOUR REF.:

24 November 1986

Mr R. Moore
Director of Social Services
Eastern Health and Social Services Board
65 University Street
BELFAST BT12

Dear Mr Moore

Please find enclosed a statement made by one of the residents of Coulter's Hill, a children's home within this Unit of Management. The girl who is 17½ years of age made the statement to a member of staff but then seemed concerned about the implications and asked to think about it before the matter went further.

She was seen on Friday, 21 November by Mrs Smyth, Assistant Principal Social Worker, with responsibility for Coulter's Hill and confirmed at that time that she wished something done about it. She informed Mrs Smyth that she had not told her parents at the time and she is now very worried about her father's reaction - her mother died two years ago. When asked why she brought the matter up now she said she felt it was not right that other children might be subjected to the same treatment. She described LS 144 as being [REDACTED] She could not guess his age but seems to think he is still there. She is aware that she may be interviewed by police but still feels she wishes to pursue the matter.

I have informed our local police that the matter has been referred to you and I should be happy to provide any further information you may require.

Yours sincerely

P. J. McHugh
MR P J McHUGH
Assistant Director of Social Services

EASTERN HEALTH & SOCIAL SERVICES BOARD	
DIRECTOR OF SOCIAL SERVICES	
FORWARD TO	Mr P. J. McHugh
SEEN BY	CSB
HOLD <input type="checkbox"/>	26 NOV 1986 <input type="checkbox"/>
COPY TO	
FOR: ACTION/COMMENT/INFORMATION	

NORTHERN HEALTH AND SOCIAL SERVICES BOARD
 LARNE, CARRICKFERGUS AND NEWTOWNABBEY
 UNIT OF MANAGEMENT

29/10/86

Statement - **LS 68** - re sexual abuse allegations while in Lurgan Hospital.

His name is **LS 144** I think. I was about seven or eight, at night he had to get me up to go to the toilet, because I used to wet the bed. He used to give me sweets when we weren't allowed to get them. It started off from that. He would get up I reckon around midnight take me to the toilet then take me back to bed again. He at first would sit at the edge of the bed, start kissing me on the cheek, then he would touch me between the legs and my "tush" ^(vagina). Then he would start pulling himself off. When this was done, I used to ask what the sticky stuff was, he would just said it was cream for sores. He used to say to me not tell any of the other kids about me doing this because they all be wanting it to. It's only special kids who get this. He also said don't tell your mummy or daddy.

was in Lurgan I think about one year, I was there about a month I think before this started happening.

think he is still employed here, because the other stuff **LS 78**

LS 21 I think one still there.

LS 68

H.O. REF. NO.

S/DIVISIONAL REF. NO.

DIVISIONAL REF. NO.

ROYAL ULSTER CONSTABULARY

'D' Division Newtownabbey Sub-Division/Department
Sub Divisional Office Station/Branch 11 November 1987 Date
SUBJECT: LETTER FROM THE DIRECTOR, NORTHERN HEALTH AND SOCIAL SERVICES RM

LS 68

TO: Sub Divisional Commander
Lisburn

I refer to the attached communication from ACC Crime.

This matters appear to be dealt with by staff from your Sub Division.

McCormick
F C MCCORMICK
Sub Divisional Commander

ROYAL ULSTER CONSTABULARY

'D' DIVISION

12 NOV 1987

Ref. No. DN57/812
SUB-DIVISIONAL OFFICE NEWTOWNABBEE

STRICTLY CONFIDENTIAL

C178/249/87



Northern Health and Social Services Board

OFFICE OF THE DIRECTOR OF SOCIAL SERVICES

COUNTY HALL, GALGORM ROAD, BALLYMENA, N. IRELAND, BT42 1QB

Telephone: Ballymena 3333

29 October 1987

FILE REFERENCE:

Assistant Chief Constable W G Monaghan (C)
RUC Headquarters
Brooklyn
Knock Road
BELFAST
BT5 6LE

Dear Sir

Re **LS 68**

In November 1986 **LS 68** who was in the care of this Board under a Fit Person Order and resident at Coulter's Hill Children's Home in Ballyclare made serious allegations of sexual abuse against a member of staff of Lissue Hospital where she had been an in-patient some years previously. **LS 68** thought that she would have been eight years old at the time the abuse occurred.

With the assistance of staff, **LS 68** prepared a statement in which she described the abuse and a copy of this statement was enclosed in a letter addressed to Superintendent Moore at Whiteabbey Police Station on 24 November 1986. On the same date a letter was addressed to the Director of Social Services in the Eastern Board so that he could take the matter up with his colleagues in that Board who are responsible for the administration of Lissue hospital. Subsequently, Senior Nursing staff in the Eastern Board were able to identify the member of staff described by **LS 68** and ascertained that he had left the service a year previously on the grounds of ill health.

Initially, **LS 68** wished the matter to be investigated by the Police and expressed that wish very strongly to staff. However, apparently she changed her mind subsequently and on 12 January 1987 it appears she made a written statement to the Police withdrawing her original complaint. As a result the Police decided not to pursue the investigation any further. That decision was conveyed verbally to my Assistant Director of Social Services in Newtownabbey by the Police at Whiteabbey and subsequently the same decision was confirmed in a letter dated 8 April 1987 from Superintendent J Willis to **LS 129** in Lisburn Unit of Management.

I wish to place on record my concern that the Police have decided not to investigate this matter, as most of the literature on abuse of this nature suggests that seldom, if ever, does a perpetrator confine his abuse to one child and that the pattern of abuse usually recurs over many years, 20 - 30 years being not uncommon. Additionally, whilst the person to whom **LS 68** refers may have left the service, there is no guarantee that he does not continue to have access to children who would be at great risk of abuse of a similar nature to that which **LS 68** was subjected.

/My colleagues in the Eastern

CONTINUATION

Northern Health and Social Services Board

Date 29 October 1987

Office of the Director of Social Services

My colleagues in the Eastern Board inform me that in a similar situation where serious allegations of sexual abuse were made against an ex-member of staff of a voluntary children's home in South Belfast, the Police have been willing to accept the Board as the complainant in lieu of the girl's parents, the girl herself having refused to make a statement of complaint. Having regard to the circumstances which I have described and in view of the precedent which appears to have been established, I would ask that the decision not to investigate the abuse alleged by [REDACTED] LS 68 in Lissue hospital should be reviewed as a matter of urgency.

For your convenience I enclose a copy of the letter addressed to Superintendent Moore together with a copy of [REDACTED] LS 68 statement and also a copy of Superintendent Willis' reply to [REDACTED]. Your assistance in this matter will be much appreciated and I look forward to your reply.

Yours faithfully



M S IRWIN
DIRECTOR OF SOCIAL SERVICES

FAS/AS

Encls.



Sub-Divisional Commander's Office

THE ROYAL ULSTER CONSTABULARY

LISBURN CO ANTRIM NORTHERN IRELAND BT27 4SP

Telephone: Lisburn 77421

E.H. 5578 LISBURN DISTRICT

DATE RECD. 14/4/87

ACTION TAKEN

Please reply to:

The Sub-Divisional Commander

Your reference:

Our reference: JN87/183

Date: 8 April 1987

LS 129

Department of Social Services
Health Centre
LISBURN

Dear **LS 129****LS 68**

C/O COULIER HILL CHILDRENS HOME, BALLYCLARE

I refer to your communication with Woman Constable Craig (Lisburn RUC) in November 1986 and subsequent telephone contact in relation to the above-named.

This is to confirm that on 12 January 1987 **LS 68** made a written statement withdrawing the original complaint. That, combined with the fact that the alleged incidents occurred 7 years ago, have led me to the decision not to pursue the investigation any further.

Yours faithfully

J Willis
J WILLIS
Superintendent

Northern Health and Social Services Board

LARNE, CARRICKFERGUS AND NEWTOWNABBEY UNIT OF MANAGEMENT

Group Headquarters

WHITEABBEY HOSPITAL, DOAGH ROAD, NEWTOWNABBEY BT37 9RH — Telephone: Whiteabbey 53031

OUR REF.: BAS/DK

YOUR REF.:

24 November 1986

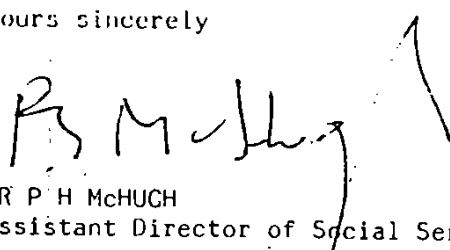
Supt. Moore
RUC Station
418 Shore Road
Whiteabbey
NEWTOWNABBEY

Dear Supt Moore

I enclose a photocopy of a recent statement made by a resident in Coulter's Hill, Ballyclare, one of our children's homes. The girl concerned is 17½ years of age and is aware of the implications of such a statement. She is conscious that she may be questioned by police and is prepared to stand over what she has said. I have referred the matter to the Director of Social Services for the Eastern Health and Social Services Board within whose area Lissue Hospital lies.

I should be happy to supply you with any further information you may require.

Yours sincerely


MR P. H. McHUGH
Assistant Director of Social Services

ROYAL ULSTER CONSTABULARY

CONVICTIONS OF

LS 68

Date of Birth:

FEMALE

NEWTOWNABBAY MC 29/1/87

Common Assault on Adult

29/8/86

FINED £50

85. The Board notes that these records of abusive behaviour relate to potential knowledge by staff of parental abuse of the child. The key criticism appeared to be a failure to follow up / report this to the appropriate authorities.
86. The Retrospective Sampling did identify two allegations against members of staff (internal page 15 of report). However, it is noted that these files were from the period 1990 – 2003 and thus do not relate to the Child Psychiatry Unit at Lissue Hospital.
87. The Board is also aware that on 19 November 1986 a female child reported her distrust of **LS 79** to **LS 21**. A review undertaken by Belfast Trust of **LS 79** staff file in or around 2008 noted that the matter was reported to **LS 8**, Assistant Director of Nursing, who interviewed **LS 79** *“The report concluded that **LS 79** was aware of this responsibilities towards vulnerable children.”* In 2008 it was noted: *“there was no evidence of the young person / parents being interviewed with regard to this matter or indeed what was meant by distrust”*.
88. In responding to this question, the Board has drawn on files identified to be relevant and sampling exercises which included a targeted consideration of files. The Board has not been able to review the file of every inpatient in Lissue Child Psychiatry Unit between 1971 and its closure in 1989. However, the Board considers that the targeted sampling exercises carried out in respect of Lissue provide a good measure of the nature and range of complaints made and, as part of its own historic case review process, the Board did not consider further sampling exercises were required.

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

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

OUTLINE OF CASE*

(Give **salient** facts in chronological order with clarity and brevity. Do not merely repeat witness statements. Where more than one person reported summarise the case against each.

Whilst the aim should be to summarise the facts on one page, a continuation page may be used if it is necessary for the inclusion of all the salient facts.)

1. On Wednesday 19 October 1988, **LS 145** 8 years, an In Patient at Lissue Hospital, Lisburn reported to staff that he had been assaulted by his room mate during the early part of the night having retired to bed.
2. This person was **LS 146** DOB [REDACTED]
3. He stated that **LS 146** had removed his pyjama bottoms having already taken off his own. He then lay on top of him. Then **LS 146** played with **LS 145** privates and then had oral sex with him.
4. **LS 146** was interviewed at the hospital on 20 October 1988 when he admitted this offence. **LS 146** declined to make a formal written statement but wrote out a few words of what he had done on a piece of paper. This was then marked IN 1 (Part III).

I certify that all witness statements taken by police in connection with this investigation are included in this file.

**EVIDENCE STILL
TO BE OBTAINED***

(Tick as appropriate.)

NB. Submission of reports should not be delayed by the absence of such evidence if a prima facie case can be established without it.)

FORENSIC REPORT	
POST MORTEM REPORT	
MEDICAL REPORT	
PHOTOGRAPHS	
MAPS	
OTHER (SPECIFY) JLO Report	X

**COMPLAINTS
AGAINST POLICE***(Delete as appropriate.
Insert C & D reference
if known)

A COMPLAINT HAS BEEN MADE	YES NO	C & D REF. NUMBER
---------------------------	-------------------	----------------------------

**ASSESSMENT OF
WITNESSES**To be completed only
when information of
particular relevance is
available.eg. character credibility,
attitude to person(s)
reported, reliability, any
disability affecting capa-
bility as witness, age,
capacity to give evidence.
State the quality of
witness to a disputed
identification.State the involvement
of witnesses in reported
crimeIn the case of a child
witness it should be
stated whether, in the
opinion of the
investigating officer,
that child will be deemed
by the court to understand
the nature of the oath.

LS 145 is 8 years old and is educationally sub normal. However, he was sure of what took place in the room. Due to his age it was thought inappropriate to record a written statement from him.

OTHER
OBSERVATIONS

(Include any additional matter relevant for DPP consideration, eg. sectarian background of case, whether any other incidents linked to the present case are being separately investigated)

Lissue Hospital is an Assessment In Patient Centre for disturbed and physicatric children where they can receive treatment.

At night there are several staff on duty in the corridors, they would only enter the rooms if found necessary.

RECOMMENDATIONS*
AS TO CHARGES
AND PROCEEDINGS

(Stated shortly by reference to section of statute)

Due to the facts I would respectfully recommend that **LS 146** be cautioned under the Juvenile Liaison Scheme for:-

Indecent Assault on Male, Section 42 Offences Against Person Act 1861.

Signature of Reporting Officer: Ivan Noble IVAN NOBLE, CONSTABLE 12555

Date: 23 December 1988

VIEWS ANDRECOMMENDATIONSOF SUPERVISINGOFFICER*

(In fast stream cases, the recommendation must be from an officer not below the rank of Inspector)

VIEWS AND
RECOMMENDATIONS
OF SUB-DIVISIONAL
COMMANDER

SUB-DIVISIONAL COMMANDER
LISBURN

LS 146 is a 12 year old boy who is educationally sub normal and an In-Patient at Lissue Hospital.

He states that he knew what he had done was wrong and alleges he had seen it on a blue movie. However, at the Case Conference his Social worker expressed concern re the unhealthy sleeping arrangements at his home. It appears that his father and mother's sexual relationship has never been satisfactory. **LS 146** had slept with his father until 1985 and had slept with his mother until he was 11 years old. Both parents denied there had ever been any sexual interference between themselves and **LS 146**.

However, Social Services had planned for **LS 146** to go home at weekends but this is now cancelled and he may be placed in a Residential Boarding School. In the meantime the Hospital are going to carry out further work with him. Therefore I respectfully recommend that he be given the benefit of a Juvenile Liaison caution.

Name & Rank: R J DUNLOP, INSPECTOR 9574

Signature:

R J Dunlop

Date:

10 January 1988

Name & Rank:

Signature:

Date:

VIEWS ANDRECOMMENDATIONSOF SUPERVISINGOFFICER

(In fast stream cases, the recommendation must be from an officer not below the rank of Inspector)

Chief Constable
Crime

The defendant in this case is a 12 year old boy (13 years
[REDACTED] an in-patient at Lissue Hospital.

He is ESN and receiving treatment at the hospital.

Clearly, a prosecution in this case is not appropriate and I therefore recommend no prosecution. A caution under the Juvenile caution scheme can be arranged locally if no prosecution is directed.

The main issue I believe concerns the supervision arrangements at Lissue hospital and it is for this reason that the file is forwarded to Headquarters with my recommendation that the matter be brought to the attention of DHSS senior staff for their attention and subsequent review of the supervision arrangements of staffing levels at Lissue.

Name & Rank: J WILLIS, Superintendent

Signature: [Signature]

Date: 13 January 1989

R v **LS 146**

PART II

WITNESSES

NOBLE, Ivan	Constable	1
DUNLOP, Robert John	Inspector	2

STATEMENT OF IVAN NOBLE
Name Rank Regd. No.
AGE OF WITNESS (if over 21 enter "over 21") OVER 21
OCCUPATION OF WITNESS: POLICE OFFICER
ADDRESS: CARE UNIT, RUC MAHON ROAD, PORTADOWN, CO ARMAGH

TO BE COMPLETED
WHEN THE
STATEMENT HAS
BEEN WRITTEN

I declare that this statement consisting of _____ 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 20 day of OCTOBER 1988

R. J. Dunlop

SIGNATURE OF MEMBER by whom
statement was recorded or received

Ivan Noble

SIGNATURE OF WITNESS

I am a Constable of the Royal Ulster Constabulary presently attached to the CARE Unit, Mahon Road, Portadown, Co Armagh. On Thursday 20 October 1988 at 4pm I saw **LS 146** DOB [REDACTED] Schoolboy, at Lissue Hospital/School, Lisburn. **LS 146** was an In-Patient at the Hospital, therefore [REDACTED] was present and I was also accompanied by Inspector Dunlop. **LS 146** mother was also at the Hospital but she preferred to stay outside while he was spoken to as he did not want her present. I then cautioned **LS 146** after explaining to him what he was going to be interviewed about. He was reluctant to say anything and Inspector Dunlop asked him if he wished to write down what had happened. He agreed to this and Inspector Dunlop gave **LS 146** a piece of paper and a pen. **LS 146** wrote, "I felt his boom and his willey and I lick it as well and then I went to bed." **LS 146** then gave me the piece of paper to me and I later marked it IN 1. **LS 146** was nervous during the interview, shifting about in his seat and not looking at anyone. He admitted he knew what he had done was wrong and said he had seen what he had done on a blue movie.

STATEMENT OF:

ROBERT JOHN DUNLOP

Name

Rank

Regd. No.

AGE OF WITNESS (if over 21 enter "over 21"):

OVER 21

OCCUPATION OF WITNESS:

POLICE INSPECTOR

ADDRESS:

CARE UNIT, RUC MAHON ROAD, PORTADOWN

TO BE COMPLETED
WHEN THE
STATEMENT HAS
BEEN WRITTEN

I declare that this statement consisting of one 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

4

day of

JANUARY

19 89



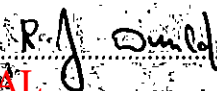
SIGNATURE OF MEMBER by whom
statement was recorded or received



SIGNATURE OF WITNESS

I am an Inspector in the Royal Ulster Constabulary presently attached to the CARE Unit, Mahon Road, Portadown, Co Armagh. On Thursday 20 October 1988 at 4pm I saw **LS 146** DOB [REDACTED] Schoolboy at Lissue Hospital/School, Lisburn. **LS 146** was an In-Patient at the hospital therefore [REDACTED] was present and I was accompanied by Constable Noble. **LS 146** mother was also at the hospital but she preferred to stay outside while he was spoken to as he did not want her present. Constable Noble cautioned **LS 146** after explaining what he was being interviewed about. He was reluctant to say anything and I asked him if he wished to write down what happened. He agreed to this and I gave him a piece of paper and pen. He wrote, "I felt his boom and his willy and I lick it as will and then I went to bed." He gave the paper to Constable Noble who marked it IN 1. He was nervous during the interview, shifting about in his seat and not looking at anyone. He admitted he knew what he had done was wrong and said he had seen it on a blue movie.

SIGNATURE OF WITNESS:



R v **LS 146**

PART III

DOCUMENTARY EVIDENCE

IDENTIFICATION NUMBER	DESCRIPTION	PRODUCED BY	REFERRED BY	REMARKS	PAGE NO
IN 1	Piece of paper	I NOBLE, Constable	I NOBLE, Constable	Attached	1

IN1

OFFICIAL-SENSITIVE-PERSONAL

LIS-31713

I Eat His Boom and has Willy and I Lick it as well and
then I went to bed

OFFICIAL-SENSITIVE-PERSONAL

R v **LS 146**

PART IV

GENERAL

JL 1 and JL 5 - **LS 146**

attached

I, Hilary R Harrison will say as follows:

This statement has been provided on behalf of the Department of Health, Social Services and Public Safety (the Department) in response to the Rule 9 request of the Historical Institutional Abuse Inquiry (HIAI) dated 16 December 2015. It has been prepared on the basis of information contained in files currently held by the Department and such evidence received from the HIAI as it has been possible to review within the required timeframe. As further information becomes available, it may be necessary to provide to the HIAI, revised or supplementary statements.

Question1

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

- 1.1 The Department understands that Lissue House, a private home, was opened in May 1947 for the treatment and convalescence of sick children. Following a brief period of closure after the ending of the war in 1945, Lissue House was privately donated to the newly created Northern Ireland Hospitals Authority (the Authority). It re-opened in 1949 as Lissue Hospital, a paediatric medical and surgical hospital and continued as such until May 1971, when it began to provide additional services in the form of psychiatric in-patient and day patient services for children and young people. In later years, prior to its closure, Lissue hospital also provided in-patient respite care for children with complex health needs.
- 1.2 The Health and Social Care Board (HSC Board) in its statement to the HIAI dated 29 February 2016¹ (the HSC Board statement) has set out in detail the history and operation of the hospital with reference to the Child Psychiatry Unit, until the service transferred to the Foster Green Hospital site, Belfast. Attached at Annex A of this statement is a comprehensive history of the hospital and all paediatric services provided on the Lissue site from the hospital's opening to its closure in January 1989 taken from a book written by a former consultant paediatrician at the hospital. entitled: 'A history of the Royal Belfast Hospital for Sick Children: a history 1948-1998'².

2. How many individuals spent time in Lissue?

- 2.1 The HSC Board statement provides the numbers of in-patient and day patient between May 1971 and 29 February 1989³ to the psychiatric unit at Lissue. During these years 1,124 children were admitted as in-patients and 250

¹ LIS 079

² Love, H. The Royal Belfast Hospital for Sick Children: a History 1948-1998. Belfast: Blackstaff Press, 1998

³ LIS 081

children were admitted as day patients.

- 2.2 More general statistics for the whole of Lissue hospital are available from annual statistics published by the DHSS between the years 1966 to 1989 which show total inpatient admissions of between 201 and 501 children per year and between 290 and 1760 day patient attendances annually (Annex B).

3. On what basis were children admitted to Lissue?

- 3.1 The HSC Board statement sets out in detail the general clinical framework under which *“24 hour intensive treatment”* services were provided. Whilst admission criteria were not precisely defined, the hospital’s range of methodologies and admission patterns indicate that children who were admitted to the Child Psychiatry Unit were those with the most complex mental health and behavioural needs. These included emotional and behavioural disturbances and psychiatric illnesses, which in addition to more traditional methods, were addressed through the provision of alternative treatment approaches such as behavioural modification programmes, family therapy and child management skills for parents.

- 3.2 With reference to the other medical, surgical and respite care paediatric services provided on the Lissue site, the Department does not have any further information other than that contained in the history of Lissue at Annex A.

4. What legislation governed the operation of Lissue?

- 4.1 Lissue was governed by the provisions of the following primary legislation in so far as its operation as a hospital was concerned:

- The Health Services Act (NI) 1948 (the 1948 Act);
- The Health Services Act (NI) 1971 (the 1971 Act);
- The Health and Personal Social Services (Northern Ireland) Order 1972 (the 1972 Order).

5. What rules, regulations or Orders (legislative or otherwise) applied to Lissue?

- 5.1 The Department has been unable to identify any subordinate legislation that addresses the management and operational questions with which the HIAI is concerned in relation to Lissue. The HSC Board’s statement, however, includes written policies and guidance⁴ which established the procedures and

⁴ LIS 084

3 THE APPLICANTS

- 3.1 There were 10 Applicants in Module 13, one of whom is deceased.
- 3.2 Two of the Applicants, HIA 404 and HIA 172, gave evidence about their time in Lissue Hospital Paediatric Ward.
- 3.3 The remaining Applicants had all been in patients in Lissue Child Psychiatric Unit and gave evidence about their experiences there.
- 3.4 Analysis of the admissions book for the Child Psychiatry Unit at Lissue shows that between May 1971 (opening) and 29 February 1989 (date of closure) 1,124 children were admitted as in-patients and between the same dates 250 children were admitted as day-patients.
- 3.5 The number of Applicants who make complaints about their time in the Child Psychiatry Unit in this Module, 8 of which relate to the Child Psychiatry Unit represents less than 1% of children admitted to the inpatient unit over its 18 years of operation between 1971 and 1989.⁶
- 3.6 The admission book for the paediatric ward at Lissue has not been found. However, Dr Harrison statement for Module 13 states that the annual statistics for the whole of Lissue hospital which were published by the DHSS between the years 1966 to 1989 show total inpatient admissions of between 201 and 501 children per year and between 290 and 1760 day patient attendances annually⁷. As already noted, the inquiry has heard from just two Applicants in respect of the Paediatric Ward. As a minimum, Dr Harrison's statement suggests admissions of over 4,500 children during the 23 year period referred to. Thus it is submitted that the overwhelming

⁶ LIS 081, paragraph 14

⁷ LIS 793, paragraph 2.2



9

LISSIE HOSPITAL



TO DISCOVER THE ORIGINS OF the important part played by Lissie in the life of the Children's Hospital, it is necessary to look back to the outbreak of World War II.

On 13 September 1939 the Medical Staff met to consider a proposal put forward by the BMA regarding the provision of emergency services in wartime. Members of the medical staffs of the Belfast hospitals were to be summoned to duty immediately in the event of an air raid or other emergency. In the case of

Lissie House, Ballinderry, near Lisburn, Co. Antrim, which opened during wartime as a hospital with two wards in July 1940



The spacious entrance hall and grand staircase of Lissue House

the Belfast Hospital for Sick Children, Professor P.T. Crymble, Ian Fraser, J.S. Loughridge, Dr Rowland Hill, Dr Muriel Frazer and Dr Ivan McCaw were responsible.

Naturally, one of their main concerns was the availability of sufficient beds to cope with a major emergency. Therefore it was with gratitude and alacrity that the Staff accepted the most generous offer by Colonel and Mrs D.C. Lindsay to hand over part of their home, Lissue House, at Ballinderry, near Lisburn, as a convalescent or evacuation hospital, should the need arise. A preliminary inspection by Dr F.M.B. Allen and the honorary secretary of the Medical Staff Committee, Dr Ivan McCaw, reported that Lissue House would be ideal accommodation for up to thirty children. The house was ready to receive evacuation patients on 15 July 1940, and the first batch arrived the following day. This proved to be a timely provision, in view of the air raids which were to devastate Belfast early in 1941.

Dr Patterson, a Lisburn general practitioner, was asked to attend Lissue as a non-resident house surgeon, for which she would receive £75 per annum. In anticipation of their own remuneration for time and travelling

to Lissue, Medical Staff decided to place a book at the Hospital recording their visits. Reminder letters regarding payment for such visits, sent to the Ministry of Home Affairs in March and April 1941, were not acknowledged; it was not until May, 1942 that a response to repeated approaches was received. The Ministry conceded that Medical Staff were being put to extra inconvenience and loss of time in travelling to Lissue but offered only to defray travelling expenses at civil service rates. This worked out at 6s 8d per visit. Staff considered this derisory and resolved to bring the matter to the attention of the Parliamentary Medical Subcommittee, then sitting. Co-operation was also sought from the medical staff of the Ulster Hospital for Women and Children, who were in the same plight. This joint approach bore fruit for in September 1942 the Ministry agreed to pay a fee of two guineas for each staff visit to Lissue, to take effect retrospectively from the original date of transfer of patients. This rather tardy offer was accepted by Staff as satisfactory and Lissue continued to play a vital role as a convalescent facility throughout the war years.

With the cessation of hostilities, the Northern Ireland government stopped payment for the upkeep of Lissue, as of 30 September 1945, and ordered that all effects must be removed and the house vacated.¹

The loss of Lissue House was a severe blow and the Medical Staff demanded the provision of a convalescent home to replace it, whether it be located inland or by the sea. The original Queen Victoria convalescent home, situated in the townland of Ballydollahgan on the outskirts of Belfast, had long since closed in 1908. (The house, now privately owned, can still be seen on the corner of the Saintfield Road and Beechhill Road, Newtownbreda.) The Board responded by purchasing Ballynascreen House, at Greenisland, Co. Antrim, for the sum of £4,500. However, by December 1946 Lissue was back on the agenda. Dr Muriel Frazer raised with Medical Staff the possibility of acquiring Lissue House as an ancillary hospital which would relieve the overtaxed accommodation on the Falls Road site. This possibility became a reality when, at its meeting on 12 August 1948, the Temporary Committee was able to announce that, through the great generosity of the Lindsay family, the Hospital was to acquire the whole of Lissue House for conversion to a branch of the Royal Belfast Hospital for Sick Children; no conditions were attached, except that the house must be occupied within nine months. Fortunately, the Board was able to sell the property at Greenisland at the original purchase price, and proceeded at speed with the necessary structural alterations to Lissue.

The first patients were admitted on 1 September 1948, and the official opening was performed by Mrs D.C. Lindsay on 21 January 1949.² A plaque to commemorate this important event was placed in the entrance hall.

THIS HOUSE WAS GIVEN BY THE
LINDSAY FAMILY
TO THE ROYAL BELFAST HOSPITAL FOR SICK CHILDREN
IN MEMORY OF
DAVID CECIL LINDSAY, D.L.
HIS SON
EDWARD WORKMAN LINDSAY
AND HIS GRAND-DAUGHTER
DEBORAH DAWN LINDSAY



William McClure Nelson, consultant psychiatrist and first director of the Child Psychiatry Unit, 1971-92

For almost forty years Lissue House was to play a very significant role in the affairs of the Royal Belfast Hospital for Sick Children. Initially, it functioned as a convalescent hospital but by 1959 it had become a busy branch facility capable of caring for a wide variety of surgical and medical patients in seventy beds. However, the following ten years saw further change. There had been a slow but steady infiltration of psychiatric patients, and by the middle of 1966 the need for an in-patient child psychiatric unit was becoming a matter of urgency. For example, at the level of practical nursing, mobile psychiatric patients were interfering with other children confined to bed, and with numbers continually rising they became increasingly difficult to control. In response to this concern, a subcommittee of Medical Staff was appointed to decide how part of the Lissue accommodation could be converted to a psychiatric unit. In June 1969 the Ministry approved in principle a proposal to adapt the first floor of the house for this purpose, and in September 1970 a tender of £14,050 for the necessary building works was recommended and accepted.

The new unit opened in May 1971, and consisted of twenty in-patient beds providing residential care for children with emotional and behavioural difficulties. There were an additional five places for children attending daily. The unit was staffed by a multidisciplinary

team comprising doctors, social workers, psychologists and Nursing Staff provided by the parent hospital in Belfast.³

The first director of the Child Psychiatry Unit was consultant psychiatrist Dr William McClure Nelson, under whom the treatment philosophy and general ethos was largely eclectic. The influence of Dr John Barcroft led to the inclusion of a psychotherapeutic approach, and with the appointment of Dr Roger McAuley in 1975 the philosophy changed to a new perspective of behavioural modification strategies. In 1976 this particular focus of treatment became the principal direction of care, with staff from all the disciplines adopting a behavioural philosophy in their work. At this time, the unit developed further with the advent of family admissions, providing a more accurate emphasis on family dynamic and the child management skills of the parents. To meet these criteria, it expanded in 1977 to provide parent accommodation

DR JOHN BARCROFT, son of Professor Henry Barcroft, past Professor of Physiology, QUB, was appointed as a consultant child psychiatrist at BCH in 1973. This service transferred to the Children's Hospital in 1974. Henceforth his remit covered the RBHSC, Ulster Hospital and Lissue Hospital. In 1978 Dr Barcroft took up a similar appointment in Cambridge.

with the conversion of additional adjacent rooms.⁴

While supporting the need for enhanced psychiatry facilities, Medical Staff became increasingly concerned at the possibility that all non-psychiatric beds at Lissue might be lost, in spite of assurances given by the Area Executive Team that such a dispossession would not occur until alternative accommodation was supplied. Dr W.A.B. Campbell, a paediatrician who took a great interest in Lissue affairs over many years, urged his colleagues to make as much use as they could of the Lissue beds. This situation contrasted with the attempts of Staff in the 1950s and 1960s to increase paediatric beds at Lissue, firstly to a figure of fifty, so that the appointment of a resident house officer could be justified, and then to eighty-five, as a final target. Efforts were made over the years to accomplish this increase by many internal architectural alterations. For example, in December 1961 the Works Committee was asked to give attention to three different needs, in order of priority: i) isolation facilities; ii) an infants' ward to accommodate twelve cots; and iii) alterations to separate the toddlers from the older children to allow easier nursing supervision. However, by January 1963 the push for more beds was losing momentum and the Staff's request to the Works Committee for more accommodation was not approved, on the basis that there was a substantial number of vacant beds throughout the area at the time. Accordingly, the request was changed to a plea for better distribution of the available beds, with no further increase.

It was not until May 1975 that Dr Campbell's fears were confirmed in a letter from the chief administrative medical officer of the Eastern Health & Social Services Board, Dr James McA. Taggart, asking the Medical Staff to address the following issues:

- 1 the long-standing low occupancy of paediatric beds at Lissue;
- 2 the possibility that the type of patient treated there could be accommodated elsewhere;
- 3 the urgent need for additional in-patient facilities for Child Psychiatry;
- 4 the Board's responsibility to ensure better utilisation of scarce resources.

The letter concluded:

It would be appreciated if you would submit a proposal to your Medical Staff that the present paediatric beds be no longer used for this purpose and that all facilities at Lissue Hospital be utilised as a regional centre for Child Psychiatry.

The Board backed up its case with the quarterly statistics of Lissue Hospital, purporting to show the low occupancy of the thirty-eight paediatric beds. Pressure was duly applied for the relocation of twenty of these beds in the Allen and Musgrave Wards of the main hospital. The Medical Staff produced counter-occupancy statistics to demonstrate that such a transfer was not feasible.

Nevertheless, the persistent underusage of the convalescent beds at Lissue could not be ignored. The decreased demand for convalescent beds had

several causes, among them the development of the nursing service in the community, with its emphasis on care and support in the home situation where possible, a trend continuing and growing today. Ironically enough, together with the greater demands of child psychiatry, another change was appearing: the paediatric beds were being occupied more and more by chronically sick and handicapped children. Furthermore, there was increasing recognition of the need to provide care for the carers, so that in 1977 an arrangement was made for the short-term admission of handicapped patients, with the object of giving their families periods of respite. In that year, only twenty-nine of the thirty-eight 'convalescent' beds were operational and seven of these were occupied by special care patients. This need to accommodate patients with multiple handicap went unacknowledged by the Eastern Health & Social Services Board, and throughout 1977 there was sustained pressure to remove all general patients from the ground floor of Lissue House and to use the vacated accommodation for psychiatric patients. This pressure was resisted, and by December 1979 the admission of special care patients to Lissue was a commonplace occurrence, largely at Campbell's instigation. Until Christmas 1988 the branch hospital at Lissue continued to serve the children of Northern Ireland through its paediatric and psychiatric units, and the new role of the paediatric unit as a facility for the care of the child with multiple handicap was emphasized further by the appointment, in November 1983, of Dr Elaine Hicks as consultant in paediatric neurology and, in June 1986, of Dr Agnes Elizabeth (Nan) Hill, as consultant with an interest in complex handicap.

Michael Swallow, consultant neurologist at the RVH, was encouraged by Ivo Carré and Claude Field to provide a service at the RBHSC in the years before Elaine Hicks was appointed. He established a weekly clinic and also took part on an ad hoc basis in a Genetic Clinic with Norman Nevin. Swallow was a strong supporter of the appointment of a full-time neurologist at the Hospital. He retired in 1989 to pursue his great interest in music, and in 1995 he was awarded an OBE for services to music therapy, art and disability.

The excellent work carried on at Lissue over so many years deserves particular credit given the difficulties which from time to time hindered the smooth functioning of the hospital. The house itself, while ideal for the care of short-term convalescent patients, was not architecturally suited to the ever-changing needs of an increasingly varied patient population, and its deficiencies as a major institutional facility were often exposed. Staff, planners and builders spent many hours making minor and sometimes major alterations to rooms, verandas, plumbing facilities and so on, in order to accommodate the demands of a wide spectrum of patients: infants, children – mobile and immobile – and those requiring education and behaviour control. This led the Nursing Staff to dub the house 'Legoland'. Some of the children called it 'The Zoo'.

In the early days tuberculosis posed a problem. For example, in July 1949 there was a case of open tuberculosis at Lissue, prompting the Medical Staff to adopt a policy stating that no open case of TB should be sent to Lissue or admitted into the main hospital. These words appeared to fall on deaf ears, for in May 1953 the Hospital Committee asked the Northern Ireland Hospitals Authority to take up with the Northern Ireland Tuberculosis Authority (NITA) the problem of the large number of cases of primary TB complex then in Lissue. In May 1955 there were twenty-four of these children at Lissue Hospital, there being no vacancies at the NITA establishment at Crawfordsburn.

Infections other than tuberculosis afflicted the hospital from time to time, and in September 1954 there was what was termed an 'explosive outbreak of enteritis', with no specific organisms found. In the same year, at a more mundane level, the ingestion of laburnum seeds by a few ambulant patients necessitated the felling of the offending tree. There is no record of any harm coming to the children.

There was the occasional brush with management at both local and area level. On 22 June 1964 a message was received from the Group secretary, R.T. Spence, who was proposing to transfer twenty-two orthopaedic cases from Greenisland Hospital to Lissue during the first week of July. This was the first notice that the Staff had of this move. Not surprisingly, they made urgent representations to the senior administrative medical officer of the Hospitals Authority, expressing deep concern at this lack of consultation before such a major step was undertaken. They pointed out the lack of space, the absence of treatment room facilities and poor sluice accommodation which should be upgraded prior to the transfer. Furthermore, the presence of so many adult-sized beds in the upstairs ward, with their necessary beams, pulleys and so on, would make it unreasonably cramped. The Nursing Staff were so perturbed that the matron, Molly Hudson, wrote to the Board in protest. Notwithstanding, by September 1964 the transfer of orthopaedic patients had taken place, with no improved hygiene facilities and no additional bed space.

Undoubtedly, the event which caused most concern and dismay to the Staff was the transfer, in 1973, of the administrative control of Lissue Hospital from the North & West Belfast District to the Lisburn District. In May of that year, the Ministry of Health (soon, with direct rule from Westminster, to become the Department of Health & Social Services) issued a memorandum to members of the EHSSB, the Central Services Agency and the Area Executive teams, concerning the overlap of services between Areas and Districts (Circular R16/73).⁵

In a section dealing with the 'Criteria for Management Arrangements', the document enunciated certain principles, among them:

- 1 The underlying policy in the administration of the Health and Personal Social Services is that the existence of administrative factors (Area or

District) should not place obstacles in the way of the provision of service to the public according to its needs, irrespective of the place of residence.

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

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

Lissue Hospital, Lisburn Health and Social Services District. Beds 58, type: Convalescent and Child Psychiatry.

Hospital Management Committee: Belfast associations – is an annexe of the Royal Belfast Hospital for Sick Children.

Catchment area is predominantly greater Belfast. Comparatively few patients are normally resident in the Lisburn Health and Social Services District.

FUTURE ROLE: In view of its current links in the catchment area, there is a good case for this hospital to be administered and staffed by North and West Belfast Health and Social Services District, rather than Lisburn Health and Social Services District.

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

We have given considerable thought to this question of overlap between Districts within an Area and have recently issued a circular [the aforementioned R16/73] to Area Boards, giving guidance on this subject. Basically, we feel that in general, Area Boards should be responsible administratively for all the facilities within their area, but we do recognise that there are special cases, such as Lissue Hospital, where for very specific reasons the administration should continue to be the responsibility of a District other than the one in which the facility exists. We have asked Boards to look at the overlap problems and to keep us informed of their decisions. To me it seems that Lissue presents one of these exceptional cases and I feel that it would be very easy for the Eastern Health and Social Services Board to resolve it this way.

The Board did not agree and ignored this nudge from Dundonald House – Lissue Hospital was hived off to the Lisburn District. Staff concern that nursing and administrative posts would be downgraded and that laboratory services, records, X-rays and so on would suffer went unheeded, and repeated representations to have the decision reversed were of no avail. The Board continued to hold the view that no post would be reduced in status by this administrative change and that the function of the clinical nurses, and other staff associated with Lissue, would in no way be disturbed. Nevertheless, the infection control sister, Patricia Symmons, immediately found great difficulty in carrying out her duties in Lissue under the new regime and asked to be relieved of her post. This dispute rumbled on, and



Children playing in the grounds of Lissue House, c. 1960s

in 1980 Dr Aileen Redmond was reporting to the Medical Staff Committee that the Nursing Staff at Lissue, who had strong loyalty to the main hospital, were feeling more and more isolated. Incidentally, the Board's opinion that the administration of Lissue could be better served by Lisburn District was not shared by the administrators and medical staff of that District, who made their contrary views clear on more than one occasion.

With hindsight, the decision to remove administrative control of Lissue Hospital from the North & West Belfast District of the EHSSB, while leaving the responsibility for patient care in the hands of the Medical Staff of the Children's Hospital, looks very much like a triumph of bureaucracy over common sense. Nevertheless, Lissue staff of that time were impressed by the efficient way in which essential day-to-day services were provided by the Lisburn District.

THE MOVE FROM LISSUE

CHILD PSYCHIATRY UNIT

Throughout 1982 and 1983 rumours were circulating that the Eastern Health & Social Services Board was considering closing Lissue Hospital and relocating the psychiatric and paediatric units at sites yet to be decided. It is an oft-repeated charge that the first inkling clinicians get of major changes in the administrative structure is through the grapevine. This has

happened frequently enough to create the suspicion that premature leaks are used by the policy makers to test the water.

Discussions eventually took place between the consultant psychiatrists and members of the EHSSB at which various reasons were given as to the desirability of a move from Lissue. The Board argued that the present unit was too expensive and too remote and that it would be more cost-effective to bring several services together on a new site. In a word, rationalization was its objective and it would not be deterred.

The news of the closure united the people of the Lagan Valley in a campaign to save Lissue. James Molyneaux, the local MP and Ulster Unionist Party leader, described the Board's decision as an appalling blunder, and the Alliance councillor Seamus Close dismissed the three-month consultative period as a 'complete and utter farce'. Albert Brown, chairman of the campaign committee, saw it as the 'old, old story of financial concerns taking precedence over parents' and people's wishes', and spoke for many in the community when he said that Lissue Hospital offered both an expert service and a loving unique environment that would be most difficult to replace.

The Save Lissue Campaign failed, and in mid-1985 the Medical Staff were invited to view various areas of Forster Green Hospital. After inspection, it seemed to them that the old Nurses' Home would be the most suitable in terms of accommodation, provided extensive alteration and refurbishment were carried out. They conceded that Forster Green had some undoubted advantages over Lissue; the site was nearer the outpatient unit at the Royal Belfast Hospital for Sick Children and was also in close proximity to the area of greater Belfast, whence the majority of patients would come.

Forster Green, a Belfast tea merchant, was a Quaker with an acute social conscience. In 1896 he purchased Fortbreda House on the Saintfield Road, Belfast, for adaptation to a sanatorium; the first patients were admitted the following year. In the 1930s TB was the main killer of young adults. It was responsible for 49 per cent of all deaths in the age group fifteen to twenty-five and for 38 per cent of those between twenty-five and thirty-five. The mortality rate was 20 per cent higher in Northern Ireland than in Britain.⁶ Forster Green's own daughter was a victim. It was not until 1941 that the Northern Ireland Tuberculosis Authority was set up to find and treat the victims of what was then a dreaded disease of frightening morbidity and mortality. With the aid of new drugs, such as PAS and Streptomycin, and BCG vaccination, together with advances in surgical and anaesthetic techniques, by 1954 the incidence of the disease had been reduced by 15 per cent to the same level obtaining in England and Wales. NITA's success was such that it was dissolved in 1959.

For two or three years after 1985, consultant staff were involved in further negotiations with the Green Park Unit of Management and the EHSSB,



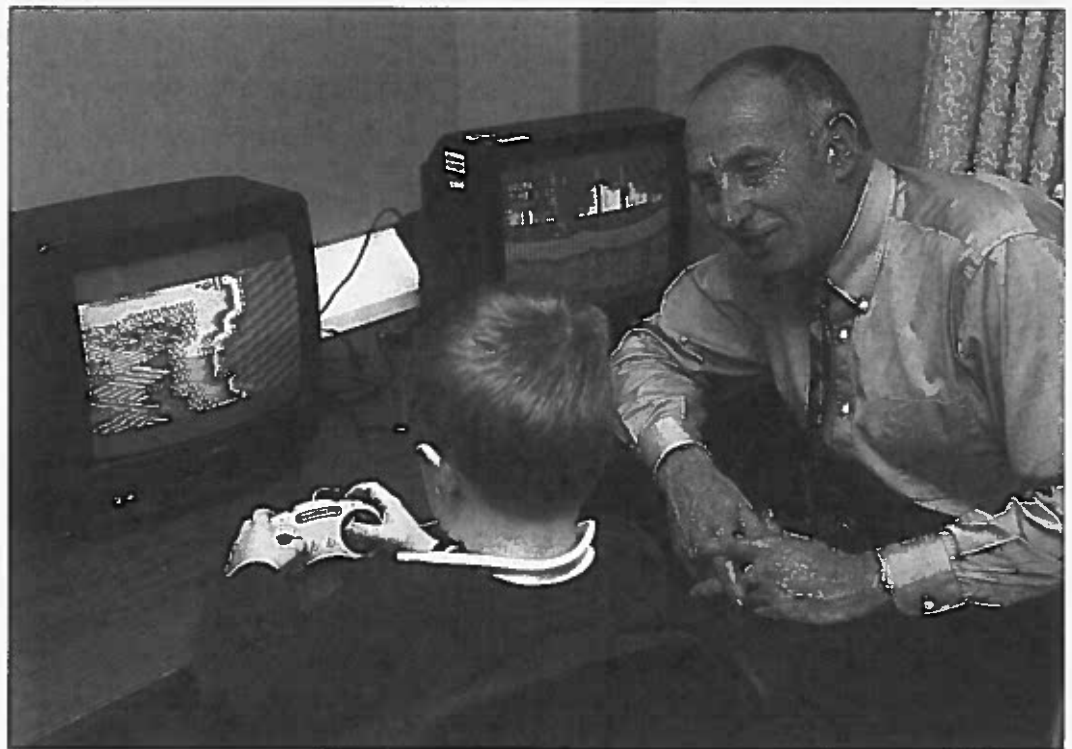
in drawing up plans for the necessary site alterations. The Board imposed financial restrictions, and the subvention of £150,000 covered only the cost of a new heating system, rewiring and redecoration of the existing building.

As the date of the planned move drew nearer, other potential teething troubles began to surface. Clinicians were worried that not only would there be a flow of Nursing Staff inexperienced in child psychiatry moving between the unit's hospitals, but traditional attitudes would involve nurses in the wearing of uniform – which was anathema to psychiatrists. Initially, they had to submit to this convention. Furthermore, mindful of the Lindsay family's past beneficence, Dr Nelson and Dr McAuley wished to have the new unit named the 'Lindsay Unit'.⁷ This request was refused on the basis of the Board's stated policy not to name units after personalities, however distinguished: a decision viewed by the Medical Staff as an example of unnecessary bureaucratic insensitivity.

Less controversially, the transfer of the Lissie Hospital School to Forster Green proceeded smoothly under the aegis of the South Eastern Education & Library Board, which readily agreed to naming it the 'Lindsay School', thus ensuring that the name so long associated with the care of children would be perpetuated in at least one area of the new facility. Together with the Child Psychiatry Unit, the Lindsay School at Forster Green Hospital opened in March 1989.

From 1 May 1995, as a result of a patient survey, both the in-patient unit at Forster Green and the outpatient facility at the RBHSC (of the Department of Child Psychiatry) became known as the Child and Family

Dr Roger McAuley outside the Child and Family Centre inpatient facility at Forster Green Hospital, 1997. The building was formerly the Nurses' Home; at the rear is the Hospital School.



Dr Roger McAuley and patient
pupil at a computer keyboard in
the Lindsay School, 1997

Centre. In 1997 the consultant staff were: Dr Roger McAuley (appointed 1975); Dr Marie Therese Kennedy (appointed 1981); Dr Geraldine Walford (appointed 1994); and Dr Morna Manwell (associate specialist).

THE HOSPITAL SCHOOL AT LISSUE AND FORSTER GREEN

The school at Lissue House commenced and prospered under the leadership of Miss McConachie, by all accounts a formidable woman, held in some degree of awe by junior members of Staff. She and Ada Kirkpatrick, a keen assistant teacher, began their work at the bedside, and readily adapted to the increasing patient population over subsequent years. Their spectrum of pupils ranged from the educationally subnormal, through those with severe emotional and behavioural difficulties, to children who were capable of eleven-plus standard – indeed, success at that level has been recorded. Sometimes there was conflict of priorities between education and Hospital routine. In 1956 Dr W.A.B. Campbell met with Miss McConachie and the Nursing Staff to find the best way of reconciling medical requirements with teaching continuity. As a result, new classroom accommodation was made available, to cope with a mixture of ambulant children in a single area; bed patients would receive individual instruction as before. While recognizing the importance of children's education, Medical Staff felt that a period of fresh air in the spacious grounds would be beneficial, especially during the winter months. The teachers had no personal objections but were concerned about the consequences of the possible unheralded arrival of a school inspector while the children were outside. It was suggested that in such an unfortunate eventuality the

outdoor activity could assume the guise of nature study. In the face of many vicissitudes, the Hospital school, through the selfless dedication of Miss McConachie and her staff, provided educational facilities for hundreds of Lissue children throughout the years.

Miss McConachie retired in 1975 and was succeeded by Mary Murphy. Joyce I. Moran, who took over as head in 1984, had the task of organizing the move from Lissue to the new accommodation at Forster Green. The Lindsay School now provides education for the children who are patients at the Child Psychiatry Unit at Forster Green Hospital. A member of its staff also teaches at the Ulster Hospital. The pupils on the roll are aged between three and a half and fourteen years and the high staff/pupil ratio allows for individual teaching, more than is possible in the mainstream of education. A child can be referred to the unit from anywhere in Northern Ireland by a psychiatrist, a medical officer, a GP, an educational psychologist or a head teacher. Parents are closely involved with the Hospital Staff in the work with their child, and the professional team concerned with each consists of a psychiatrist, a clinical psychologist, the school principal, the social worker and nurses. On Joyce Moran's retirement in 1993, Phillip Doherty became principal, with Patricia Aust as vice-principal. (See Appendix 6.)

The school's advice to parents could be taken to heart by parents of children without any identifiable psychological handicap:

PLEASE –

TALK to your child – children love to 'chat' and have things explained to them.

READ to your child – daily, if possible.

TAKE your child on visits – to the park, to the leisure centre, to the library, etc.

PLAY games with him/her indoors and outside.

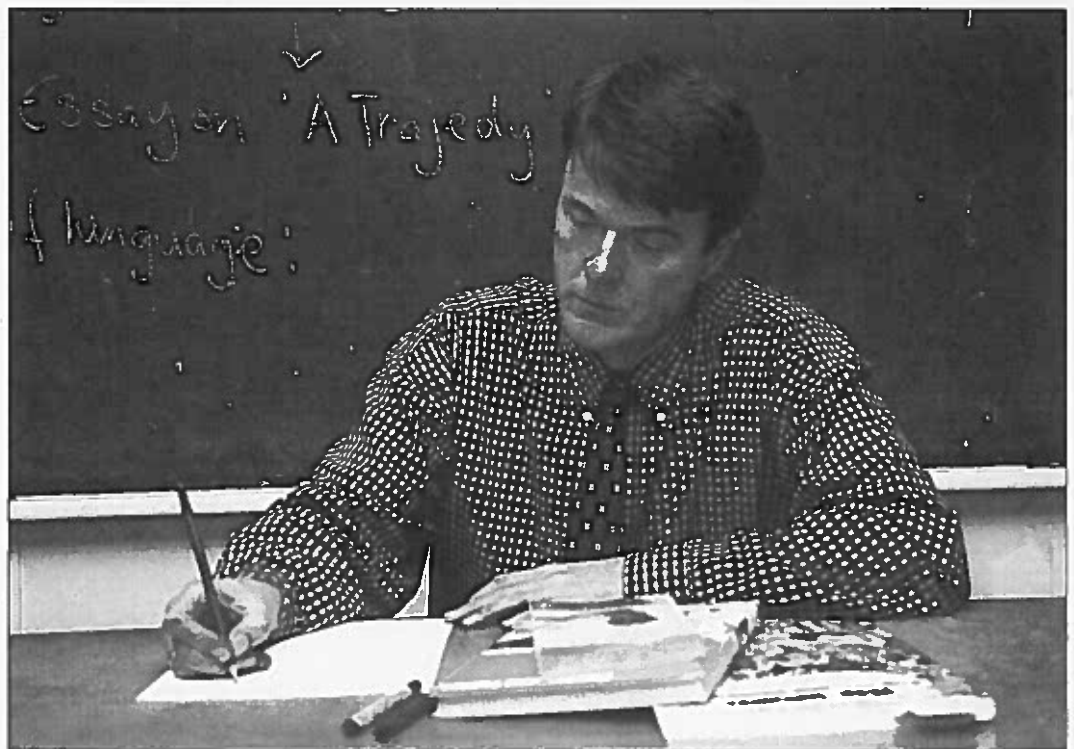
ENCOURAGE your child – give praise and appreciation when it is appropriate.

SPEND TIME WITH YOUR CHILD – ENJOY EACH OTHER'S COMPANY

The Lindsay School continues to build upon the pioneering work of Miss McConachie and her colleagues, to enable children with handicaps to climb the tree of knowledge to the best of their ability. Lately, patients have been admitted from a wider catchment area, including Donegal, Limerick and the Isle of Man. Among the subjects taught are English, mathematics, science and technology, the environment and society, and creative and expressive studies.

The character and ethos of the school are excellently set out in a pamphlet issued by Phillip Doherty and his staff:

As an integrated all ability school, we aim to provide a happy, secure environment in which children can learn effectively to realise their full



Phillip Doherty, principal
of the Lindsay School at
Forster Green, 1993-

potential as unique individuals. This aim permeates the ethos of the school, the teaching styles and approaches, the pastoral care and the discipline policy of the school. As children have different abilities, aptitudes and needs, their performances will vary from their peers and every opportunity is given for children to experience success. Positive encouragement and praise for all pupils, regardless of gender, colour or creed, enables them to develop intellectually, socially, morally and spiritually and become full contributing members of the school community. The school provides an opportunity for children from the two main traditions in Northern Ireland, as well as those from other traditions and cultures, to develop a knowledge, understanding, appreciation and respect for their common culture. All pupils are encouraged to explore and value their own particular tradition so as to encourage the education together of children of various beliefs, cultures and traditions. A happy and caring environment is promoted, centred on the needs of the child in preparing him or her for a creative and satisfying life in a plural society. The right of parents to be involved in the decision making and community life of the school is protected, while respecting the role of staff as professional teachers. All pupils are equally cherished, nurtured and respected without discrimination based on sex, religion, ethnic origin, class or ability. The Lindsay School aims to -

- 1 create a happy, stimulating environment in which pupils can learn effectively;
- 2 nurture the pupils' sense of self esteem so that they can accept others whose ideas and beliefs are different from their own;
- 3 develop skills and knowledge to become independent thinkers whose attitudes and opinions are based on rational judgement;
- 4 provide a broad and balanced curriculum by implementation of the programmes of study of the Northern Ireland curriculum;

- 5 help pupils develop personally, spiritually and socially and recognise the importance of fulfilment, irrespective of ability;
- 6 foster in children the skills needed to develop and maintain healthy relationships;
- 7 encourage all children to give of their time and talents with generosity and with good grace;
- 8 promote the supportive, respectful partnership between the school, the home and the wider community.

THE PAEDIATRIC UNIT

In 1988 the Respite Unit at Lissie House was providing a service for up to one hundred families and over one hundred children, seventy of whom came from the Eastern Health & Social Services Board area, although patients from the Northern and Southern Area Boards still made up a significant minority. The accommodation offered as the new home for the paediatric unit was the ground floor of Belvoir Park Hospital, Pavilion 2, with the proviso that no structural alterations should be made. Dr Elaine Hicks and her colleagues, Dr Nan Hill and Dr Mark Reid, considered this accommodation unsuitable for the children concerned. Their anxieties were compounded by a suggestion from the EHSSB that immediate steps should be taken to reduce the number of beds from twenty to fifteen to fit the new accommodation.

On 18 March 1988 Dr Hicks wrote to Dr Angela Greer, acting administrative medical officer of the Board:

You will not be surprised when I say that I do not think I can support a suggestion that we undergo a decrease in beds from the autumn of this year to fit the offered accommodation. I feel the temporary nature of this accommodation to be unsatisfactory and, while I quite accept that in the long term we wish to have most of this service community based, there is no possibility of this coming about to any significant degree in the shorter intermediate term . . . we are talking several years before we can really start to see a community based programme with significant numbers.

Change, with its close companion uncertainty, is an unsettling, often traumatic experience for patients, parents and staff alike, so it is not surprising that Dr Hicks's letter ended on a rather despairing note:

The morale of the staff in the paediatric unit at Lissie is at an all-time low. Together with the parents, they are deeply concerned at the uncertainty of the [future] of the unit. The lack of substantive communication from the Board as to their definite plans and, above all, the suggested decrease in bed accommodation at the new location is not helpful.

The fears and concerns of the paediatricians at Lissie were shared by the members of the Paediatric Division at the Children's Hospital. They were worried about the fate of those patients residing outside the Eastern Board who had been receiving respite care in Lissie, now that the bed accommodation was to be reduced. The Board replied that the number of beds

which would be available in Belvoir Park had been considered with regard to the needs of the Eastern Board children, who would take precedence over children from the other Board areas. In the EHSSB's view, respite care did not require a regional resource and other areas should be encouraged to set up their own units.⁸

The Board's determination was irresistible and on 3 August 1988 Dr Hicks informed the Division of Paediatrics that in January 1989 the paediatric unit at Lissue was to move to refurbished accommodation at Belvoir Park, Pavilion 1 (this having proved more suitable than Pavilion 2, originally offered). The cost of upgrading the accommodation came to £86,000 plus VAT.

The new unit, named Forest Lodge Children's Respite Care Unit, became part of the Green Park Trust, which includes Belvoir Park, Forster Green and Musgrave Park Hospitals. It has a complement of fifteen beds and cares for children up to the age of fourteen. The ward is staffed, as at Lissue, by nurses who have paediatric training and are under the charge of Sister R. Lloyd, who moved with the unit from Lissue Hospital. The medical care is provided by Dr Elaine Hicks (who assumed a regional role in 1992), Dr Nan Hill and Dr Paul Jackson. There are ninety-five to one hundred children on the books at present.

The appointment of Dr Nan Hill in 1986 was another step in the evolution of the neurodevelopmental service at the Royal Belfast Hospital for Sick Children. Eighty per cent of her work was hospital-based – at the Children's Hospital, Musgrave Park Hospital and Lissue House – with the balance involving responsibilities at the two regional schools for children with physical disabilities, Fleming Fulton and Mitchell House, and at schools for children with speech and language problems, namely, Thornfield and Seagal House (Mencap Nursery). (This situation is now reversed as she is almost entirely based in the community.) Dr Hill's work has been built on the labour and dedication of colleagues who preceded her, Dr Chris Green, Dr Maurice Savage and Dr Claude Field.

Dr C.M.B. Field wrote a report in 1948 on the types of illness in children admitted to a typical twenty-six-bed children's ward in that year. There were 94 children with lobar pneumonia, 63 with various strains of tuberculosis, 129 with rheumatic fever or chorea and 29 with heavy infestations with various kinds of worm. Writing in 1982, he noted that these illnesses had almost completely disappeared and that handicapping disorders of children were becoming a large and important part of paediatrics. Furthermore, he observed that children were rarely afflicted by a single handicap, most having several additional problems. Dr Field recognized that a special clinic was required where children with complex problems could be seen at leisure, not only by the paediatrician but by other



Nurses Linda Williamson and Sandi McTrusty consult a patient's notes at Forest Lodge Children's Respite Care Unit, 1997

personnel skilled in speech therapy, occupational therapy, physiotherapy, orthoptics, psychology and social work. He found these skills available at Fleming Fulton and Mitchell House, and a start was made by the seconding of these therapists to his clinic one day each week. The Belfast Education & Library Board provided an educational psychologist who had special skills. Dr Field had started his assessment clinic in 1976 in a suite of rooms in the Wakehurst House annexe of the BCH, in what used to be the Child Guidance Clinic. He held strongly to the belief that a clinic entirely devoted to the needs of children should be a centre not only for the assessment of handicap but for treatment. This far-seeing, pioneering work culminated in the opening of the new Child Development Centre at the Royal Belfast Hospital for Sick Children in 1991.

The years after Dr Hill's appointment saw continual development in the care of children with complex handicaps. The referrals to the Child Development Centre at the Children's Hospital became more complicated with the proliferation of community-based child development clinics. The work involved children with very complex problems or those for whom a second opinion was being sought. The investigative facilities on the Royal Hospitals site became increasingly important in the areas of neuro-imaging, neurochemistry and neuropathology. There was ongoing endeavour to unfold for worried parents the exact nature and causation of the different problems afflicting their children.⁹ In more recent years, however, a volte-face has occurred. The new orientation towards a community-based service has resulted in the running down of the centre for complex handicap at the RBHSC.

The two former Lissue units are now settled in their accommodation at Forster Green and Belvoir Park, but the horizon is somewhat obscured by clouds heralding more change in the administrative climate. Indeed, in the case of the psychiatric unit, the recent change to Trust Status has resulted in the child psychiatry service being split between the RBHSC and Forster Green Hospital, run by the Royal Hospitals Trust and the Green Park Trust respectively. There is anxiety that such arrangements might result in administrative complexity, which could be detrimental to the efficient running of the service. The future of the paediatric unit remains uncertain in view of the planned closure of Belvoir Park Hospital.

Its forty years of service over, Lissue House was left empty to become run-down and overgrown, until its destruction by fire in 1996. The plaque commemorating the gift of the house to the RBHSC now resides in Lindsay House at Seymour Hill, Lisburn. Many would argue that a more appropriate home would have been within the precincts of the original object of the Lindsay family's generosity – the Royal Belfast Hospital for Sick Children.

Lissue House		
Year	In-patients Admitted	Day-patients -total number of daily attendances
1966	432	-
1967	385	-
1968	454	-
1969	382	-
1970*	279	-
1971	316	-
1972	348	221
1973	357	631
1974**	267	1253
1975**	270	1282
1976	217	1605
1977	235	1436
1978	273	762
1979	252	1129
1980	201	1643
1981	283	1760
1982	288	1197
1988***	501	868
1989	424	290

Notes:

Source: Department of Health and Social Services Northern Ireland - Analysis of running costs, related income and statistics of hospitals, other residential facilities administered by Health and Social Services Boards

* 32 beds out of commission from 5 January until 31 March 1970 due to alterations

** Titled 'Children Lissue'

***Years 1983 – 1987 missing

LISSUE HOSPITAL

LISSUE HOUSE, 31 BALLINDERRY ROAD
LISBURN CO. ANTRIM

Telephone Tel: Maze 621511/513

HISTORY 1981



LISSUE — A CHILDRENS HOSPITAL

It is no real wonder that Lissue Hospital now finds itself enjoying this title—when the original act of kindness which has resulted in to-day's development of the service is reflected upon.

During the second world war (in 1940) at the time of the first blitz in neighbouring Belfast, Colonel D. C. Lindsay of Lissue House telephoned the Royal Belfast Hospital for Sick Children offering accommodation in his home, to give as many children as possible care and safety. Such a charitable act was only matched by the speed and gratitude of the response, and within hours the large billiard room was prepared and occupied. Those first two bus loads of patients and staff were to signal the beginning of a significant and progressive service at Lissue to children with an extensive range of disabilities and distress.

After the uncertain war years this link with R.B.H.S.C. continued to flourish and strengthen, the location being an ideal setting for long term and convalescent care and treatment — and on 1st May, 1947 Lissue House was donated by the Lindsay family to the R.B.H.S.C. in memory of:

Col. D. C. Lindsay

His son, Edward Workman Lindsay

His grand-daughter, Deborah Dawn Lindsay

In 1959, it was a busy Branch Hospital of R.B.H.S.C. treating surgical and medical patients and providing training and experience under full supervision, for doctors, nurses and physiotherapists. By now the number of patients had swelled to 70 children and these ranged over the many categories of illness in childhood — surgical, medical, orthopaedic and general.

This valuable and industrious service continued through the sixties, and so much had Lissue become part of the fabric and essence of the R.B.H.S.C. that it again became an admirable location for the development of a new area of service in May 1971 — a regional in-patient unit for Child Psychiatry — to this day the only such facility in Northern Ireland.

Thus, as the Lindsay family had opened its doors to the R.B.H.S.C. it came the turn of R.B.H.S.C. and Lissue to adapt and welcome this expansion of its role; now the new facility was established by an internal/reorganization of Lissue — achieving two new units for care and treatment within the Hospital.

1. Paediatric Unit for 20 beds providing the full range of services for physically ill children.
2. Child Psychiatry Unit — 20 beds and 5 day-patients providing specialist help to children and families with emotional and behavioural disturbances.

Therefore — not only because Lissue, by the early seventies had a history of Paediatric care and treatment to look back on, but also because it was continuing to meet new needs in this field, — could this stage be regarded as a watershed; in the interests of setting out the developments and progress of the two units within the hospital, it is proper that they should be dealt with separately in this article, so as the reader can fully appreciate the events, efforts and hopes of the staff at all levels who are concerned with its operation.

The Paediatric Unit (20 places up to 14 years of age)

This can be regarded as the present stage of development and evolution, due to a variety of trends and changes in the previous twenty years, namely, a decrease in demand for paediatric beds, the general build up and development of the community nursing service in all districts, and the motivation to provide, where possible, care and support in the home environment. Consequently demand in this unit created a need for total nursing care for those whose needs could not be met outside of hospital. Again, in responding to this role, a commitment to progressive nursing care and a readiness to display new attitudes towards the chronically disabled child and his family, were immediately in evidence; nursing staff, some of whom could reflect easily on previous phases took this new opportunity for service and found new satisfaction and joy in their work with children and their families.

This important change of role can be best described as a change from general paediatric nursing to that of the long term chronically sick, and handicapped, and thus necessitated the development of new skills and attitudes, which the nursing staff in the unit were quick and ready to acquire. Some of these were gained by reading and discussion at ward level, some by visits arranged to other services in the field of mental handicap, though it must also be said that everyone connected with the unit has contributed with enthusiasm to achieve a highly acceptable and well admired standard of care and understanding.

Recognising also that there are many families in the community who care for mentally and physically handicapped children at home in 1977, an arrangement for short term admission of these children was embarked on. This has the chief aim of giving such families a period of respite and support to continue in their caring, and over the past few years an area of useful and much welcomed service to relatives has been established. The length of time such children are admitted for varies according to individual circumstances and availability of beds, but most, if not all requirements can be met by the unit's arrangement of booking in advance, with the assurance of an agreed place for a specific period, and the availability of complete hospital services. Contact and familiarisation of nursing staff and parents is considered to be of high value in the case of all children in the unit — whether long or short term, and to maintain and develop this, open visiting is in operation,

assistance is given in some cases with travelling, brothers and sisters may also visit with parents, and a small booklet is available to give basic information about the hospital.

It follows of course that the more the unit knows about a child and family, particularly if the admission is short-term, the more able are nursing staff to meet individual needs; and in order to develop this aspect it is the aim to engage the interest and understanding of parents as a group, and it is hoped that in this present year (1981) periodic gatherings of the parents and nursing staff will begin and become a further feature of this very special unit.

The Child Psychiatry Unit

As stated earlier, this development at Lissue began in May 1971, but further reading will describe not only the course of events since then, but also, it is hoped, provide an understanding of the value and function of a residential treatment setting as part of the complete Child and Family Psychiatry Department.

A chance remark by Queen Elizabeth the Queen Mother during a visit early in the war to Royal Belfast Hospital for Sick Children led to the establishment of a "Child Guidance Clinic" in an old nissen hut in the grounds, financed by the "Bundles for Britain Fund".

The unit was provided by the 'Belfast Child Guidance Council' in 1943 and was staffed by a full time Psychiatrist, a Psychiatric Social Worker and an Educational Psychologist. It continued dealing with out patients, and in 1948, became part of the Health Service. In 1955, the then expanding speciality, was transferred to a house in Mulholland Terrace on the Falls Road, Belfast, where it remained until 1974 when, after reorganization of the Health Service, it transferred to the 1st floor of the Royal Belfast Hospital for Sick Children under the directorship of Dr. W. McC. Nelson.

This final transfer coincided with the amalgamation of the Child Guidance Clinic at R.B.H.S.C. and the Department of Child Psychiatry, established in May 1960 under Dr. W. F. McAuley, in the Belfast City Hospital, providing a similar out-patient service in the South Belfast area and operating out-patient clinics in major centres in Northern Ireland.

There had been serious consideration given, since 1969, to the provision of an in-patient unit, catering for the more seriously disturbed child, hitherto placed inappropriately in adult Psychiatric hospital wards, and in May 1971, after many setbacks, a 20 bed unit was provided in the Lisburn area on the 1st floor of Lissue Hospital, an established branch of the Royal Belfast for Sick Children.

The Paediatric Unit, and the new Child Psychiatry In-Patient facility were absorbed in the Lisburn District of the Eastern Area Board following reorganization of the Health Service in 1974. However, while administrative responsibility for the hospital fell to the Lisburn District, clinical links were maintained with the parent hospital in Falls Road, now with reorganization, the North-West Belfast District.

In the initial phases of the development of the in-patient unit, medical social work, psychological and nursing staff were provided by the parent hospital in Belfast, though in 1974, nursing staff came under the control of Lisburn District, which is part of the Eastern Health & Social Services Board.

Under the direction of the Consultant, Dr. Nelson, with his colleagues, the unit provided, from its inception, an in-patient facility and the availability of 24 hour intensive treatment, which prior to 1971 was not available in Northern Ireland.

Alternatively, these children were compelled to be admitted to adult psychiatric wards in the large hospitals in N. Ireland. Often the criteria determining the choice of placement would be simply the physical distance from the patient's home to the Out Patient Clinic, rendering daily attendance for treatment impractical.

In effect, facilities for treatment of psychological disturbances manifest in children, prior to the availability of residential treatment in the in-patient centre in 1971, proved to be an ad-hoc arrangement depending all too often on chance opportunities for care.

During the years following the establishment of Lissue in-patient centre, the speciality has undergone a number of both physical and therapeutic changes, influenced by thoughts and attitudes reflected in the succession of nursing, medical, and paramedical staff.

With the appointment of Dr. R. McAuley in 1976 the previously eclectic milieu changed to absorb a more behaviourist approach which incorporated intensive behaviour modification programmes. Another major change was the advent of family admissions in 1976, focusing on the child management skills of the parent. To meet this demand, the unit necessarily needed to expand, and in 1977 parent accommodation was achieved by the conversion of additional rooms adjacent to the unit. In the development of this extension of the milieu, greater demands were created on the therapeutic team, both in staff hours and in the additional skills required to facilitate the treatment programme.

More emphasis consequently had to be on an ongoing development of academic and practical instruction, aimed at maintaining treatments in line with contemporary knowledge. This consolidation of practical and theoretical study helped to serve the immediate and continuing need for "on the job" training of staff in post.

In December 1979 recognition of the speciality became more manifest in the placement of nursing students from the Central School of Psychiatric and Special Care Nursing, Purdysburn Hospital, for periods of 4-5 weeks. (Prior to this date, students, often graduate nurses, were seconded for experience of the speciality from the large Psychiatric Hospital Schools in the province). This development provided the stimulation and incentive for a reassessment of training needs in Child Psychiatry, leading to the development of a training manual for nurse learners and more systematised approach to teaching.

In January 1980 following a global recognition of the significance of Family Psychopathology in the aetiology of psychological disturbances, the repertoire of treatments extended to include a study of Family Therapy and the development of this alternative approach to psychiatric illness, the main emphasis here being on seeing every member of the child or young person's family. This particular approach also makes additional high demands on the treatment skills of the large number of staff involved.

Epilogue

This short history of Lissue was conceived following discussions involving Mr. J. Martin, Senior Nursing Officer, Lisburn District (D.A.N.O's Office) and the following senior nurses at this hospital:

LS 8 [REDACTED]

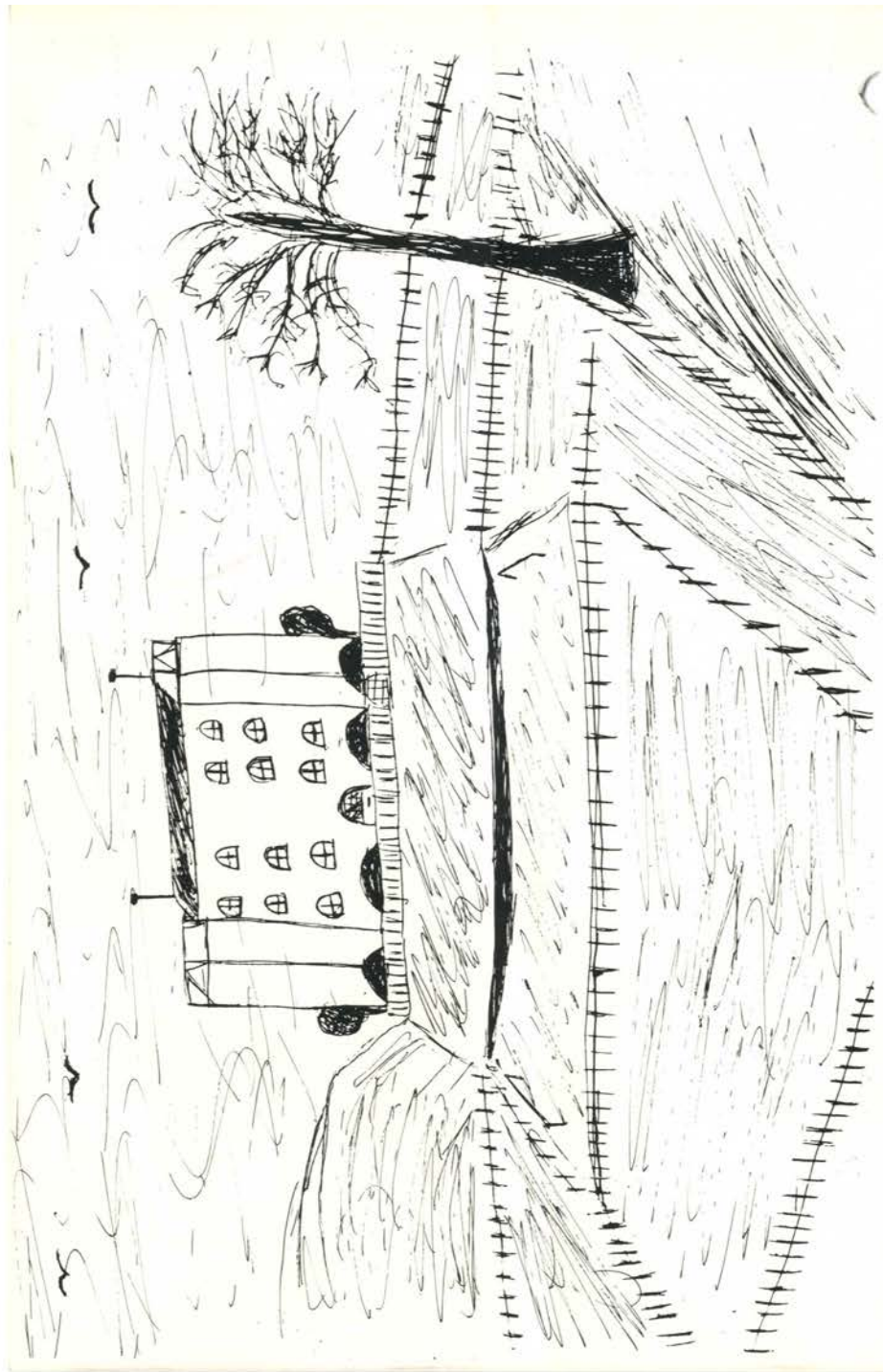
Mrs. H. Murphy, Ward Sister, Paediatric Unit

LS 21 [REDACTED]

LS 78 [REDACTED]

Mrs. M. McManus, Night Sister

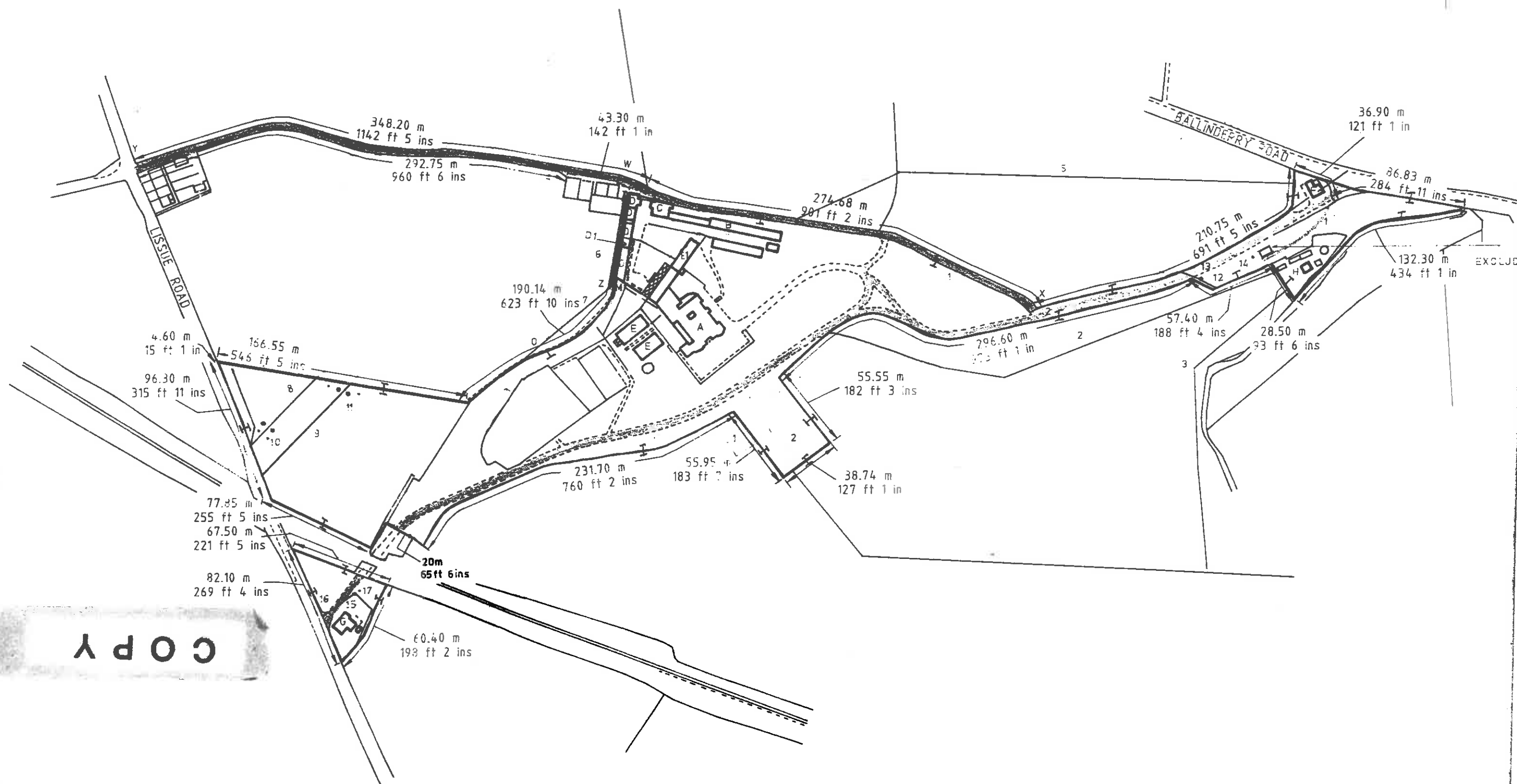
It is hoped that the resulting effort of this group, who found welcome encouragement and information from many of their colleagues, and the usual reliable support of clerical staff in particular, will bring to our reader an appreciation of our continuing service in this International Year of Disabled Persons.



Drawing by one of the children at Lissue Hospital.

LISSUE HOSPITAL AND GATE LODGES 18 LISSUE ROAD AND 29 AND 31 BALLINDERRY ROAD LISBURN

399



approaches to be taken in the management and care of children and child patients. The HSC Board understands that although these post-dated the closure of Lissue, they reflect what was already accepted practice within the hospital. The Department has no reason to dissent from this view.

6. Who regulated Lissue and what approach was taken to regulation?

- 6.1 In so far as the concept of 'regulation' in its broadest sense relates to the control and governing of the conduct of a hospital, there was, prior to the establishment of the Regulatory and Quality Improvement Authority (RQIA), no independent body responsible in Northern Ireland for the 'regulation' of hospitals. The Mental Health Commission established by section 20 of the Mental Health (NI) Order 1986 (the 1986 Order) (see paragraph 7.3) had a limited role in seeking to monitor patient treatment and care. However, the 1948 Act and subsequently the 1972 Order which established the legal framework in which Lissue was directed and controlled, placed a range of powers and duties by the Ministry of Health and Local Government (MHLG) on the administering bodies established to ensure the proper and effective running of the hospital. The 1948 Act provided for the establishment of the Authority which was a body corporate consisting of a Chairman and Vice-Chairman appointed by the MHLG Minister and such other persons as the Minister saw fit, which included the membership as prescribed within Part II of the First Schedule to the 1948 Act⁵. Under the 1948 Act the Authority was responsible for the development, co-ordination and over-all control of the Hospital and specialist services but the duty of administering services provided at or in connection with hospitals was entrusted to Hospitals Management Committees (Committee/s). The Committees were responsible for the day to day running of hospitals under a General Scheme and a Management Scheme made by the Authority and in this matter acted as the Authority's Agents.
- 6.2 The 1972 Order established Health and Social Services Boards (HSC Boards) to exercise on behalf of the Ministry of Health and Social Services (subsequently, the DHSS) the functions relating to the requirement in the 1972 Order for DHSS to provide hospitals and their necessary medical, nursing and other services. HSC Boards were also required to submit for approval by the DHSS a scheme for the exercise of these functions. As in the case of the Authority, each HSC Board consisted of a Chairman and Vice-Chairman appointed by the DHSS Minister and such other persons as the Minister saw fit, which included the membership as prescribed within the 1972

⁵ The 1948 Act provided that the Authority would be constituted by order – this was done by the Health Services (Constitution of the Northern Ireland Hospitals Authority) Order (NI) 1948 which listed all the members of the Authority by name – S.R. & O 1948 No. 81

- 7.4 The HSC Board has provided evidence to the HIAI to the effect that a visit was made by two members of the Commission to Lissue Hospital in or around January 1987 as part of an intended programme of annual visits to each hospital by the Commission⁸. A subsequent report (undated) by one of the visiting members of the Commission indicated that the Commission *“commented favourably on the multi-disciplinary approach and on the obvious harmony between the various professional disciplines. The only doubt raised concerned the adequacy of staffing in view of the high turnover and high occupancy rates.”*⁹ Further reports are not available, but as the HSC statement has noted, the child psychiatry in-patient service moved from the Lissue site in 1989.

8. What were the governance arrangements for Lissue?

- 8.1 In so far as the term ‘governance’ relates to the structures and processes for ensuring that the hospital provided quality of care, paragraphs 6.1-6.3 above and the HSC Board statement have set out in detail the hospital management and administrative structures established by the 1948 Act and the 1972 Order and the responsibilities of the various administering bodies. Within these structures, the HSC Board statement has noted that a committee within the Royal Belfast Hospital for Sick Children (RBHSC) also governed the Lissue Hospital. The RBHSC committee was responsible to the Belfast Hospital Management Committee, which in turn reported to the Authority.
- 8.2 From October 1973, Lissue Hospital came under control of the EHSSB. The HSC Board statement explains the management and reporting structures that were in place on the implementation of the 1972 Order. The HSC Board statement explains that on a day-to-day basis Lissue was a Consultant led unit.
- 8.3 The Department has no further information to add to the HSC Board’s response to this question save to note that the Authority was responsible for the discharge of its functions to the MHLG and not to the Ministry of Home Affairs as suggested by the HSC Board statement.

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

- 9.1 Apart from the information presented in paragraph 8.1 above regarding the RBHSC Committee and the Belfast Committee, the Department has no further information presently to hand regarding whether each hospital had a visiting Board. The HSC Board statement has noted that the Belfast Committee

⁸ LIS 088

⁹ LIS 088

children were admitted as day patients.

- 2.2 More general statistics for the whole of Lissue hospital are available from annual statistics published by the DHSS between the years 1966 to 1989 which show total inpatient admissions of between 201 and 501 children per year and between 290 and 1760 day patient attendances annually (Annex B).

3. On what basis were children admitted to Lissue?

- 3.1 The HSC Board statement sets out in detail the general clinical framework under which *“24 hour intensive treatment”* services were provided. Whilst admission criteria were not precisely defined, the hospital’s range of methodologies and admission patterns indicate that children who were admitted to the Child Psychiatry Unit were those with the most complex mental health and behavioural needs. These included emotional and behavioural disturbances and psychiatric illnesses, which in addition to more traditional methods, were addressed through the provision of alternative treatment approaches such as behavioural modification programmes, family therapy and child management skills for parents.

- 3.2 With reference to the other medical, surgical and respite care paediatric services provided on the Lissue site, the Department does not have any further information other than that contained in the history of Lissue at Annex A.

4. What legislation governed the operation of Lissue?

- 4.1 Lissue was governed by the provisions of the following primary legislation in so far as its operation as a hospital was concerned:

- The Health Services Act (NI) 1948 (the 1948 Act);
- The Health Services Act (NI) 1971 (the 1971 Act);
- The Health and Personal Social Services (Northern Ireland) Order 1972 (the 1972 Order).

5. What rules, regulations or Orders (legislative or otherwise) applied to Lissue?

- 5.1 The Department has been unable to identify any subordinate legislation that addresses the management and operational questions with which the HIAI is concerned in relation to Lissue. The HSC Board’s statement, however, includes written policies and guidance⁴ which established the procedures and

⁴ LIS 084

- 7.4 The HSC Board has provided evidence to the HIAI to the effect that a visit was made by two members of the Commission to Lissue Hospital in or around January 1987 as part of an intended programme of annual visits to each hospital by the Commission⁸. A subsequent report (undated) by one of the visiting members of the Commission indicated that the Commission *“commented favourably on the multi-disciplinary approach and on the obvious harmony between the various professional disciplines. The only doubt raised concerned the adequacy of staffing in view of the high turnover and high occupancy rates.”*⁹ Further reports are not available, but as the HSC statement has noted, the child psychiatry in-patient service moved from the Lissue site in 1989.

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⁸ LIS 088

⁹ LIS 088

In the early days tuberculosis posed a problem. For example, in July 1949 there was a case of open tuberculosis at Lissue, prompting the Medical Staff to adopt a policy stating that no open case of TB should be sent to Lissue or admitted into the main hospital. These words appeared to fall on deaf ears, for in May 1953 the Hospital Committee asked the Northern Ireland Hospitals Authority to take up with the Northern Ireland Tuberculosis Authority (NITA) the problem of the large number of cases of primary TB complex then in Lissue. In May 1955 there were twenty-four of these children at Lissue Hospital, there being no vacancies at the NITA establishment at Crawfordsburn.

Infections other than tuberculosis afflicted the hospital from time to time, and in September 1954 there was what was termed an 'explosive outbreak of enteritis', with no specific organisms found. In the same year, at a more mundane level, the ingestion of laburnum seeds by a few ambulant patients necessitated the felling of the offending tree. There is no record of any harm coming to the children.

There was the occasional brush with management at both local and area level. On 22 June 1964 a message was received from the Group secretary, R.T. Spence, who was proposing to transfer twenty-two orthopaedic cases from Greenisland Hospital to Lissue during the first week of July. This was the first notice that the Staff had of this move. Not surprisingly, they made urgent representations to the senior administrative medical officer of the Hospitals Authority, expressing deep concern at this lack of consultation before such a major step was undertaken. They pointed out the lack of space, the absence of treatment room facilities and poor sluice accommodation which should be upgraded prior to the transfer. Furthermore, the presence of so many adult-sized beds in the upstairs ward, with their necessary beams, pulleys and so on, would make it unreasonably cramped. The Nursing Staff were so perturbed that the matron, Molly Hudson, wrote to the Board in protest. Notwithstanding, by September 1964 the transfer of orthopaedic patients had taken place, with no improved hygiene facilities and no additional bed space.

Undoubtedly, the event which caused most concern and dismay to the Staff was the transfer, in 1973, of the administrative control of Lissue Hospital from the North & West Belfast District to the Lisburn District. In May of that year, the Ministry of Health (soon, with direct rule from Westminster, to become the Department of Health & Social Services) issued a memorandum to members of the EHSSB, the Central Services Agency and the Area Executive teams, concerning the overlap of services between Areas and Districts (Circular R16/73).⁵

In a section dealing with the 'Criteria for Management Arrangements', the document enunciated certain principles, among them:

- 1 The underlying policy in the administration of the Health and Personal Social Services is that the existence of administrative factors (Area or

1 Board" -- sorry -- "who took on administrative
2 responsibility for the hospital after reorganisation.
3 Clinical links were maintained, however, with the parent
4 hospital, which, following reorganisation, fell within
5 the North Belfast District."

6 Now I am going to look at that a little bit, if
7 I may, because I was showing you --

8 A. Uh-huh.

9 Q. -- the history of the Royal Belfast Hospital for Sick
10 Children that was written for its anniversary, I think
11 ninety years' anniversary or something. It is exhibited
12 to Dr Harrison's witness statement. I can get the
13 reference in a moment.

14 It is clear that there was this split between the
15 Lisburn District and the North & West Belfast District.

16 A. Uh-huh.

17 Q. The medical staff still came under the authority, if you
18 like, of North & West Belfast. Nursing staff were then
19 looked after in Lissue.

20 Now the Department -- if we look at the extract from
21 that book, and it is 815 to 817, if we can scroll down
22 to the bottom of that page, please, it goes on here:

23 "Undoubtedly the event which caused most concern and
24 dismay to the staff was the transfer in '73 of
25 administrative control of Lissue from North & West

1 Belfast District to Lisburn District. In May of that
2 year The Ministry of Health, soon to become The
3 Department of Health & Social Services, issued a
4 memorandum to members of the Eastern Health & Social
5 Services Board and the Area Executive Team's Central
6 Services Agency concerning the overlap of services."

7 If we can scroll on down, essentially it says that:

8 "In the appendix cases of overlap between districts
9 in an area were set forth with Lissue being quoted as
10 an example.

11 Lissue had 58 beds.

12 The Hospital Management Committee, Belfast
13 Association, annexe of Belfast Hospital for Sick
14 Children.

15 Catchment area is predominantly greater Belfast.
16 Comparatively few patients are normally resident in the
17 Lisburn Health & Social Services District."

18 Then it goes on to:

19 "The Ministry's position was stated in a letter from
20 the Chief Medical Officer to the Chairman of the Medical
21 Staff Committee and it says:

22 'We have given considerable thought to this question
23 of overlap between districts within an area and have
24 recently issued a circular to the Area Boards giving
25 guidance on this subject. Basically we feel that in

In the early days tuberculosis posed a problem. For example, in July 1949 there was a case of open tuberculosis at Lissue, prompting the Medical Staff to adopt a policy stating that no open case of TB should be sent to Lissue or admitted into the main hospital. These words appeared to fall on deaf ears, for in May 1953 the Hospital Committee asked the Northern Ireland Hospitals Authority to take up with the Northern Ireland Tuberculosis Authority (NITA) the problem of the large number of cases of primary TB complex then in Lissue. In May 1955 there were twenty-four of these children at Lissue Hospital, there being no vacancies at the NITA establishment at Crawfordsburn.

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In a section dealing with the 'Criteria for Management Arrangements', the document enunciated certain principles, among them:

- 1 The underlying policy in the administration of the Health and Personal Social Services is that the existence of administrative factors (Area or

District) should not place obstacles in the way of the provision of service to the public according to its needs, irrespective of the place of residence.

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

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

Lissue Hospital, Lisburn Health and Social Services District. Beds 58, type: Convalescent and Child Psychiatry.

Hospital Management Committee: Belfast associations – is an annexe of the Royal Belfast Hospital for Sick Children.

Catchment area is predominantly greater Belfast. Comparatively few patients are normally resident in the Lisburn Health and Social Services District.

FUTURE ROLE: In view of its current links in the catchment area, there is a good case for this hospital to be administered and staffed by North and West Belfast Health and Social Services District, rather than Lisburn Health and Social Services District.

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

We have given considerable thought to this question of overlap between Districts within an Area and have recently issued a circular [the aforementioned R16/73] to Area Boards, giving guidance on this subject. Basically, we feel that in general, Area Boards should be responsible administratively for all the facilities within their area, but we do recognise that there are special cases, such as Lissue Hospital, where for very specific reasons the administration should continue to be the responsibility of a District other than the one in which the facility exists. We have asked Boards to look at the overlap problems and to keep us informed of their decisions. To me it seems that Lissue presents one of these exceptional cases and I feel that it would be very easy for the Eastern Health and Social Services Board to resolve it this way.

The Board did not agree and ignored this nudge from Dundonald House – Lissue Hospital was hived off to the Lisburn District. Staff concern that nursing and administrative posts would be downgraded and that laboratory services, records, X-rays and so on would suffer went unheeded, and repeated representations to have the decision reversed were of no avail. The Board continued to hold the view that no post would be reduced in status by this administrative change and that the function of the clinical nurses, and other staff associated with Lissue, would in no way be disturbed. Nevertheless, the infection control sister, Patricia Symmons, immediately found great difficulty in carrying out her duties in Lissue under the new regime and asked to be relieved of her post. This dispute rumbled on, and

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27. From October 1973, Lissue Hospital was the responsibility of the Eastern Health and Social Services Board. The nursing reporting and management structures within the Board were (as also developed in Module 5):
- a. District Administrative Nursing Officer, at District Level, who was a member of the District Executive Team, reporting to the Area Executive Team;
 - b. Chief Administrative Nursing Officer, who was a member of the Area Executive Team who reported to the Health and Social Services Board.
28. The Health and Social Services Board reported to the Ministry, later the Department of Health.
29. In 1986, Part VI of The Mental Health (Northern Ireland) Order 1986 established the Mental Health Commission for Northern Ireland ("the Commission"). Functions conferred on the Commission by the 1986 Order included a duty "*to keep under review the care and treatment of patients..*" (Article 86). By virtue of Article 86(2) there were specific duties placed upon the Commission to exercise this function, with powers as to how the functions were to be exercised in Article 86(3). Broadly, this required the Commission to inquire into any case where it appeared there may be ill-treatment, deficiency in care or treatment, improper detention in hospital, or where a patient's property may be exposed to loss or damage. The Commission also had a duty to visit patients liable to be detained, and to bring matters to the attention of the Department of Health and Social Services, Secretary of State or a Board such matters as may be appropriate, including where the Commission considered that that body should exercise its functions to prevent the ill-treatment of a patient or to remedy the care provided. The legislation gave the Commission powers, among others, of visiting hospitals and requiring the production of any records in relation to the detention or treatment of a patient.
30. The Board has not addressed provisions relating to Mental Health Review Tribunals within this statement. The Board does not believe children were detained in Lissue, and as such those provisions did not apply.



Children playing in the grounds of Lissue House, c. 1960s

in 1980 Dr Aileen Redmond was reporting to the Medical Staff Committee that the Nursing Staff at Lissue, who had strong loyalty to the main hospital, were feeling more and more isolated. Incidentally, the Board's opinion that the administration of Lissue could be better served by Lisburn District was not shared by the administrators and medical staff of that District, who made their contrary views clear on more than one occasion.

With hindsight, the decision to remove administrative control of Lissue Hospital from the North & West Belfast District of the EHSSB, while leaving the responsibility for patient care in the hands of the Medical Staff of the Children's Hospital, looks very much like a triumph of bureaucracy over common sense. Nevertheless, Lissue staff of that time were impressed by the efficient way in which essential day-to-day services were provided by the Lisburn District.

THE MOVE FROM LISSUE

CHILD PSYCHIATRY UNIT

Throughout 1982 and 1983 rumours were circulating that the Eastern Health & Social Services Board was considering closing Lissue Hospital and relocating the psychiatric and paediatric units at sites yet to be decided. It is an oft-repeated charge that the first inkling clinicians get of major changes in the administrative structure is through the grapevine. This has

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

6. Lissue Hospital Inpatient Records.

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

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

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

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

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

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

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

1 It goes on to say:

2 "Lissue staff were content with the way Lisburn
3 District handled their day-to-day services."

4 I wanted to explore that a little bit, if I may,
5 with you. First of all, why do you think the Board
6 ignored the advice of the Department or their nudge?

7 A. I can only assume they got caught up in local population
8 needs in terms of it was physically located in
9 a population. Therefore the population -- the
10 organisation that served that population should look
11 after that service. I think as a consequence you had
12 a multiplicity of accountability lines, communication
13 lines, information lines and therefore no -- and I can
14 understand the frustrations expressed in this history,
15 because you had no one organisation looking out for
16 Lissue and all the services that Lissue provided. I am
17 sure everybody did their best to work together, but
18 hospitals are communities of practitioners. Of course
19 they are made up of doctors and nurses and clerical
20 staff and all the pieces and the elements that go
21 together, but actually one of the best ways of
22 describing a hospital is a community of practitioners
23 who work together in the best interests of the patients
24 that they serve. I think the managerial and
25 organisational arrangements that Lissue through this

1 period had to work with didn't help them make that
2 happen.

3 It is interesting, because it appears an exception
4 was made for Muckamore Abbey, which is based in Antrim,
5 but managed through the Belfast Trust still currently.

6 Q. I think the comment that you made to me was that the
7 structures don't lend themselves to the strength of
8 having a total picture of the unit.

9 A. Yes.

10 Q. That total picture could be missed because there was
11 no-one with overall control, as it were.

12 A. It is the in charge question. When you walk into
13 a building, if you ask someone, "Can I speak to who is
14 in charge?", if you walked into Lissue, they would have
15 said, "Of what?"

16 Q. Going back to your statement, Mary, paragraph 67 you
17 make reference to there being an incident book in
18 Lissue. That has never been located. Isn't that
19 correct?

20 A. No.

21 Q. Paragraphs 70 to 73, which is on 095, you talk about the
22 issue of restraint.

23 A. Uh-huh.

24 Q. And you conclude -- I am not going to go through all of
25 the statements, but you conclude that:

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

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

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

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

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

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

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

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



Children playing in the grounds of Lissue House, c. 1960s

in 1980 Dr Aileen Redmond was reporting to the Medical Staff Committee that the Nursing Staff at Lissue, who had strong loyalty to the main hospital, were feeling more and more isolated. Incidentally, the Board's opinion that the administration of Lissue could be better served by Lisburn District was not shared by the administrators and medical staff of that District, who made their contrary views clear on more than one occasion.

With hindsight, the decision to remove administrative control of Lissue Hospital from the North & West Belfast District of the EHSSB, while leaving the responsibility for patient care in the hands of the Medical Staff of the Children's Hospital, looks very much like a triumph of bureaucracy over common sense. Nevertheless, Lissue staff of that time were impressed by the efficient way in which essential day-to-day services were provided by the Lisburn District.

THE MOVE FROM LISSUE

CHILD PSYCHIATRY UNIT

Throughout 1982 and 1983 rumours were circulating that the Eastern Health & Social Services Board was considering closing Lissue Hospital and relocating the psychiatric and paediatric units at sites yet to be decided. It is an oft-repeated charge that the first inkling clinicians get of major changes in the administrative structure is through the grapevine. This has

1948-1998", Mr. Love said that the event which caused most concern and dismay to the staff was the transfer, in 1973, of the administrative control of Lissue Hospital from the North and West Belfast District to the Lisburn District.

2.12 As explained by Mr. Love in his book, Lissue was located within the Lisburn Health and Social Services District and although it was generally felt that Area Boards should be responsible administratively for all the facilities within their area, the Department of Health nevertheless recognized that there were special cases, such as Lissue hospital, where for very specific reasons, the administration should continue to be the responsibility of a District other than one in which the facility exists. However, in the case of Lissue, it seems that the Board decided upon arrangements, whereby Nursing Services were administered by Lisburn Health and Social Services District, Medical Services were administered by the Royal Hospital and the administration of the Social Workers remained with the North and West Belfast District.

2.13 This led to complex administrative arrangements, the outworking of which is described by Dr. McAuley in paragraph 7 of his written statement:

*"There were a number of issues concerning day to day running of the Unit which caused concern...The interests of different line managements resulted sometimes in a lack of empathy with the overall purposes of the Unit. As already mentioned – issues regarding the building were dealt directly by E.H.S.S.B, medics were the responsibility of E.H.S.S.B., Social Workers were managed by N. and W. Belfast Trust, Nurses were managed by the Lisburn and Down District, and psychologists by the Royal Group of Hospitals Trust. The different Trusts were always looking to cut staff – in other words there was little cohesive caring for our service, as might have occurred if we had operated under one Trust."*¹

¹ LIS 484

1 a line of accountability that certainly wasn't unified.

2 They were accountable through their professional line.

3 Q. Yes.

4 A. They were also accountable through their authority
5 line through the relevant organisation, as you say, and
6 that appears to have caused some difficulties in Lissue.

7 Q. So where in the structure did it come together that
8 there was one person who had responsibility for Lissue
9 Hospital as a whole?

10 A. Well, my understanding would have been that it would
11 have been the Eastern Board at the time I think. I am
12 not entirely clear about that, I have to say.

13 Q. Right. Thank you.

14 MS SMITH: Chairman, that concludes the evidence in relation
15 to Module 13, Lissue. It would be an appropriate time
16 to take a short break before we deal with the next
17 module.

18 CHAIRMAN: Well, there may, as in every module, be some
19 matters that we wish to pursue in correspondence,
20 depending upon our review of the evidence we have heard
21 to date. Should that be the case, we will let the
22 relevant party know as soon as possible, but subject to
23 that caveat, that concludes our examination of Lissue.

24 We intend later this morning to turn to the topics
25 of finance and governance, which we had hoped to be in

1 A. I don't remember that, but that -- you know, I actually
2 went out on home visits. So it may have happened.

3 Q. So nurses did actually go on home visits?

4 A. Yes, if you were the key nurse and that was part of the
5 plan.

6 Q. Just I was wondering about how you -- about supervision
7 in terms of your work. You talk here about observing
8 other people's work, but were you yourself as part of
9 the training observed in how you were carrying out your
10 duties?

11 A. That would have happened, yes.

12 Q. In terms of specialism, if I have understood the
13 discussion that we had and from what you have said in
14 your statement, every nurse who was trained had this
15 element of mental health training as part of the
16 training as standard. Is that correct?

17 A. My understanding is that as -- when I made the
18 application to work in Lissue, it was a requirement for
19 me to have my registered mental health nursing training.
20 So therefore I can only think that each of the other
21 nurses needed that qualification to be there.

22 Q. Or certainly from 1984 when you were applying --

23 A. Certainly from 1984, yes.

24 Q. So it may be prior to that a general nursing
25 qualification might have been sufficient. We will hear

then moved on from these determinations. Any change in any child which was apparent was noted and determined on a daily basis.

12. Once I became ward manager I then undertook the training of my staff and maintaining their progress records. I had evaluations to do on each of them and prepare them for different courses that they might have undertaken and evaluate their reports and the records that were made by each of the staff. Although I would have observed the staff with the children I had an enormous amount of administrative work to do. My involvement directly with the children would have been in therapy. In particular I was involved with systems theory. In it I would direct sessions that were taking place between a family, child and psychologist. A session would be looking at the issues that were presented and ways of how to cope with it. I remember working with Dr Nelson and Dr McAuley. Some of my other duties included attending the main hospital and meeting the other managers.

13. I would only have done night shift if I had to cover for someone who was sick or some other particular reason. Any night shifts I would have done would have been quite rare during my career at Lissue.

14. I both gave out medication and supervised the giving of medication. Initially this was done through a medicine trolley. In later years there was a defined letterbox for each child. I was one of 15 staff who were trained in this role.

15. My designation was child and adolescence psychiatry. I did not work in the paediatric area. Both units were on separate floors. The children in my ward would have been aged between 4 and 14 years of age.

16. I worked on the first floor of the building. It also had access to the ground because the building was built on a hill. There was a play ground and garden accessible where I worked. There was a day room. Off it were 3 x 4 bedded dormitories. The dormitories were not mixed sex. There was one 8 bedroom dormitory which was across the corridor from the main office used by all staff.

17. I did not wear a uniform. I would wear casual trousers, a shirt, jacket and tie.

18. I have been asked what type of motor car I had between 1971 and 1988. I had many cars. I would change my car every 2 or 3 years. I remember having an [REDACTED]

19. I did not drive a [REDACTED] I have been asked if I had a [REDACTED] remember having a [REDACTED]

20. I never worked with a nurse called LS 26 I did not work with a nurse called LS 27 I remember LS 22 as a staff nurse who was very competent. I remember LS 23 She was not called LS 23 LS 23

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1 A. No cooking.

2 Q. Okay. In relation to the staff:child ratio did you
3 think that that was adequate?

4 A. At the time that I was there, yes.

5 Q. Do you remember a staff member by the name of LS35?

6 A. No.

7 Q. In relation to LS7, would you have been regularly on
8 duty with her?

9 A. I would have been on occasions, yes, but not necessarily
10 regularly, but certainly during the week I would have
11 been on at least maybe three out of five. So, yes, you
12 could say regularly. Regular enough.

13 Q. So you would have been regularly -- there would have
14 been regular contact. In terms of supervision you
15 talked about supervision and being observed, but were
16 there formal supervision sessions that you --

17 A. Yes.

18 Q. Who were those with?

19 A. That would have been with LS21, and/or if I was working
20 closely with Roger McAuley and/or Billy Nelson, they
21 would have offered supervision, but from a nursing point
22 of view I would have had my nursing supervision with
23 LS21.

24 Q. With Dr McAuley would that have been about particular
25 cases --

1 Q. So who would have supervised you?

2 A. That's a good question, because I think, going back to
3 this idea of becoming a kind of team of practitioners,
4 I think that the social work supervision was light
5 compared to today and certainly compared to statutory
6 Social Services, where I later went then in 1990 as
7 a team leader, where supervision was every month and
8 looked at files and you -- there was a greater degree
9 of, if you like, just supervision really.

10 Q. Oversight.

11 A. Oversight, yes. Uh-huh.

12 Q. When you say light, how light?

13 A. I think it would be if an issue had come up that
14 I needed some help with or I needed to discuss --

15 Q. You could approach somebody?

16 A. Approach them, yes.

17 Q. As opposed to kind of a monthly meeting --

18 A. Yes, yes.

19 Q. -- to consider your ...?

20 A. Yes. Uh-huh.

21 Q. So issues about work load, work balance, how you were
22 working with families --

23 A. Yes.

24 Q. -- all of that was for you to deal with --

25 A. Uh-huh. Yes.

1 Q. -- unless you brought forward a ...?

2 A. Yes.

3 Q. Your support for your practice came off the
4 multi-disciplinary team then from the ...?

5 A. Yes, yes, that's correct.

6 Q. Did you think that was satisfactory at the time?

7 A. Well, I think at the time I saw myself more as a senior
8 practitioner. So that was -- to me that was consistent
9 with that. Now there may be weaknesses in that, which
10 I would admit, but that's how I saw my own role.

11 Q. Okay. Thanks very much.

12 A. Okay.

13 MR LANE: Just a follow-up on that one. Who are you
14 actually accountable to?

15 A. I would have been accountable initially to the
16 consultant --

17 Q. Uh-huh.

18 A. -- for the work done.

19 Q. As your line manager?

20 A. No, just because he had the -- for example, when
21 I worked in out-patients, so out-patients clinic, you
22 would have the same sort of set-up of
23 a multi-disciplinary team of a consultant, psychologist,
24 social worker -- no nurses obviously -- but all the work
25 we did there, we were accountable to the consultant for

Policy Number ANT/8/86

EASTERN HEALTH AND SOCIAL SERVICES BOARD
AREA NURSING TEAMNURSING POLICY ON BEHAVIOUR MODIFICATION

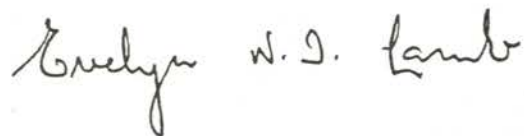
The First Level Nurse in the field of Mental Health (ie, Part 3 and Part 5 of the UKCC Register) is a competent practitioner in planning, programming, implementing and reviewing behaviour modification therapy.

Objective

To ensure that patients who require specialist therapy have this provided in a controlled and monitored environment and that staff have the appropriate resources to acquire further knowledge and skill in specialised areas.

Policy

- 1 Before commencing behaviour modification the Directors of Nursing Services together with the local Nurse Managers Group should establish the parameters within which all programmes should operate.
- 2 The Assistant Director of Nursing Services or Nursing Officer responsible for the Unit should be the principal nursing input into the Multidisciplinary Clinical Team, thus ensuring good communication and liaison.
- 3 In no circumstances should a patient be deprived of his/her basic needs nor should his/her dignity be diminished. Positive and negative reinforcers should in no way impinge on the patient's human rights or dignity.
- 4 The consent of the patient and/or relative must be sought and a full explanation of the care programme and its implications given.
- 5 The care programme must be clearly defined for each individual and the nursing staff in the ward be fully conversant with the programme.
- 6 "Time Out" is an important part of the therapy and is a break from the treatment programme. It does not mean "seclusion" in a secure room.
- 7 It is essential that detailed nursing records of behaviour modification programmes are kept for all patients involved.

December 1986
0181D

Policy Number ANT/9/86

EASTERN HEALTH AND SOCIAL SERVICES BOARD
AREA NURSING TEAMNURSING POLICY ON SECLUSION

Objective:- To differentiate between 'time out' and 'seclusion', to ensure that Nurses are fully aware of the action to be taken when seclusion is used, and to ensure that the patients rights are protected at all times.

Definitions:- For the purposes of this policy 'seclusion' is defined as the social isolation of a patient in a locked room, on his/her own which he/she is unable to leave of their own volition.

'Time out' is defined as a break from the treatment programme.

Policy

- 1 Seclusion must only be used in instances of prolonged uncontrollable aggressive or violent behaviour where the patient is a danger to himself or others.
- 2 There are a small number of patients with established disturbed behaviour patterns where such outbursts can be anticipated. When these indicators are present it is necessary that alternative nursing action is taken before seclusion is considered.
- 3 A full description of the behaviour preceding seclusion must be recorded by the Nurse in charge of the Ward or Department. This record also requires the observations of the Assistant Director of Nursing Services/or Nursing Officer and the format agreed locally.
- 4 A patient may not be secluded unless this has been agreed by the relevant Doctor and this recorded in the patients case notes.
- 5 On each subsequent occasion when seclusion becomes necessary the Assistant Director of Nursing Services/Nursing Officer on duty and the relevant Doctor must be notified without delay and a procedure for this developed locally.
- 6 Nursing records must give full details of the seclusion period/periods and the Nurses' observations.
- 7 Accommodation used for seclusion must ensure adequate observation of the patient at all times.
- 8 The patient must be removed from the seclusion for a minimum of five minutes in each one hour period.
- 9 All incidents requiring seclusion should be regularly reviewed by the Directors of Nursing Services with senior nursing staff and detailed guides developed locally.

December 1986
0181

Evelyn S. J. Lamb

EASTERN HEALTH AND SOCIAL SERVICES BOARD.AREA NURSING TEAM

Policy No. ANT/4/88

POLICY - USE OF RESTRAINT *

Objective: To detail the nurse's role where restraint is deemed necessary.

Attention is drawn to the Eastern Health and Social Services Board letter dated 23rd December, 1982, regarding use of restraining equipment which states: -

"while it is accepted that there are occasions when such forms of restraint are required and they cannot be entirely discontinued, the Board wishes their use to be confined to extreme and exceptional circumstances on the understanding that joint consultation between medical, nursing and, where appropriate, social services staff is undertaken prior to devices being brought into use".

Policy:

1. Restraint is only to be used where all other methods of management have failed.
2. In deciding to use restraint, the nurse must assess and record in the nursing notes:
 - (a) problem behaviour
 - (b) why this behaviour is a problem (i.e. is it a danger to the patient or to others)
 - (c) the proposed solutions (which will include restraint)
 - (d) the reason why restraint is the method of choice.
3. Restraint should be a time-limited intervention with built-in review.
4. Guidelines should be agreed by Unit of Management Groups on a multi-disciplinary basis to reduce the use of restraint - this to include the involvement of relatives.
5. The Royal College of Nursing document "Focus on Restraint" should be used as a basis for local nursing policy.

* 'Restraint' is defined as restricting someone's liberty, preventing him from doing something he wants. Commonly used methods include -

• cotsides
harness
sedative drugs
baffle locks
arranging furniture to impede movement
inappropriate use of night clothes during waking hours
chairs whose construction immobilises patients.

Evelyn W. Shank
Chief Administrative Nursing Officer.

4.1.89

TIME OUT

There are a number of simple guidelines for the use of time-out. The first involves the actual place selected. This should be a place which is reasonably non reinforcing and which is not associated with any potential for reinforcement - for example time-out in a corridor may be ineffective because other passing persons may provide the child with a source of amusement or attention. Bedrooms will only be ideal if they are devoid of enjoyable activities. Also in the selection of a place one wants to give some consideration to potential destructive behaviours, that some children might exhibit. If the child is likely to kick, or throw things around then the place selected for time-out should be one where such behaviours, are not only less likely (because there isn't much to destroy or throw) but also are of least concern to parents (perhaps because they are not as concerned about the paintwork in the area). Next is the duration of time out. In most young children short durations of approximately five minutes are quite appropriate. However in general the duration should not begin until the child is reasonably quiet. Once time-out has been completed then the child should be released. There is no excuse for extending the time or forgetting that the child is in time-out. Finally the implementation and handling of behaviours during time-out needs attention. When a rule has been violated or a behaviour which warrants time-out has been exhibited, then the time-out should be applied efficiently and with a minimum of fuss. A statement of the infringement should be made to the child, and then he should be asked to go to time-out. If he refuses he should be taken. If he refuses to remain in time-out then he should be restrained there physically (and only providing that this is feasible). The overall effort should be aimed at the child sitting (or standing) quietly on his own without restriction and also with the adult applying the time-out remaining at distance from the time out. As mentioned above the time-out does not begin until this state of affairs has been reached. If it is reached and disrupted further then the time commences once again. Time-out only ends when the supervising adult decides that the requirements have been met. Right throughout the period of implementation to end, all other behaviours should be ignored. There should be no arguing or debating with the child. It is particularly important to avoid all manipulative efforts by the child to frustrate the application. Children quite naturally will pull every "play under the sun" in order to disrupt the process. On some occasions they will show automatic obedience and on others they will simply refuse to leave time-out at its end - these all should be ignored. Perhaps the only circumstance which might be handled differently relates to requests to go to the toilet. In this case the child can be taken but is immediately returned to time out after toileting.

EASTERN HEALTH AND SOCIAL SERVICES BOARD

TELEPHONE No.:
BELFAST 44611

65 UNIVERSITY STREET,
BELFAST,
BT7 1HL

Our Ref: EB 569/75/1

14th March, 1983

Dear Sir/Madam,

Procedures For Dealing With Cases of Child Abuse & Neglect

I refer to previous correspondence on non-accidental injury to children and, in particular, to the Board's booklet outlining procedures for dealing with cases of non-accidental injury to children, copies of which were distributed to appropriate Board staff and other Agencies in November, 1977.

As you are aware, these procedures have been in the process of revision for some time and there has been consultation with Board staff, and other Agencies involved with children, to seek their views as to the changes required. Account has also been taken of the Campbell Committee's recommendations, following an enquiry by this Committee into the death of a child in the Board's area.

The procedures have now been revised and extended to include cases of child abuse and/or neglect. The revised booklet supersedes the guidance given in the previous booklet and the procedures outlined in the revised booklet are mandatory.

Those grades of staff who have access to the Central Register are identified in the booklet. The District Executive Team should compile a list of these staff to include their name, position and work telephone number and forward this to the District Social Services Officer, East Belfast and Castlereagh District, for onward transmission to Palmerston Assessment Centre. This list should be kept updated.

Copies of the revised booklet have been included with this letter for distribution to appropriate staff within your discipline.

It is important that all appropriate staff are informed of this booklet, have the opportunity to assimilate the procedures outlined in it and are able to refer to it when occasion demands.

The Area Executive Team should be notified immediately of any instance in which the death of a child has occurred when there has been suspected or known child abuse and/or neglect. This notification should be followed, as soon as possible, by the submission of a detailed report to the Area Executive Team from the District Executive Team outlining the circumstances of the child's death, and any help or services provided by the Board to the child or family.

The revised procedures should be implemented with effect from 1st April, 1983.

Yours faithfully,

P. Kindel

Secretary and Chief Administrative Officer

28-3-83	
N.O	
Action Taken	Booklet to each unit
File	+ N/S-28/3/83

REMOVE FROM COVER TO
READ COMPLETE DATA

MANAGEMENT OF VIOLENT OR POTENTIALLY VIOLENT PATIENTS
WARD 7, FORSTER GREEN HOSPITAL

(Ref: Report of the Advisory Group on the Management of violent or potentially violent patients - September 1980)

AIM

To give guidance to nursing staff in Child Psychiatry Unit on prevention and the management of violence in children in our care.

To ensure that all staff have instruction and training in dealing with violent or potentially violent patients.

(A) PREVENTION :

Many contributory factors to violent outbursts can be lessened considerably by appropriate attention to key elements.

- 1) An awareness of the propensity for violent outbursts in some children.
- 2) The importance of building relationships and providing stability for children and of controlling ones own emotions.
- 3) The development of and the display of objectivity in all reports and interventions.
- 4) The avoidance of repressive regulations and unnecessary restrictions.
- 5) The pursuit of simple and clear forms of communication between children, nursing staff and parents.

(B) MANAGEMENT OF THE VIOLENT INCIDENT :

- 1) Avoid confrontation and try to avoid physical intervention even if there is a display of temper which you think may cause damage; unless you feel that someone is likely to be hurt you should try to divert the child's attention by talking and listening.
- 2) If force is necessary then the minimum needed to achieve control should be used and the aim must be to safely reduce the outburst to a degree where the child can talk and be listened to.
- 3) If it is necessary to remove a child for the purpose of getting rid of an 'audience' or to ensure that he/she remains in his/her room for a short while to settle or as a punishment (if appropriate), then the door must not be locked, the nurse must close vicinity if not in the room and when the episode has passed there should be no change in the prescribed attitude to the child.
- 4) Whilst bearing in mind that confrontation and excessive force must be avoided, extra help should be called when it is judged necessary. This can be achieved in Child Psychiatry Unit by the use of a buzzer in Day and Night Station which can alert other nurses in the vicinity.

(C) RECORDING OF INCIDENTS : (Page 8, section 4.9)

- (a) A detailed summary of the incident must be entered in child's daily nursing notes.
- (b) Names of all nursing and other staff directly involved must be shown.
- (c) An entry should be detailed in nursing notes.
- (d) Medical staff must be informed immediately.

over/2

2.

(D) INSTRUCTION AND TRAINING (Page 7 , section 4.6)

During initial orientation period for all nursing staff to Child Psychiatry Unit, Ward 7, Forster Green Hospital, instruction must be given on prevention and management, paying particular attention to the principles stated in this policy. This is the responsibility of the nurse in charge of the ward.

Thereafter "Teach-Ins" on the practices and principles of dealing with violent outbursts should be arranged. This could entail the use of film/video/lecture/discussion or role play and should be undertaken by A.D.N.S. or Charge Nurse.

Full reading of the "Report of the Advisory Group on Management of Violent or potentially Violent Patients" is recommended, particularly by senior nursing staff, and appropriate publications which are in the Hospital Library should also be read, as a preparation to giving and receiving instructions on the prevention and management of violence in Child Psychiatry Unit, Ward 7, Forster Green Hospital.

LS 8

EB/RG

9th August 1989

*See attached
memo.*

LS 8

EASTERN HEALTH AND SOCIAL SERVICES BOARD

GREEN PARK UNIT

WARD 7 - FORSTER GREEN HOSPITAL

Procedure to be followed in the case of abscondments involving children in the Child Psychiatry Unit :

1. When a child is thought to be missing, the Nurse in Charge should be informed and an immediate search of the building and surrounding areas initiated. It is the duty of the Nurse in Charge to advise the Assistant Director of Nursing Services. He/she in turn will report to the Director of Nursing Services if necessary.
 2. If, after a thorough search, the child is not found, the following people should be notified :
 - [i] The doctor responsible for the child's treatment.
 - [ii] The Unit Social Worker involved. Contact Unit Social Worker (Ward 7) if on duty at the time OR contact Contactors Bureau for Social Worker if the child is on a Statutory Order OR even if the child is known to Social Services.
 - [iii] The Police - a description of the child should be given.
 - [iv] The parents or guardian. If unable to contact parents by telephone, the assistance of the Police should be enlisted.
 - [v] The Administrator for hospital services.

Parents should be asked if they know where the child might go and advised to contact the hospital should he/she arrive home.

If the child is found to be in the vicinity of the hospital, nursing staff must maintain surveillance in order to ensure the safety of the child and must take advantage of any reasonable opportunity to apprehend him/her. The Doctor, Social Worker and Assistant Director of Nursing Services should be kept up to date with developments.
 3. When the child has been found, the parents, Police, Doctor, Social Worker and Assistant Director of Nursing Services should be informed.
 4. Details of the incident must be entered in the nursing notes.
 5. An Abscondment Form must be sent to the Assistant Director of Nursing Services.
 6. When A.D.N.S. acting officer is on duty he should be kept up to date regarding the child's absence.
WHEN A.D.N.S. IS OFF DUTY - only if the child's absence is prolonged and no news of whereabouts is known, thus causing increased concern about safety and wellbeing - then nursing staff should try to contact A.D.N.S. at home telephone number and if unavailable D.N.S. should be contacted via hospital switchboard.
 e.g. If the child has not been returned or accounted for by 11.00 p.m. all the personnel listed in "1" and "2" should be informed.
- The titles in this Procedure will be altered when the new management structure is in place, the content will not be altered.

Policy to be followed if any child (in patient or day patient) goes on the roof of Ward 7, Forster Green Hospital.

Aim - to ensure that all disciplines are aware of the course of action to be taken to ensure full co-operation of all staff.

A. The following persons must be informed immediately by Nurse in Charge:-

- (1) Consultant Psychiatrist of the child/children.
- (2) Parent/guardian of the child/children.
- (3) Assistant Director of Nursing Services, WARD 7, who should inform Director of Nursing Services.
- (4) The Unit Social Worker (Child Psychiatry, F.G.H. if present, and in cases where child is the subject of a Court Order the Senior Social Worker in the Social Services Department which has taken out the Order. Outside of office hours the Social Worker on standby for that department should be contacted through Contactors Bureau.
- (5) The Administrator for Hospital Services should be contacted via switchboard in main hospital - (Dial 0)
- (6) An entry should be made in the Nursing Notes giving the times that above persons have been contacted.

B. Action to be taken when child/children come down from the roof.

- (1) Child is isolated in his/her room immediately for a 24 hour period, during which all comics, books, radios and drawing materials should be removed. Posters may be removed from the walls for this period and all personal clothing except night clothes, dressing gown and slippers. No interaction to be allowed with other children. School work may be asked for from teaching staff. Members of nursing staff will be allocated to stay with child/children during this 24 hour period.

Medication will be prescribed and administered intramuscularly if the child refuses to accept it orally.

- (2) On completion of this 24 hour period all clothes, posters, personal belongings shall be returned to the room.
- (3) The child/children will for the next 24 hour period be supervised on the ward. For this period they may not be given or share in any of the pleasurable activities available to other children. They should be closely accompanied to and from classroom by nursing staff in this period.
- (4) If at the end of this 24 hour period there is sufficient demonstration of compliant behaviour the privileges available to all the other children may be gradually restored to the child/children at the discretion of the nurse in charge in consultation with other disciplines.
- (5) If the above measures are not effective this policy should be reviewed and as a last option if this course of action fails discharge of the child will be undertaken.
- (6) During the first 24 hour period (isolation period) recreational activities to all other children may be restricted as a consequence of any child having climbed on to the roof.

W. McC. Nelson *R. McAuley*
 Dr. W. McC. Nelson Dr. R. McAuley

LS 8

LS 8

EASTERN HEALTH AND SOCIAL SERVICES BOARD

MEMORANDUM

From: Mr K Gallagher
 Acting Director of Nursing Services
 Ref. Belvoir Park/Forster Green Hospitals

To: ALL NURSING STAFF
 BELVOIR PARK/FORSTER GREEN HOSPITALS
 Ref.

17 September 1990

Re : ACTION TO BE TAKEN IN RELATION TO INCIDENTS OCCURRING

Over recent months a few incidents occurred which were not reported until some considerable time had elapsed. Therefore, I intend to clarify in these Guidelines the steps to be taken regarding events occurring.

- 1 It is very important that an effective reporting system be maintained at Unit level to ensure that all i.e. clinical, non-clinical incidents, are notified to your immediate superior, and if unavailable, the next person in the chain of command.
- 2 I realise staff are uncertain at times about what to report, but should anything occur at ward level/department that is in anyway unusual, please report it to the nurse-in-charge.

Events/incidents should be reported which might :

- a) be of interest to the public or political life
- b) result in legal action against the Unit/Board
- c) give rise to criticism about professional standards of care
- d) be presented in the Press/media.
- 3 The nurse-in-charge or the person with knowledge of any event should make sure that Senior Nurse Management be informed as soon as possible so that they in turn can take appropriate action and discuss the matter with the Site Director.
- 4 He/she will then decide whether or not the Unit General Manager and/or Eastern Health & Social Services Board should be notified.

It is imperative that Nursing staff observe these Guidelines and your co-operation will be greatly appreciated.

K. Gallagher

K Gallagher (Mr)
 Acting Director of Nursing Services

24/9/90

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Please see Over 8

1 on to another point and then it will probably come back
2 to me.

3 One of the things we were talking about when we were
4 speaking earlier was that although there was legislation
5 -- the legislation that governed the operation of Lissue
6 was different to that governing children's homes, there
7 was nonetheless a similar power to inspect in the sense
8 that, as you have actually described to me, it was
9 a much wider power under the health legislation to
10 inspect not just hospital facilities, but pharmacies and
11 GPs' surgeries. So there was a very wide power there
12 for the Ministry --

13 A. Yes.

14 Q. -- and then the Department to go in and inspect if they
15 had concerns.

16 Now you refer to it in paragraph 7 of your statement
17 and say there was no evidence that that power was, in
18 fact, used until 2005. To your knowledge was any
19 consideration given to an inspection of Lissue when
20 these matters were coming to light in the
21 mid-1980s/early '90s?

22 A. To my knowledge I don't know. It's possible that some
23 consideration was given about the need for action, but
24 that I imagine had the three incidents been put
25 together, that that would have been -- there would have

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

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

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

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

Order.

- 6.3 In addition, the HSC Board statement has pointed out that medical and nursing staff were registered and regulated by their respective professional bodies⁶.

7. Who inspected Lissue on behalf of the regulator and when? Please provide copies of any inspection reports

- 7.1 The power to inspect hospitals was afforded to the MHLG and subsequently the DHSS under section 63 of the 1948 Act, section 70 of the 1971 Act and Article 50 of the 1972 Order.
- 7.2 The Department presently has no information to indicate whether this power was ever exercised by the MHLG or the DHSS other than by means of a Social Services Inspectorate (SSI) led inspection of services for disabled children in hospital, the report of which, 'Care at its Best' was published in 2005 (Annex C). This inspection considered the care of disabled children in a range of hospital settings, including the Foster Green Child Psychiatry Unit and the Adolescent Psychiatric Unit, then based at College Green, Belfast and made a number of recommendations regarding the inpatient care of such children.
- 7.3 The HSC Board statement makes reference to the role of the Mental Health Commission (the Commission), established by the 1986 Order. Whilst an inspection role *per se* was not conferred on the Commission by the 1986 Order, many of the duties and powers afforded to it were similar to that of an inspection body. These were subsumed under a general duty on the Commission under Article 86 "*to keep under review the care and treatment of patients..*" Specific duties identified in Article 86(2) included *inter alia* the duty to inquire into any case where it appeared to the Commission that there may be ill-treatment, deficiency in care or treatment and to bring to the attention of various authorities, including the DHSS and the relevant Health and Social Services Board the facts of the case in order to secure the welfare of any patient. Article 86 (3) of the 1986 Order empowered the Commission *inter alia* to: refer to the Review Tribunal⁷ any patient who was liable to be detained in hospital; visit, interview and medically examine in private any patient; and inspect any records relating to the detention or treatment of any patient.

⁶ LIS 086

⁷The Mental Health Review Tribunal is an independent judicial body set up under the 1986 Order to review the cases of patients who are compulsorily detained or are subject to guardianship under the Order.



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Everyone wants what's best for children in Hospital

CARE AT ITS BEST**OVERVIEW REPORT OF THE
MULTIDISCIPLINARY REGIONAL INSPECTION
OF THE SERVICE FOR DISABLED CHILDREN
IN HOSPITAL**

October 2005

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This document can be made available in Irish, Chinese, Audio Cassette, Braille and large type. The Department will also consider requests for translations into other ethnic minority languages.



Contents

Part	Page
1 INTRODUCTION	1
2 THE INSPECTION	3
Background	3
Aim and scope of the inspection	4
The children and young people	5
The hospitals	6
3 THEMES TO INFORM STRATEGIC PLANNING FOR DISABLED CHILDREN	11
Children and young people in specialist hospitals	11
Children in mental health hospitals	11
Children in hospitals for people with learning disabilities	12
Children and young people admitted to adult wards	13
The interface with community provision	15
Technology dependent children and those with complex needs	15
Respite care of disabled children	16
4 COMMISSIONING ARRANGEMENTS, THE STRUCTURE, ORGANISATION AND MANAGEMENT OF HOSPITAL SERVICES	19
Development of services for disabled children	19
Commissioning arrangements	20
Needs assessment	21
Children's Services Planning	21
Involvement of children, families and staff in service planning and development	22
The organisation of hospital services - management issues	22
Child protection	23
The organisation of hospital services - professional services	25
Social Work services	25
Medical services	27
Nursing services	28
Allied Health Professional services	29
Psychology services	30

Part	Page
Pharmacy services	31
Clinical and social care governance	31
Risk management	32
Audit arrangements	33
Standards	33
5 ASSESSMENT AND CARE PLANNING	35
Policies to inform the admission, care and discharge of children	35
Assessment	36
Pre-admission assessment information and fast tracking	36
Multidisciplinary assessment	37
Risk assessment	38
Care planning	39
Discharge planning	40
Notification arrangements	42
Looked after children	43
Transfer arrangements	44
Child protection issues	45
Hospital records, recording practices and storage arrangements	46
6 THE RANGE AND QUALITY OF SERVICE PROVISION	49
Responsiveness to children and families	49
Care of children and young people in adult wards	51
Home visits	51
Restriction of liberty	52
Group support for children, parents and siblings	53
Bereaved families	54
The physical environment	55
7 EDUCATION PROVISION	57
8 WORKFORCE PLANNING, TRAINING AND SUPPORT	61
Workforce planning	61
Social Work services	62
Medical services	62
Nursing services	63
AHP services	64
Psychology services	65

Part	Page
Pharmacy services	65
Staff Induction, supervision and appraisal	65
Staff development and training	66
9 COMMUNICATION AND INFORMATION	69
Information	69
Complaints, access to patient information and consent to treatment	70
Communication with children and families	71
10 EQUALITY AND HUMAN RIGHTS	73
The rights of children	73
Charters for children and young people	73
Advocacy services	74
Play and leisure	74
Issues impacting on the rights of children	75
Equality Initiatives by Boards and Trusts	78
11 CONCLUSION AND SUMMARY OF THE RECOMMENDATIONS	81
Conclusion	81
Summary of the recommendations	81
APPENDICES	97
Appendix A	97
The terms of reference for the inspection and methodology	
Appendix B	100
Members of the multidisciplinary team and the steering group	
Appendix C	102
Draft standards and criteria	
Appendix D	116
Tables	



CARE AT ITS BEST

Regional Multidisciplinary Inspection of the Service for Disabled Children in Hospital

1. Introduction

1.1 Everyone wants what's best for children in hospital. For most children and young people, hospital stays can be a daunting experience, but they are usually short and relatively rare events in a child's life. For a significant number of disabled children, however, hospital admissions can be frequent and prolonged. Their needs bring many additional challenges to the children, their families and the hospital team, as well as to those responsible for their continuing care in the community. It is crucial that all involved in the care of such children should work together in the best possible ways to secure the best possible outcomes for them. 'Care at its Best' provides a framework to enable this to happen.

1.2 The members of the Inspection Team wish to record their thanks to staff in Health and Social Services Boards and Trusts for their willing assistance throughout the inspection and in particular to the inspection coordinators for their help in easing what was at times a complex and resource intensive process. The Team is also most grateful to the members of the reference group who worked hard to develop the standards and provide useful information, tips and suggestions, clearly born out of invaluable personal and professional experience. Very special thanks is due, however, to the children, young people, parents and carers who not only gave their time but shared their deepest personal experiences in the most open and uncritical manner, with a view to making the service better for children in the future.

1.3 We hope this report will do justice to the input of everyone who assisted the inspection. We believe that the findings and recommendations have much wider application than to the particular children under consideration. It is - after all - widely accepted that what's good for disabled children is more than likely to be good for all children.



2. The Inspection

Background

2.1 The Children (NI) Order (1995) (The Children Order) sets out the powers and responsibilities of Health and Social Services Boards and Trusts (Boards and Trusts) to provide services to children in need and their families. A central principle of the Order is that whilst disabled children are children in need, they are children first and they should have access to the full range of general children's services as well as specialist provision. Amongst the additional life challenges that disabled children may face, is the fact they are likely to be more dependent on health and social care services than other children. Inevitably they will also spend more time in and out of hospital. The Children Order recognises the vulnerabilities of children in hospital, particularly those who experience a long term hospital admission of 3 months or more. It contains special provisions aimed at safeguarding their welfare - these are set out in full in Part 5.26 of this report.

2.2 This report presents the main findings of a multidisciplinary regional inspection, led by the Social Services Inspectorate (SSI), of the service for disabled children in hospital. The inspection came about as a result of concerns expressed to SSI and brought to the attention of the Children Matter Task Force¹ about the number of disabled children who spend long periods in hospital due to the absence of appropriate community based provision. It was therefore included in the SSI 2002 – 2005 inspection programme and approved by the then Minister for Health, Social Services and Public Safety.

2.3 In terms of the wider implications of the inspection, the Department of Health, Social Services and Public Safety (the Department) is currently developing a Health and Social Services Strategic Framework for Children, Young People and Families to keep pace with local, regional, national and international changes in service provision and policy for children. The Framework will set high level outcomes, indicators, targets and action plans covering all activities across health and social services. With regard to providing services for disabled children, the Framework will be significantly informed by the findings of this inspection.

1 An inter-agency group established by the Department to take forward the recommendations of the 'Children Matter' (DHSS, 1998) report into residential care provision for children in Northern Ireland.

Aim and scope of the inspection

2.4 The aim of the inspection was to assess the extent to which the service for disabled children in hospital met the requirements of the Children Order and reflected standards of best practice in the key areas of:

- commissioning arrangements, structure, organisation and management of children's hospital services;
- assessment and care planning for disabled children;
- the range and quality of service provision;
- educational provision for children in hospital;
- workforce planning, staff training and support;
- communication and information; and
- equality and human rights.

2.5 In determining how to achieve as full a picture as possible of disabled children and their needs, the Inspection Team decided to concentrate on a sample of children and young people who had a long term hospital admission of 3 months or more and who therefore fell within the statutory provisions of the Children Order. It was felt that their care was likely to demonstrate in a comprehensive way, the range of issues affecting all disabled children in hospital.

2.6 The Team considered medical, nursing, social work, psychology, allied health professional (AHP) and education services as well as multidisciplinary and partnership working in the service provided to children and their families. Although the inspection did not specifically review pharmacy services, the findings identified a number of issues within the pharmaceutical domain which are reflected in the recommendations. These have been discussed with the Department's Chief Pharmaceutical Officer for Northern Ireland.

2.7 The inspection fieldwork was conducted in 2003 across 8 hospital sites and final reports were issued to each hospital in 2004. Appendix A contains the terms of reference for the inspection and the methodology for the process. The members of the multidisciplinary team and the reference group are detailed in Appendix B. To assess the quality of the service provided, the Inspection Team developed a framework of draft standards and criteria for each of the areas to be considered. These are set out in full in Appendix C. This report considers key issues that emerged under each of the standards and contains recommendations about how the service should be improved.

The children and young people

2.8 Each Hospital and Health and Social Services Trust in Northern Ireland was asked to submit to the Department, anonymized information on all children who had been admitted to hospital (or were already inpatients) for a period of not less than 3 months between 1 April 2000 and 31 March 2002. The inspection included some additional children who met the 3 months criterion and who were patients in the selected hospitals during the fieldwork process, which commenced in January 2003.

2.9 The Tables in Appendix D provide a detailed breakdown of the children's information. Reference is made to the information contained in relevant Tables throughout the report. The following is, however, a 'headline' overview of the key characteristics of this population of children:

- At least ¹173 children and young people had been in hospital for 3 months or more during the period under consideration (Table 1);
- Slightly more boys (92) than girls (81) had long term hospital stays (Table 2);
- Of the 173 children, there were more babies under 12 months (28%) and children aged 11-15 years (35%) than children of any other age group (Table 2);
- Of those children whose religion was recorded, there were significantly more Catholic (75) than Protestant (50) children. In 18% of cases, religion was recorded as 'unknown' (Table 3);
- The vast majority of the children (84%) were of white ethnic origin – the ethnicity of 14% of children was unknown/unrecorded (Table 4);
- The largest numbers of children came from Homefirst Trust (32 children), North and West Belfast Trust (28 children) and South and East Belfast Trust (26 children) (Table 5). The numbers of children from North and West and South and East Belfast Trusts were larger than expected, particularly for those admitted to the Young People's Centre and Muckamore Abbey Hospital. (Census figures show that Foyle and Down Lisburn Trusts have larger child populations than either South and East or North and West Belfast Trusts and that Homefirst Trust has approximately twice as many children and young people than either of the latter);

1 This allows for some margin of error in the data i.e. returns not made by some Trusts on children who fell within the criteria.

- The most recent hospital admission for children who were discharged during the period under consideration lasted between 3 and 5 months for 81 (59%) children and between 6 and 11 months for 28 (20%) children. The remaining 24 (18%) children who were discharged and whose length of stay was known had been in hospital for 1 year or longer (Table 6);
- At least¹ 43 (25%) children in the sample had been in hospital on at least one previous occasion and a further 29 (17%) had been in hospital continuously or almost continuously since birth (Table 7);
- Of those children who had been in hospital since birth, all but 2 were discharged or died before they were 6 months old. One child was discharged at 13 months and another child died just after her second birthday (Table 8);
- Four hospitals that provided Northern Ireland wide regional services in learning disability; mental health (children and adolescents); and neonatal, medical and surgical services including most regional specialities accounted for 71% of long term admissions (Table 9);
- Many children had multiple disabilities. The main disabilities reported were developmental delay (41%); learning disability (39%); challenging behaviour (39%); behavioural disorder (35%); emotional disturbance (31%); severe or chronic illness (28%) and physical disability (27%) (Table 10); and
- The most important reasons cited for children's admissions were challenging behaviour (22%), in hospital since birth (16%) and risk to self (14%) (Table 11).

2.10 The Inspection Team undertook an in depth analysis of the case records of 39 children and young people admitted to the hospitals whose children's services had been selected for inspection. Interviews were carried out with key staff responsible for the children's care as well as with children themselves (where possible) and with parents, carers and families.

The hospitals

2.11 The Inspection Team selected 8 hospitals (Figure 1) that together represented the main features necessary for an effective and province-wide overview of the hospital service for children. The hospitals chosen

1 There was most likely some under-recording of this since some children's previous admissions were picked up from the other hospitals' returns.

included those that were part of a dedicated hospital services Trust and those that formed part of a Trust responsible for both hospital and community services. They each fell within the remit of one of Northern Ireland's 4 Health and Social Services Boards. The choice took into account the profile of regional (i.e. Northern Ireland wide), specialist and acute services as well as types of disability, the age range of children and the location of children's inpatient care in dedicated children's or adult facilities. The hospitals in the sample accounted for some 145 children i.e. 84% of 173 children who experienced a long-term hospital admission during the period under consideration (Table 12).

2.12 As with most inspections of services, the recommendations of the report tend to focus on what needs to change to improve the quality of service provision. There were, however, several examples of good practice and some examples of excellent practice in the hospitals inspected. Of the many that might have been included, the Team have chosen one particular example of good practice in each of the hospitals inspected. These are by no means the most important clinical or care matters commended in each hospital, but they offer an opportunity for shared learning in innovation that might easily be transferred to other settings. The hospitals are described briefly in Figure 1, which includes paragraph references to the examples of good practice cited in the report.

2.13 Each of the hospitals had a significant interface with community Trusts through the provision of social work, AHP services, Child and Adolescent Mental Health Services (CAMHS) or other specialist services. In some cases, there were joint hospital and community based appointments of medical staff. There were also liaison relationships with community Trusts in the admission and discharge of children from hospital. These are referenced at appropriate stages throughout the report.

2.14 Final inspection reports were issued to Trusts responsible for each of the above hospitals, their respective Boards and relevant community Trusts in 2004. These are public documents, copies of which may be obtained by contacting SSL. A separate executive summary of this report is also available.

Figure 1: Profile of the hospitals inspected and good practice examples

Hospital	Description	Good practice example	Paragraph reference
Altnagelvin Hospital (Londonderry)	An acute hospital with one children's and one neonatal ward serving the Londonderry, Limavady and Strabane District Council areas of the Western Board.	The support of technology dependent children from hospital to the community.	3.19
St Luke's Hospital (Armagh)	A mental health hospital for adults incorporating Cloughmore Ward which provides two mental health inpatient beds for adolescent patients from across the Southern Board's area.	Links with the community based Child and Adolescent Mental Health Team.	5.8
The Longstone Hospital (Armagh)	A Southern Board area hospital within the adult learning disability programme of care, which occasionally admits young people under the age of 18 years.	Links with the community based Social Services Trust's Children with Disabilities and the Child Care teams.	5.34
Muckamore Abbey Hospital (Antrim)	A regional care and treatment hospital for adults with learning disability and for children with severe, moderate and profound learning disabilities who need specialist care.	Behaviour Nurse Therapy Team.	4.37
Antrim Area Hospital	An acute hospital with one children's and one neonatal unit to serve the communities of Antrim and surrounding districts within the Northern Board's area.	Multidisciplinary arrangements and the use of multidisciplinary recording.	5.44
The Royal Belfast Hospital for Sick Children	An acute hospital which also provides most regional specialities. The hospital is part of the Royal Belfast Hospitals Trust in the Eastern Board's area,	Play specialists in the children's wards.	10.10
The Young People's Centre (Belfast)	A centre that during the period of the inspection provided regional mental health inpatient services on 2 separate sites to young people aged between 13 and 18 years.	Engagement with and involvement of young people in their care planning.	5.18

Hospital	Description	Good practice example	Paragraph reference
Forster Green Hospital (Belfast)	Part of the Green Park Hospitals Trust in the Eastern Board's area. Two services were inspected on the Forster Green site.		
Neuro-rehabilitation services	A regional unit for people with acquired brain injury which admits some young people from the age of 14 years.	Multidisciplinary assessment and care planning.	5.13
The Child and Family Centre	A regional centre which is the only mental health inpatient facility for children under the age of 14 years in Northern Ireland.	Baseline audit against child specific service standards.	4.55



3. Themes to inform Strategic Planning for Disabled Children

3.1 A number of overarching themes emerged during the course of the inspection. These mainly concerned hospital-community interfaces that need to be addressed at a regional level within children's services planning frameworks. Of relevance to the themes outlined below will be the findings of the Review of Mental Health and Learning Disability, Northern Ireland, established by the Department in 2002 and led by Professor David Bamford. The Review, which will inform Departmental planning, is due to produce its final reports on children's mental health and learning disability services by early 2006. These may well draw similar matters to attention. They are well worth repeating.

Children and young people in specialist¹ hospitals

3.2 The Regional Strategy for Health and Wellbeing 1997–2002 contained the objective that by 2002, children should not be admitted to specialist hospitals, other than in exceptional circumstances (DHSS, 1997).

Children in mental health hospitals

3.3 During the 28 month period under consideration by the Inspection Team, 51 children and young people had spent periods of 3 consecutive months or longer in mental health hospitals (Table 13). Of these, 5 children had been admitted to adult psychiatric units, 28 children had been admitted to the Child and Family Centre at Forster Green Hospital and 18 young people to the Young People's Centre, then based in the centre of Belfast. The latter 2 facilities are the only inpatient mental health units in Northern Ireland dedicated exclusively to the care of children and young people. The Inspection Team supported the need for inpatient mental health provision for children and young people and strongly endorsed the continuing need for regional or area wide children's inpatient services. It was disappointing to note, however, that whilst both of these facilities, which should have been leading centres of excellence in short term assessment, treatment and care, were operating without the full multidisciplinary staffing necessary to achieve the best outcomes for children and young people in the shortest possible time. Both had significant waiting lists and a number of children had been admitted

1 Hospitals providing either dedicated mental health services or services to patients who have learning disabilities.

to, or remained in, each facility longer than was clinically necessary due to lack of community support or alternative specialist services, such as day units, appropriate to their needs (see 3.15-16). Neither service was operating in buildings that were suited to their purpose. The Department has, however, recently approved a business case for the replacement of the current regional inpatient mental health facility for young people with an 18 bedded purpose built adolescent unit on the Forster Green site. This will address some, but not the full developmental needs, of the child and adolescent mental health service.

3.4 Boards should give priority to establishing Tier 4¹ child and adolescent mental health services. The services should provide for full and intensive multidisciplinary assessment, treatment and care of children in facilities that are specifically designed for specialist interventions.

3.5 Mental health inpatient provision for children and young people is currently under consideration by an interagency group established by the Department to advise on the regional development of child and adolescent mental health services. It is important that the findings of this inspection should inform the work of the regional group.

3.6 The Departmental Regional CAMHS Development Group should take account of the findings of this inspection to inform strategic planning of services and the development of new provision for children and young people with mental health needs.

Children in hospitals for people with learning disabilities

3.7 During the 28 month period under consideration by the Inspection Team, 44 children and young people had been admitted for periods of 3 consecutive months or longer to hospitals for the learning disabled (Table 13). One children's ward in the regional facility (Muckamore Abbey Hospital) accounted for 17 children in the sample. Of the remaining 27 children and young people, 20 were accommodated in the adult wards of Muckamore and 7 in other learning disability hospitals. Conditions in the hospitals inspected, where some children had been accommodated for a number of years, were generally outdated and institutional both in the characteristics of the physical surroundings and in some of the care routines. These were found to be wholly unacceptable environments for the care of children or young people. The Department has endorsed a business plan to replace all

1 Definition of Tier 4 services:
"essential tertiary services for children and young people with the most serious problems, such as day units, highly specialised outpatient teams and in-patient units."

existing provision presently offered on the site of Muckamore Abbey Hospital. As part of this new development, current provision for younger learning disabled children will be replaced with a small community based short-term clinical assessment and treatment facility. This is commended. Of concern to the Inspection Team, however, was the lack of a similar plan to address the future inpatient clinical assessment and treatment needs of learning disabled young people who are, in the main, accommodated in the adult wards of the regional centre.

3.8 In the context of the planned reprovision of regional inpatient services for adults and children with learning disabilities, commissioning Boards should formally recognise the needs of young people as being distinct from those of children or adults and should address these as a matter of urgency.

Children and young people admitted to adult wards

3.9 In addition to the issues surrounding the continuing care of children within specialist hospitals, of further concern was the fact that during the period under consideration by the inspection, 31 children and young people had been accommodated in the adult wards of a range of hospitals (Table 14). The majority of these children (23) had learning disabilities. Of these, 18 young people were aged 16 – 17 years and 12 children were aged 11 – 15 years. The Inspection Team was also made aware that younger disabled children were, from time to time, admitted to wards accommodating a range of age groups which included adult patients. One child in the sample who was under 5 years old had spent a period of more than 3 months in a ward of this type. There were, however, special circumstances attached to this situation (Table 15).

3.10 Although it does not formally extend to Northern Ireland, the 'Standard for Hospital Services' (DOH, 2003), publication which is part of the Department of Health's National Service Framework for England states:

'Children should not be cared for on adult wards Actual age is less important than the needs and preferences of the individual child or young person. In particular the needs of adolescents require careful consideration. In general adolescents prefer to be located alongside people of their own age who are more likely to meet their need for social interaction...'

3.11 The Department's policy document 'Child and Adolescent Mental Health services' (DHSS, 1998) stated that adult based provision for adolescents should cease as soon as possible.

3.12 Apart from the unsuitability of the social setting, some young people were being cared for alongside older patients who displayed sexually inappropriate or – on occasions - violent behaviour. There were clear child protection issues to be considered and increased pressures on staff in terms of the management of such high risk situations. Part 6.9-10 of this report contains a recommendation aimed at minimising risk if, in exceptional circumstances, children or young people are admitted to adult wards. In terms of the overall profile of such admissions, however, it is imperative that commissioners and service providers are fully aware of the use of each adult placement and address the need in a collaborative way.

3.13 *Boards and Trusts should monitor the numbers of children and young people admitted to adult wards and the length of their stay with a view to determining whether there are sufficient children's specialist inpatient places and community based provision to meet their needs. Where there are deficits these should be addressed in a cross Board coordinated manner.*

3.14 The inspection focused on children and young people who had spent prolonged periods of time in hospital and drew particular attention to those in adult wards. It was evident in discussion with parents and professionals, however, that there was general concern about the ambiguity surrounding the age at which young people were referred to adult hospital and community services and a lack of consistency in approaches to this. In some cases children aged 14 years were referred to adult medical services and in other situations, 16 years was the upper age limit for paediatric services. The multidisciplinary clinical expertise required by young people may not be available to a very young teenager within adult medical services or to an older young person within paediatric services. Issues of age can also have an impact on the transitional arrangements for children who require services into adulthood. This is considered further in Part 5.35-37.

3.15 *Boards should develop a regionally agreed protocol for referrals of young people aged 14 years and over to hospital and other clinical and community services. This should promote consistent approaches that take account of the young person's age and stage of development and enable appropriate expertise to be available to meet each young person's needs.*

The interface with community provision

3.16 The pre-inspection data did not cover disabled children and young people who were admitted to hospital for periods of less than 3 months. The true usage, therefore, of specialist hospitals and adult wards for children and young people is greater than the figures presented in this report. This issue cannot be considered in isolation from the current profile of community services provision. Many of the children had spent prolonged time in specialist hospitals because of the lack of appropriate community facilities for them. A number of young people had been admitted to adult wards because there were no inpatient places in the specialist centres or because there were no residential or other community facilities suited to their needs. Of further concern was the fact that the planned inpatient developments (3.3; 3.7) are unlikely to fully meet the requirements of learning disabled children and young people and those with mental health needs. There was an absence of coordinated regional plans which ensured the development of adequate community provision to support the reconfiguration of inpatient services.

3.17 *The 'Children Matter' Task Force¹ should in its Phase 2 implementation consider the impact of impending reductions in children's specialist hospital places on current and planned community residential and other community provision with a view to informing strategic planning for future services to disabled children.*

Technology dependent children and those with complex needs

3.18 Many children have complex needs. Some are dependent on technological equipment whilst in hospital. It was evident during the inspection that some children required initial admission to specialist regional centres and there could be significant delay in transfer to local hospitals. The care of the children and their ultimate discharge home depended on the availability of trained care staff and Trusts' financial capacity to support intensive packages of community care. Neither was always readily available. The Inspection Team commended the efforts of hospitals meeting such needs, their commitment to working towards the development of new skills in staff and community carers and their expertise in helping children and their families towards discharge.

1 An interagency group, led by the Department and established to implement the recommendations of the Children Matter report (DHSS, 1998).

3.19 Good practice example:

Altnagelvin Hospital provided an example of an excellent training programme for nurses, parents and carers which resulted in the successful discharge home of a number of children who required long-term ventilation. The Inspection Team commended the hospital for its commitment to developing staff skills in this area, the standard of the training programme for staff, parents and carers, the multidisciplinary formal discharge planning associated with the programme and the effective support arrangements the hospital had established for parents and families.

3.20 More children are surviving premature birth and neo-natal complications and those with acquired serious injuries or degenerative conditions are living longer. No child should remain in hospital longer than is clinically necessary. The number of technology dependent children is likely to rise in the future and, in comparison with other community care needs, their support at home will be resource intensive. This is a relatively new and emerging matter which needs to be addressed within a policy context that takes account of the projected future demand as well as the training needs and resources required to provide effective services to children and their families.

3.21 *The Department should agree a regional policy to address the emerging needs of technology dependent children for community care services, including the skills base required in staff, parents and carers, to ensure minimum delay in progressing care plans for these children.*

Respite care of disabled children

3.22 A few of the hospitals in the sample retained hospital beds for respite purposes. Whilst the reasons for this were generally to do with the familiarity of the hospital setting for some children who required frequent admissions, no child should be admitted to hospital for reasons other than clinical needs. An unanticipated outcome of the inspection, however, was the identification of two residential respite care units for disabled children that were associated with the hospitals in the sample, but that were operating outside the regulatory framework of the Children Order and Departmental guidance. Although they were designated as respite care units, children who needed emergency care placements had been accommodated in these

facilities. During the period under consideration by the inspection, 11 children had remained in these units for periods of at least 3 months. Some children had remained a number of years. Other children had been admitted more frequently and for longer periods than would have been normally warranted within a respite arrangement. This is an unacceptable situation.

3.23 These issues raised questions and concerns about the profile of respite care provision for disabled children and young people throughout Northern Ireland. 'Children Matter', published by the Department in 1998, proposed the need for a regional review of such provision.

3.24 *A regional review of respite provision for disabled children should be progressed by the Department without delay as part of the implementation of the Children Matter Phase 2 initiative.*



4. The commissioning arrangements, structure, organisation and management of the hospital service

Standard

The commissioning arrangements, structure, organisation and management of hospital services promote optimum quality in the planning and provision of services for disabled children.

Development of services for disabled children

4.1 The principle that disabled children are children first should govern organisational, management and planning structures as well as the services that children receive. Historically in Northern Ireland, however, services for disabled children have developed around the disability rather than the child. The Department is responsible for making legislation and establishing policies to direct and guide the provision of health and social services. Within the Department, however, policy issues for disabled children can fall within the Primary, Secondary and Community Care Directorates as well as within the Child Care Policy Directorate. Whilst the Strategic Framework for Children (2.3) will address disabled children's issues, there is currently no integrated Departmental policy on disabled children.

4.2 The Inspection Team found similar fragmentation in Boards and community Trusts. In addition to acute and specialist hospital services programmes, the commissioning, planning and delivery of services for disabled children and their families tended, with only a few exceptions, to span as many as 7 health and social care programmes.

4.3 There was a general view amongst senior managers in Boards and Trusts who were interviewed, that the lack of a unified Departmental approach to disabled children was a significant factor in sustaining artificial boundaries between services at area Board and local levels. There is a need for a strong policy focus both within the Department and regionally that will:

- recognise and value disabled children as children first and children in need within the context of the Children Order;

- tackle the range of needs common to children and their families without defining these by categories of illness or disability;
- ensure accountability for the full range of statutory obligations on Boards and Trusts in respect of disabled children;
- address the strong interface between social care services, community health (including AHP services) and hospital services;
- set out, when children have specialist community care support needs, how these will be met within children's services; and
- reliably inform and establish priorities and objectives for other overarching Departmental and inter-Departmental policies and strategies.

4.4 A Children's Services Committee has recently been established within the Department to ensure coordination across all Departmental Directorates and professional groups in relation to children's services. The above needs should inform the work of this Committee.

4.5 *The Department's Children's Services Committee should address the need for an integrated policy on services for disabled children and establish arrangements across relevant Departmental interests to enable a coordinated approach to the matters outlined in 4.3.*

Commissioning arrangements

4.6 There were similar issues in the commissioning arrangements of Boards. None of the Boards' senior managers held overall responsibility for disabled children's services or was the 'champion' of their cause. One Board had, however, established a 'Children with Disabilities Commissioning Sub Group' and this was commended. Others were intending to review their arrangements to promote a more co-ordinated approach between the various disciplines involved in providing services to disabled children. Commissioning arrangements and management structures should assist rather than hinder the development of innovative provision so that services are not confined within programme of care boundaries and can serve the needs of a wider range of children.

4.7 Boards should establish commissioning and management structures that are capable of addressing the needs of disabled children and enable services to be developed in a comprehensive, child centred and fully integrated way.

Needs assessment

4.8 There were examples of helpful needs assessments and strategy documents containing recommendations for the development of services for disabled children in each Board's area. Whilst implementation plans existed for some of these, a number lacked an implementation strategy and most had not established arrangements for monitoring and reviewing progress against the recommendations. Boards reported a problem with the lack of consistent baseline information on disabled children in their area to assist needs assessment. This included incomplete information about the number of children in each Board's area, the nature of their disabilities and their support needs. Paragraph 3 of Schedule 2 to the Children Order requires Trusts to establish 'a register of children with a disability' to inform service planning. A regional 2 year project to develop a model for the register was completed in June 2003, but Boards and Trusts reported that due to resourcing difficulties this had not been taken forward. This legislative requirement, which should have been implemented in 1996, is therefore still outstanding. Trusts are accountable through their commissioning Boards for the discharge of statutory functions under the Order.

4.9 In fulfilment of the requirement of the Children Order and the need to inform service planning with reliable and comprehensive information, Boards should ensure that Trusts establish a register of disabled children as a matter of urgency.

Children's Services Planning

4.10 Despite the higher-level divisions in programme of care structures, there were a number of good planning initiatives by Boards and Trusts. Some of these had been facilitated by the Children's Services Planning (CSP) process. All Boards had undertaken general or specialist reviews of services for disabled children and young people. Some initiatives had been clearly prompted by pressing needs, such as each Board's Review of Child and Adolescent Mental Health Services. Yet others had been carried out in response to new or emerging issues such as the needs of

children with a life limiting or terminal illness and assessments to inform the development of new projects. These were commended. In general, however, hospitals and Hospital Trusts were not represented within CSP groupings.

4.11 In view of the importance of the links between hospital and community services for children who require periods of hospital care, the CSP process should include representatives from hospitals providing children's services.

Involvement of children, families and front line staff in service planning and development

4.12 Each Board's CSP for disabled children included parents, voluntary sector and user representative groups. There were also examples of good initiatives to promote the involvement of disabled children and young people in service planning. These were commended. In a number of situations, however, where hospitals had planned new children's inpatient developments, consultation with parents and children had either not happened at all or had not happened at a sufficiently early stage in the process. Parents and children can provide valuable contributions to inform the structure and design of buildings and services. In some situations, practitioner staff also felt that they did not have sufficient opportunity to influence the planning of new services or buildings.

4.13 *From the outset of new service developments or new build projects for children's services, Trusts should establish planning reference groups that include children, parents and front line staff.*

The organisation of hospital services - management issues

4.14 Hospital structures and the way services are organised should enable all aspects of children's needs to be addressed and ensure that their welfare is safeguarded whilst they are in hospital. Disabled children and young people who spend frequent or prolonged periods in hospital are particularly vulnerable to any gaps or weaknesses in the system. An overarching theme, which emerged from the individual inspections was the need for a dedicated focus on children's inpatient issues at senior management level within hospital Trusts and community Trusts responsible for hospital services. Where a Children's

Services Directorate or equivalent existed within hospital services, there tended to be better planning and delivery of children services.

4.15 A designated senior manager with lead responsibility for children's services should be established within these hospitals providing children's inpatient services to:

- ***promote an integrated approach to clinical and social care matters and the planning of children's services;***
- ***support the development of the full range of policies governing the treatment and care of children in hospital, including the 'child' proofing of general hospital policies as well as providing a focus for child protection policies and related issues;***
- ***ensure that child focused management of risk and clinical and social care governance concerns are reflected in appropriate planning and other groupings within the Trust.***

Child protection

4.16 Hospital staff may on occasions be the first to identify potential child abuse or to observe family interactions that might raise concerns about a child's well-being. It is essential, therefore, that staff are familiar with children protection issues and are aware of current issues and developments in this area. The Department's guidance, 'Co-operating to Safeguard Children' (2003) states that 'A Child Protection Panel in a hospital Trust can be helpful particularly where their work brings them into front-line contact with children and involves the assessment and treatment of children, some of whom may be at risk of significant harm'.

4.17 Of the 3 hospital Trusts considered during the inspection, 2 were represented on the Child Protection Panels of their local community Trusts. There were examples of good practice in the sharing of information from the Panels within appropriate management meetings and this was commended. The two community Trust hospitals that provided significant children's and young people's services, however, were not represented on their respective Trusts' Child Protection Panels.

4.18 *To ensure that hospital and community links are properly managed and that general hospital-related child protection issues are addressed, hospital Trusts providing acute or specialist children's services should consider establishing a Child Protection Panel. As a minimum alternative, a senior hospital representative should have membership of an appropriate community Trust's Child Protection Panel. Community Trust hospitals providing children's services should be represented on their Trust's Child Protection Panel.*

4.19 The hospitals inspected were not members of the Boards' Area Child Protection Committees (ACPCs), whose role is to develop a strategic approach to child protection within the overall children's services planning process. There is a significant interface between hospital and community services which should be reflected in the membership of ACPCs.

4.20 *Boards and Trusts should determine whether child protection issues for children in hospital are adequately represented at ACPC level and in light of this consider whether hospitals providing children's services should have membership of ACPCs in their own right.*

4.21 Of all professionals based in the hospital, nurses have the most face-to-face contact with children, their families and other visitors during the child's hospital admission. Each nurse has a professional responsibility to recognise and respond to child protection issues. As recommended in the Co-operating to Safeguard Children Guidance, most Trusts had a named nurse for child protection. However, in general, nurses' knowledge and understanding of child protection issues varied considerably and only one hospital Trust had established formal links with a community based child protection nurse specialist.

4.22 *Hospitals should establish formal arrangements with local community child protection teams to ensure that hospital based nursing staff are appropriately supported by, and have timely access to, a child protection nurse specialist.*

The organisation of hospital services - professional services

4.23 Several aspects of the professional services examined were unique to the particular hospitals considered in the inspection. Key issues that had wider implications for all hospitals providing children's services are summarised below.

Social Work services

4.24 Where hospitals had established social work services, social work teams were located in the hospital and staff were employed and managed by local community Trusts. There were examples of hospital based social workers being well integrated into children's multidisciplinary teams and offering a much valued service to children and families. The Inspection Team commended the quality of social work support in a number of hospitals, where it was evident that staff had developed specialist knowledge in a range of disability related areas such as learning disability, mental health, brain damage, rehabilitation, technology dependency and bereavement counselling. Where they were based in a hospital setting, social workers generally had clearly defined roles and responsibilities within the multidisciplinary team.

4.25 In some situations however, social work teams were not adequately resourced to provide an appropriate level of service. This was evident in situations where more input was required to support families and siblings in coming to terms with or coping with the child's disability or in situations where children had died and families had a need for continuity of contact and support in their bereavement experience. Of more concern were situations in which there was no dedicated hospital based social work support to children's or young people's inpatient services. This was the case in one general hospital, in some adult hospital facilities and in the specialist mental health facility for young people. In another hospital setting, the social work role appeared to be indistinguishable from that of other professionals. In these situations, disabled children who spent long periods in hospital, their families, carers and the hospital team missed out on a range of services that should have been integral to the care of the child and the support of the family. The Inspection Team also noted that some patients' surveys that had been conducted with children did not take account of their social care needs.

4.26 All children in hospital and their families have particular needs that may become more pressing as the hospital stay is prolonged, especially when families experience additional pressures of extensive travelling and balancing other responsibilities at home. Unlike other members of the clinical team, social workers often have the flexibility to, where necessary, interview families outside the normal hospital routines and the immediate hospital setting. Social workers can have a clearly defined role in providing:

- a social work contribution to the multidisciplinary comprehensive assessment and planning for all children admitted to hospital;
- social history information on the child and family;
- an assessment of the impact of diagnosis, illness, disability and bereavement on children and their families and counselling support to assist children and their families deal with the trauma of changed lives;
- group work support to provide the opportunity for children, parents and the wider family to share experiences with, learn from and gain encouragement from others;
- access to social care and practical support arrangements for families and children for the duration of the hospital stay and beyond;
- awareness, identification and assessment of child protection risks, including the handling, notification and follow up of child protection concerns in accordance with 'Co-operating to Safeguard Children', DHSSPS, (2003);
- coordination of the care plan and review of looked after children and children who require long term hospital care;
- advice on the notification requirements and other provisions of the Children Order and ensuring that relevant actions agreed in the care plan are followed through by community services while the child is in hospital; and
- a contribution to effective discharge planning for children and the establishment of links with community support services, including, where appropriate, voluntary agency support to promote continuity of care.

4.27 *Dedicated and specialist children's social work services should be available to children and families in hospitals providing acute or specialist services for children and young people. Where social workers are part of a hospital based multidisciplinary team, they should have a clearly defined role, which ensures that the support needs of children and families are addressed in a comprehensive way.*

4.28 *Patient surveys should take account of the social care support needs of patients and their families.*

4.29 It is preferable for social workers dealing with inpatient services to be based in the hospital. Some social workers reported, that at times they were not included in events or informed about new community initiatives relevant to children's services. They were not always made aware of new policies that had implications for practice, particularly in the area of child protection. It is vital that hospital based social workers should be kept abreast of developments in services and policies that affect their work.

4.30 *Trusts should establish formal arrangements which ensure that hospital based social workers are aware of new initiatives and are inducted, together with community based workers, into new policies that have implications for their practice.*

Medical services

4.31 The Inspection Team was impressed by the skill, training and commitment of staff, evidenced within hospital services for disabled children. The Team in particular commended innovation in services, and the establishment of consultant posts to take forward advances in treatment to the most vulnerable children and young people. A model of consultant working in paediatrics between hospital and the community in some of the hospitals inspected was also commended as an effective model of service provision which supported continuity of care to disabled children and their carers.

4.32 *Trusts should consider establishing joint paediatric and community based medical consultant posts to promote continuity of care for children and their carers.*

4.33 The inspection highlighted gaps, however, in the medical services available in Trusts, particularly in rehabilitation and neurorehabilitation, learning disability services and services for children and young people with mental health needs. These had an impact on the timeliness of the care children and young people received whilst in hospital. A recommendation to address these deficiencies is made in Part 8.8-9 of this report, which deals with medical workforce planning issues.

Nursing services

4.34 The hospitals inspected had comprehensive commissioning arrangements in place with their respective Boards. The continuous evolution and diversification of nursing skills required to care for disabled children with complex needs was reflected in imaginative developments in nursing services and associated business cases for new development. These were commended. Inspectors found that the structure of nursing services was generally appropriate to meet the needs of children in hospital. All acute hospitals employed Registered Children's Nurses on children's wards as recommended in the Allitt¹ inquiry. Nevertheless, children with learning or mental health disability were mostly cared for by nursing staff trained in the equivalent adult field. Most Trusts facilitated post-registration training in children's nursing. In view, however, of continuing and significant recruitment and retention issues experienced in some mental health and learning disability facilities, it was not always possible to release staff to undertake this training. Where this is the case, arrangements should be in place to enable adult trained nursing staff to access the appropriate support and advice of a registered children's nurse.

4.35 *Trusts should ensure that all adult trained nurses caring for children with a mental health or learning disability have access to advice and support from a qualified children's nurse.*

4.36 Some hospitals had employed a variety of specially trained nurses whose skills enhanced the care and management of children in hospital. These were commended.

1 Independent Inquiry Relating to Deaths and Injuries on the Children's Ward at Grantham and Kesteven General Hospital. London: HMSO, 1994.

4.37 Good practice example:

The Behaviour Nurse Therapy Team (BNT) based in the children's ward of Muckamore Abbey Hospital advised nursing staff on the management of children with challenging behaviours. For children who were referred, the team established individual behaviour management plans which were reviewed as appropriate. The Team also worked closely with teaching staff, AHPs and social workers. This initiative was clearly valued by staff and parents and was commended by the Inspection Team.

Allied Health Professional services

4.38 The Inspection Team considered the general provision of physiotherapy, occupational, speech and language therapy, nutrition, dietetics, and podiatry services in the sample of hospitals inspected. There were a variety of arrangements for the delivery of AHP services to children in hospital which included:

- hospital based services, where staff were directly employed by the hospital – physiotherapists were the most likely staff to be hospital based;
- service level agreements with community Trusts who provided, for example, occupational therapy services; and
- ad hoc arrangements with community Trusts' staff who attended the hospital 'as and when' required or, on occasions, on a good will basis.

4.39 Some hospital based AHP staff had developed a range of highly specialised skills, for example, in the areas of brain injury and rehabilitation and learning disability. This was commended. Nevertheless, the above variations in the way children's AHP services were delivered tended to limit the development of skills in children's services. This meant that few staff were afforded the opportunity to develop knowledge and receive training in paediatrics despite the fact that staff themselves regarded this as a highly specialised area.

4.40 In a number of cases the lack of hospital based staff resulted in long waiting times for AHP services, which on occasions delayed the

child's discharge and meant that children did not receive therapy at the most appropriate time in their treatment plan. For children in intensive AHP programmes, such as brain injured children, the lack of AHP staff at weekends had the potential to impact adversely on their progress. There was a clear need for protocols to be developed to ensure timely response to referrals and appropriate deployment of AHP staff.

4.41 The Inspection Team also noted that there was little contribution of AHP staff to children in mental health hospitals or within the CAHMS community teams linked to the hospitals inspected. The guidance, however, on 'Staffing of Child and Adolescent Inpatient Psychiatry Units' (1997) produced by the Royal College of Psychiatrists identified the need for AHPs to form part of the multidisciplinary team.

4.42 *Boards should assess the current provision of AHP services for children in hospital with a view to identifying unmet needs and addressing the need for future services. Formal arrangements should be established which ensure that children receive timely access to the full range of AHP services they need and staff are enabled to develop expertise in paediatric care.*

Psychology services

4.43 In view of the complex nature of disability and the adjustments required by children and their families at the time of diagnosis and afterwards, all disabled children should have access to a specialist clinical psychology assessment and treatment service. Psychology services were available to children and young people in all but one of the hospitals inspected and made a valued contribution to children's care. As with AHP services, however, there were a variety of arrangements for the provision of this support. Some hospitals had specialist staff in post. Others had been allocated an agreed number of psychology sessions per week but this was generally not regarded to be sufficient. In some situations the community Trust provided services on a good will basis and services were therefore not always available when they were most needed. Deficits in psychology services are considered further in Part 8.17-18 which deals with workforce planning. There is, however, an immediate need to address these concerns in respect of disabled children currently in hospital.

4.44 *Boards and Trusts should establish arrangements to prioritise the timely provision of psychology support services to disabled children and young people in hospital.*

Pharmacy services

4.45 The inspection did not specifically review pharmacy issues. It was evident, however, during the fieldwork observation of ward rounds and the functioning of multidisciplinary teams that appropriate pharmaceutical input is vital to the care of children in hospital. Children cannot be treated as 'small adults' in the use of medicines, many of which have been developed for adult patients. Furthermore, disabled children are more likely to have multiple health conditions that require a holistic approach to the choice of medicines to which the contribution of clinical pharmacy is essential. The prescribing, dispensing and administration of medicines to children is therefore a critical governance and risk management issue for all hospitals providing children's services. The National Service Framework Standard for Children's Hospital Services in England (DoH, 2003), states that 'ideally, sufficient trained pharmacy staff should be available to cater for the special needs of children, to ensure that medicines are managed safely and effectively and to play an active role in the multidisciplinary team caring for children'. The Framework also stresses the need for pharmacists to advise other professionals and parents on the use of medication. Only two of the larger hospitals had pharmacist staff with a specific paediatric commitment. Where this was the case, parents and staff found their expertise an invaluable resource.

4.46 *Hospitals providing children's services should establish dedicated expertise in paediatric pharmacy services and ensure that there is a sufficient pharmacy resource to contribute to each child's care as part of the multidisciplinary team.*

Clinical and social care governance

4.47 There were many positive aspects to clinical and social care governance arrangements within the selected Trusts responsible for children's hospital services. These included clear structures for the delivery of clinical and social care governance and in the case of some Trusts, strategies and action plans with monitoring and review arrangements. Two Trusts were using the European Foundation for Quality Management model with associated assessments and action plans. These initiatives were commended. Most hospitals had delivered training in clinical and social care governance issues. Where comprehensive governance arrangements were in place, staff were clear about their contribution to the quality agenda and had had an opportunity to attend relevant training and skills updates.

4.48 There were, however, two key areas identified for improvement. The first centred on the need to recognise in the implementation of clinical and social care governance, the particular vulnerabilities of children and young people and particularly those of disabled children in hospital. There was a need to establish discrete structures, procedures and reporting arrangements for clinical and social care governance issues in relation to children. The second area which needed to be developed was the promotion of comprehensive multidisciplinary and user representation approaches to clinical and social care governance matters. In a number of hospital settings not all professions were represented in key groupings and in some cases, children, young people and their families or carers did not have an input into the establishment of appropriate clinical and social care governance arrangements.

4.49 *Hospitals should address children's services as a discrete area within clinical and social care governance and include a report specifically on children's issues in annual governance reporting arrangements.*

4.50 *Trusts should ensure that the membership of clinical and social care governance (including risk management) groupings within hospitals represents as far as possible the range of professional disciplines working with child inpatients and families and includes the participation of child and parent/carer representatives.*

Risk management

4.51 All Trusts had developed risk management strategies. In some cases these included computerised databases, which retained information on all complaints, accidents, near misses and other critical incidents and provided information on trends. This was commended. All but one Trust had completed policies on promoting a learning culture, honesty, openness and minimum blame in the reporting of incidents. The remaining Trust was in the process of addressing this during the period of the inspection.

Audit arrangements

4.52 A number of helpful unidisciplinary audits had been carried out in children's services. There was just one example, however, of a full multidisciplinary audit in paediatric services. This approach needed to be developed in all hospitals providing services for children.

4.53 *Trusts should develop full multidisciplinary audit and monitoring of services for children in hospital.*

Standards

4.54 The Inspection Team was provided with examples of unidisciplinary standards. In some situations, multidisciplinary standards had been developed to inform aspects of children's care, for example, the management of long term ventilated children and discharge planning for children in hospital. One Trust had established multidisciplinary standards for the care of children in hospital. This was commended.

4.55 Good practice example:

An example of the use of child specific standards was found in the Child and Family Centre at Forster Green Hospital. The Centre had carried out a baseline audit against a national set of comprehensive, specific and measurable standards produced in 2001 by the Quality Network for Inpatient Child and Adolescent Mental Health Services. These were used as a benchmarking exercise to identify strengths as well as practice issues and other areas to be developed in striving to promote high standards of practice. This initiative was commended.

4.56 Where standards were in place, these were commended. There was a need, however, to develop regional multidisciplinary standards to inform the care of disabled children in hospital. The draft standards developed for the purpose of this inspection should assist the development of comprehensive regional standards (Appendix B).

4.57 *The Department's Standards and Guidelines Unit should take forward the development of multidisciplinary standards to inform the care of disabled children in hospital.*



5. Assessment and Care Planning

Standard

The well being of disabled children is promoted through multidisciplinary assessment and care planning arrangements, which enable children's needs to be identified and met in a coordinated manner.

Policies to inform the admission, care and discharge of children

5.1 From admission to discharge, disabled children, young people and their families should receive care and support that is well planned and consistent with best practice. Hospitals need to consider what this means for children at each stage of the process within their particular hospital setting. Consistency can only be assured when there are written policies governing key areas of work and all professional staff involved in the child's care are familiar with the procedures and work to best practice expectations.

5.2 The Inspection Team examined a range of policy documentation. Most of the hospitals inspected had written policies covering the admission and discharge of children. With a few exceptions, there were a number of key areas where written policies either did not exist or were deficient.

5.3 *Boards and Trusts should ensure that hospitals providing children's inpatient services have established, as a minimum, written policies and procedures on the following:*

- *pre-admission, admission and discharge of disabled children and young people, including emergency admissions and procedures covering children who require frequent admissions to hospital;*
- *philosophy of care of disabled children in hospital, including the role of parents, families and carers;*
- *multidisciplinary assessment and care planning, including contact with community care services;*

- *child protection, to include easily accessible copies of 'Co-operating to Safeguard Children' (DHSSPS, 2003) and the Area Child Protection Committee's Child Protection Policies and Procedures;*
- *the impact of domestic violence on children;*
- *consent to examination, treatment or care;*
- *intimate/invasive care of children and young people;*
- *anti bullying;*
- *notification to Social Services of children who have been or are likely to be in hospital for 3 months or more (this should include neo natal children); and*
- *discharge arrangements.*

Assessment

5.4 The treatment and care of each child admitted to hospital should be based on a comprehensive assessment of the child's needs. The assessment should enable a care plan to be established that is reviewed at agreed intervals and covers the period from pre-admission through to discharge.

Pre-admission assessment information and fast tracking

5.5 It was noted in 2.9 that at least 43 children in the sample had experienced at least one previous admission to hospital in the 2 year period under consideration. Two of the acute hospitals that were inspected had fast tracking arrangements for children who needed frequent admissions. Parents particularly valued these arrangements as they prevented children from spending long periods in accident and emergency departments. This was commended.

5.6 *Acute hospitals providing children's services should establish fast tracking arrangements for children needing frequent admissions to hospital.*

5.7 The Inspection Team commended the practice in some hospitals of completing pre-admission assessments on children who were already known to other services, including children who were being transferred to another hospital from a specialist regional centre. These focused on key aspects of the child's care and enabled staff to make prior contact with parents and plan ahead for the child.

5.8 Good practice example:

St Luke's Hospital provided an example of good partnership arrangements with community CAMHS teams in the pre-admission assessment of young people who had a planned admission and in the initial assessment of those who required an emergency admission to hospital. The Consultant Psychiatrist from the CAMHS team remained responsible for the young person's treatment while in hospital and the multidisciplinary CAMHS team's assessment was shared with hospital staff. Community staff were involved in subsequent revisions to the assessment and care planning during the young person's hospital stay. These arrangements provided continuity of care for young people and were commended by the Inspection Team.

Multidisciplinary assessment

5.9 Most medical, nursing, AHP and where appropriate, social work staff and psychologists had completed unidisciplinary care assessments on children. These generally represented a good standard within each of the respective disciplines. The principle of multidisciplinary working was implicit in the practice of each hospital but the Inspection Team observed two settings: neurorehabilitation services at Forster Green Hospital (5.13) and children's services in Antrim Hospital (5.44), that demonstrated truly integrated and coordinated working by multiprofessional teams. Parents commented on the excellent standard of communication they experienced in these situations. In each of the hospitals inspected, staff without exception had themselves recognised the value of multidisciplinary working and were aware of shortcomings in current practice, which in most cases required both a cultural shift and a realignment of resources to enable effective multidisciplinary working.

5.10 Due to the fact that assessments in general tended to be unidisciplinary, there were few examples that enabled the whole needs

of the child (and not simply clinical needs) to be addressed in a structured and multidisciplinary way. 'Whole child' assessment is particularly important for disabled children and children who spend long periods in hospital where, in the context of a clinical care or treatment process, there is the potential for the full range of the child's needs to be overlooked.

5.11 With a few exceptions, assessments did not evidence that they had been informed by the views of children and families. Parents reported to the Inspection Team that the range of professionals they encounter can be a daunting experience. It is easier for everyone if assessment and care planning are coordinated in a way that makes sense of the child's treatment and enables ease and clarity of communication between professionals and with parents.

5.12 *To assist care planning and ease of communication, assessments completed by all professionals involved in the child's care should be integrated into one multidisciplinary assessment. In addition to the child's physical and clinical care needs, the assessment should address in consultation with parents, 'whole child' needs such as social, cultural, spiritual, family support, education and children's rights issues.*

5.13 Good practice example:

The assessment and care planning arrangements in neurorehabilitation services at Forster Green Hospital provided an example of integrated assessment and care planning for young people who had an acquired brain injury. The assessment methods, introduced by the Consultant, were both comprehensive and succinct in assessing the patient's needs and in setting clear objectives with timescales for the multidisciplinary team in meeting these. The objectives formed the care plan which was reviewed at weekly team meetings. Team members recorded progress directly onto the assessment framework and thus the extent of each professional's input was immediately accessible to all members of the team. Parents and young people reported that they were fully involved in the assessment process and were aware of the progress made and future plans. This was commended.

Risk assessment

5.14 The evaluation of risk is central to any assessment, whether the risk is due to health, behaviour and social or environmental factors. Some hospitals were commended for their risk management strategies and the Inspection Team saw examples of unidisciplinary risk assessments that had been undertaken in respect of children and young people. Where risk assessments had been completed, it was however noted that:

- there was no process for sharing the risk assessments or undertaking a multidisciplinary risk assessment which brought together clinical, environmental, child protection and social issues for children and young people; and
- risks linked to social factors and unmet needs e.g. prolonged stay in hospital due to lack of community facilities; lack of schooling for children and young people were not generally formally assessed or documented.

5.15 *As part of the assessment process, hospitals should include a multidisciplinary assessment of risk on each child and young person which addresses the above issues.*

Care planning

5.16 A care plan for each child should flow from the assessment. The Inspection Team recognised that it can be difficult to maintain an up to date written multidisciplinary care plan in the acute phases of a child's illness. In the children's cases examined, where children had been in hospital for long periods, the Team found some excellent multidisciplinary 'person centred' care planning which identified targets in each clinical area of work, including social work, and focused clearly on the child.

5.17 In general, however, where plans existed many were unidisciplinary. Children and parents were not always involved in the planning and the plan was often not shared with them. In some cases the plan was contained in the medical file and was not easily accessible by other professionals.

5.18 Good practice example:

An example of care planning partnership approaches with children was found in the Young People's Centre. Each young person attended weekly meetings which focused on his or her care plan and provided an opportunity for the young person to contribute to the ongoing assessment, reflect on the plan and assist in reviewing progress. This was commended.

5.19 Each disabled child should have a 'child centred', focused care plan based on the multidisciplinary assessment which:

- ***covers the period from admission through to discharge;***
- ***takes account of the needs of the 'whole' child - including cultural, social and spiritual needs - in accordance with the period of time the child is likely to stay in hospital;***
- ***identifies key tasks to be undertaken by each professional, with timescales and arrangements for review; and***
- ***is easily accessible by staff, parents and children.***

Parents and children should be given the opportunity to document their agreement with the plan and if they wish, receive a copy.

Discharge planning

5.20 All children should remain in hospital for as short a time as possible. Planning for discharge should therefore commence from the point of the child's admission. For disabled children in particular, such planning forms a vital bridge between hospital and community services and serves to:

- reassure children and families about continuity of care and support;
- clarify the roles of all relevant professionals in the child's ongoing treatment and care;

- enable potential gaps or difficult issues in the provision of services to be identified at an early stage and enable these to be addressed before the child's discharge; and
- secure the involvement of community services (including education and voluntary sector support services) in planning prior to the child's discharge.

5.21 The Inspection Team commended situations in the children's cases examined where multidisciplinary discharge planning meetings had been established with parents and early links made with community services. In one hospital a Discharge Liaison Coordinator was about to be appointed for a trial period and in others, social work or nursing staff assumed the lead in this process. There were examples of excellent multidisciplinary planning in the discharge of technology dependent children and children with complex needs. In some situations, however, there was no lead professional in discharge planning and not all children had a formal discharge planning process. In these children's cases, appropriate links had not been established with key professionals or support agencies in the community. In the view of the Inspection Team, children and families were missing out on some important sources of support and unnecessary delays had occurred in securing community services.

5.22 *As part of each child's care plan, a structured discharge process should be established which:*

- *identifies a professional to take the lead in planning and coordinating discharge arrangements;*
- *takes account of the ongoing support needs of children and families (see 6.1-2);*
- *ensures that appropriate community services (including voluntary sector and education services) are notified in a timely manner and where possible contribute to the discharge arrangements; and*
- *provides for clear and consistent communication with families about the discharge process and follow up arrangements.*

5.23 Trusts should consider whether it would be helpful to take forward the assessment and care planning recommendations on a regional basis with a view to developing jointly agreed protocols and proformas.

5.24 Some staff in the regional centres reported to the Inspection Team that the quality of post discharge support for children and families and subsequent outcomes in children's progress varied considerably between Trusts.

5.25 Where hospital staff are aware of inequities or gaps in the community service provision of Trusts, the hospital should ensure that Boards are formally notified of these.

Notification arrangements

5.26 When a child has been in hospital for a consecutive period of 3 months, or when it becomes evident that the child will need to be in hospital for at least three months, the hospital has a duty under Article 174 of the Children Order to notify the community Trust in whose area the child resides. The hospital must also notify the Trust when it is proposed to end the child's hospital stay. The 'Guidance and Regulations to the Children Order Volume 5 - Children with a Disability' (DHSS, 1996), states that the Trust must 'take all reasonably practical steps to decide whether the child's welfare is adequately safeguarded and to decide whether it is necessary to exercise any of its functions under the Order'. Notification arrangements are to ensure that children are not forgotten, that Trusts assess the quality of care offered and that there is coherent planning for children.

5.27 Of 173 children who were in hospital during the period under consideration, 54 (32%) children were formally notified to community Trusts (Table 16). In 35 (20%) cases, Trusts were not notified because the child was already known to the Trust. 36 (21%) children were not notified and in 37 (21%) cases it was not known whether the children had been notified or not. In a significant number of cases, therefore, community Trusts were not fulfilling their responsibilities under the Order. Some hospital staff reported to the Inspection Team that neonatal children who spend long periods in hospital are not normally notified. Of 29 children who had been in hospital since birth and most of whom were in the neonatal wards (Table 7) only 10 children had been notified to the community Trust (Table 17). Article 174 of the Children Order also applies to these children.

5.28 Hospitals should ensure that they are fulfilling the notification requirements of the Children Order. This should apply to all children, including neonatal children and those who are already known to the Trust. Notifications should serve to alert Trusts' senior management of children and families who may require a service or additional services. Community Trusts should establish procedures for responding to notifications by hospitals.

5.29 The Inspection Team was informed that some parents were concerned about Social Services knowing about their child's stay in hospital as they did not wish to have a social worker involved with their family.

5.30 As children and parents may not be aware of the legal requirements regarding notification and the reasons for these, hospitals should liaise with community Trusts to ensure that there is appropriate written information available for parents and children which explains the role of community services and the rights of children and parents within this process.

Looked after children¹

5.31 Looked after children and those who become looked after while in hospital are more likely to be adversely affected than other children if proper assessment and care planning arrangements are not in place. When the looked after child is a disabled child, there are further compounding factors which make it imperative that there should be a structured and focussed approach to the child's treatment, care and discharge. Of the 173 children in the sample population, 46 (27%) were looked after at the time of their admission (Table 18).

5.32 The Inspection Team found that a significant number of disabled children had remained in hospital longer than was clinically necessary. Thirty six children were in hospital at the end of the period under consideration by the Inspection. The discharge of at least 21 children² had been delayed due to the lack of appropriate community care services, equipment or an alternative community care placement (Table 19). This was mainly due to the lengthy planning process required to secure appropriate community based services for children on discharge. If a child remains in hospital in such circumstances he/she is effectively 'accommodated' by the Trust from the point at which the child is declared clinically fit for discharge. All the provisions of the Children

1 within the meaning of Article 25 of the Children Order.

2 In 4 cases no reason was given for the child remaining in hospital.

Order in respect of 'looked after' children therefore apply. Such children should always be notified by the hospital or community Trust to the commissioning Board. The community Trust has regulatory responsibilities under the Order to assess, plan and review the child. Staff in some hospitals had not been aware of this until the commencement of the inspection. Hospitals should ensure that respective community Trusts are aware of and are fulfilling their duties under the Children Order towards such children. Good working relationships and communication between hospital and community services are vital in these circumstances.

5.33 Children who cannot be discharged from hospital due to the lack of community provision should be notified to the relevant commissioning Board. Hospitals and community Trusts should ensure that the relevant Trust is fulfilling its responsibilities under the Children Order to assess and review children in these circumstances and plan to meet their needs.

5.34 Good practice example:

An example of effective working relationships in respect of looked after children was noted in the Longstone Hospital. Good links had been established between the hospital, the community team that provided support for disabled children and the community child care team responsible for looked after children. There was evidence of working together with education services to provide a range of suitable services as well as effective coordination and communication in child protection matters. This was commended.

Transfer arrangements

5.35 The transfer of children to adult services can be a source of anxiety to children, parents and families because of the loss of a familiar consultant or nursing staff and fear of the child going unnoticed in the adult world. In general, clear transitional arrangements did not exist within hospitals. Ambiguity about the age at which children should access adult services at times created stress for children and parents, and highlighted further the lack of focus on the needs of young people within clinical services (see 3.14).

5.36 The Inspection Team also considered the transfer of information between children's hospital services and community services. With the

exception of nursing staff (because of the nature of the records and work routines) most disciplines were able to facilitate the sharing of information and this is commended.

5.37 Boards and Trusts should establish a regionally agreed protocol to inform the transfer of children and young people to adult hospital or community services which:

- ***takes account of chronological age and developmental issues;***
- ***provides for a flexible transition period; and***
- ***promotes a coordinated strategy across all disciplines that includes, with the consent of children and parents, the sharing of professional information.***

Child protection issues

5.38 The review of children's cases demonstrated that a small number of children during their time in hospital were the subject of incidents that fell within a child protection framework. In general, the issues in the initial stages were handled appropriately by staff. As they unfolded, however, it was noted that:

- some incidents involving injury to children or young people had not been fully reported to parents and relevant professionals;
- hospital files did not always contain evidence that agreements made in case conferences had been fully implemented;
- written allegations made in respect of one child's treatment were not responded to in writing;
- information which had implications for the care of specific children was not always shared with the full hospital team; and
- on occasions, communication between hospital and community services staff was by telephone when it would have been more appropriate to have convened a formal meeting.

5.39 Within the hospital team there was not always a person such as a named nurse or key worker who was responsible for checking that all aspects of the child's care (including those relating to child protection)

were attended to, agreed actions were followed through and delay or lack of action in any areas were reported to an appropriate line manager. This is particularly important for children who spend long periods in hospital when decisions may be taken in relation to social care and other issues, which are not always acted upon.

5.40 Hospitals should review their child protection policies and procedures with a view to ensuring that procedures for dealing with the issues reported in 5.38 are included and that all staff working with children are familiar with the policy and procedural guidance in this area.

5.41 For children who are in hospital for extended periods, a member of the team should be appointed as a key worker to check that all aspects of the child's care are attended to, agreed actions (including those relating to child protection) are followed through and any delays or lack of action are reported to the ward manager or an appropriate line manager.

Hospital records, recording practices and storage arrangements

5.42 There were a number of examples of well constructed files. In general nurses, AHP staff and social workers maintained unidisciplinary files, although some professionals also made notes in discrete sections of the medical file. One hospital had introduced computerised recording in children's records. The hospital recognised that this had the potential, however, to adversely impact on multidisciplinary working, as the records were accessible only to nursing staff and records that were archived could not easily be retrieved.

5.43 Well organised and contemporaneous records are a valuable asset in ensuring that those involved in assessing and planning for children have ready access to information which presents as full a picture as possible of the child's treatment, care and family circumstances. It is the view of the Inspection Team that the best method of ensuring this is through the establishment of a single continuous record to which all disciplines contribute. The record should contain the full multidisciplinary assessment of the child's treatment and care needs, the multidisciplinary care plan for the child and relevant documentation and correspondence. Unidisciplinary records should back this up where professionals such as AHP and social work staff are employed by a community Trust.

5.44 Good practice example:

Antrim Hospital had established structures that ensured effective communication between all professionals involved in each child's assessment and care planning. These included the use of comprehensive multidisciplinary admission, assessment and care planning pro formas. A multidisciplinary method of recording in children's case records was also evident. Records were found to be well organised and clearly written, with relevant professionals recording in a consecutive manner in the multiprofessional progress notes. The hospital was commended for having achieved a consistently high standard of multidisciplinary working and recording.

5.45 *To assist multidisciplinary working in children's services, it is recommended the hospitals should consider establishing a single continuous record to which all disciplines contribute and which contains the child's multidisciplinary assessment and care plan.*

5.46 In a number of cases it was noted that only a few health care staff in the hospital were aware of the Parent Child Health Record (PCHR), although it was evident that others made effective use of the record and this was commended. The object of the PCHR is to ensure that a parent has a comprehensive record of the child's health and treatment.

5.47 *Hospitals should establish a policy, in consultation with parents, on the use of the PCHR when children are admitted to hospital.*

5.48 The storage arrangements for closed and current files were in general satisfactory. In some settings, however, closed and current files were not stored in a secure manner and this could have led to inappropriate access to the confidential information of patients and their families.

5.49 *Hospitals should ensure that when files are not in immediate use they are at all times securely stored in accordance with agreed procedures to prevent breach of patient confidentiality.*



6. The Range and Quality of Service Provision

Standard

The hospital provides responsive services that are child friendly and offer choice and flexibility to disabled children and their families.

Responsiveness to children and families

6.1 Children and families were in general very positive about the care and support they had received during their hospital stay. Many parents who had long awaited a place for their child conveyed to the Inspection Team their tremendous sense of relief when a bed became available. Children and their families often experienced the most difficult of personal circumstances which were compounded, for example, by frequent or prolonged admission to hospital. Families could experience difficulty in integrating the child back into family life. Other families spoke of the sense of isolation they experienced in caring for an ill or disabled child. When help was available through the support of the hospital or community services social worker, this was appreciated. Such support, which was not always available (4.25), has an important contribution to make in helping parents to care for and more effectively support their child.

6.2 *The needs of parents and families of disabled children for individual support should be separately assessed and addressed as part of the plan for the child's care whilst in hospital. Appropriate links with community services should also be established to ensure that parents and families continue to receive support in their own right when caring for their child at home.*

6.3 In addition to speaking to parents, children and other family members, the Inspection Team observed daily routines on the wards and made evening pre-bedtime visits to selected wards. Of the many matters raised in each of the individual hospitals, the following is a summary of common themes and issues:

- in general there was good interaction between children and staff;
- most dedicated children's wards had established good bedtime routines that were sensitive to the age of the children and took account of their holistic health needs;

- medication was generally administered in a sensitive way;
- most parents felt welcome in the hospital and were not unduly restricted in visiting their child;
- most parents felt that the hospital's initial communication with them was good;
- most parents and families felt that their views were listened to;
- staff placed value on children's contact with siblings and other family members;
- children and young people in general liked the staff and enjoyed engaging in activities with them.

6.4 The Inspection Team commended in particular, examples of child focused initiatives which included play specialists (see 10.10) in 2 of the acute hospitals and the introduction of art and music therapy in one other setting. These proved to be of enormous benefit to children and young people.

6.5 Hospitals providing children's services should establish age appropriate special provision such as play, music and art therapy services aimed at offering children an opportunity for reflective individual expression. This is particularly appropriate for children and young people who spend extended periods in hospital.

6.6 Some of the areas where there was room for positive change included:

- communication - parents sometimes felt that good communication tailed off as their child's stay was prolonged;
- child protection - parents were not always fully informed about significant or potential child protection issues in their child's care;
- transport – this was often difficult for parents and they did not always receive the help they needed in claiming reimbursement;
- leisure and social activities for young people – these were generally insufficient in the hospital setting;
- equipment - when children were home for short periods as part of their rehabilitation programme, it was difficult to get appropriate equipment, such as an electric wheelchair, to assist the child's stay at home.

6.7 Hospitals providing children's services should establish arrangements that promote best practice in each of the above areas and ensure that the needs of children and their families are addressed in a sensitive manner.

6.8 There were a number of matters, however, that were of particular concern to the Inspection Team. These are outlined below and must be addressed to maintain responsive approaches to the needs of children and families.

Care of children and young people in adult wards

6.9 This issue has already been considered in Part 3.9-14 of this report. It is important to record however, the concerns and in some cases, fears of parents that their children continued to remain on the adult wards of learning disability and mental health hospitals where they were exposed to inappropriate adult behaviour or the undue influence of adult patients and had little opportunity for social interaction with their peers. This matter will be considered regionally, as recommended in 3.13 and the use of adult wards will be monitored by Boards and Trusts. It is important however in the meantime that the care of each individual child and young person is safeguarded by appropriate assessment and management of risk.

6.10 *If, in exceptional circumstances, a child or young person is admitted to an adult ward, the Board and Trust should ensure that:*

- *a full multidisciplinary assessment of risk is undertaken with actions identified to safeguard the child during the hospital stay;*
- *the child and staff have access to professionals who have appropriate expertise in children's services;*
- *there are plans to address the child's needs for leisure, social interaction with peers and an appropriate physical environment;*
- *there is a discharge plan to move the child quickly to a suitable alternative placement.*

Home visits

6.11 It is vital that children who spend long periods of time in hospital, should be able to have visits home or spend time away from the hospital setting with their families, when it is safe and appropriate for

them to do so. This right should be upheld in the hospital's principles and practice. Opportunities to meet with families outside the hospital should be considered as part of each child's care plan. There were good examples of such initiatives which formed part of children's rehabilitation programmes or ensured that a child was able to maintain family ties, even when there was not likelihood of a return home. These were commended. One situation was noted however, when matters such as hospital staff resources and other issues, not related to the child, prevented planned visits home. Staff may not always be fully alert to the importance of ensuring that the child's pre-arranged contact with family is maintained and promoted, particularly at times when staff are working with limited resources.

6.12 *When the child's care plan includes visits to family, staff should ensure that visits take place as planned. If matters unrelated to the child or family circumstances prevent this happening, staff should inform senior management immediately and seek advice to ensure that children and families are not disadvantaged by events outside their control.*

Restriction of liberty

6.13 During the period under consideration by the Inspection Team, 17 children, representing 10% of the sample had been placed in a secure (locked) ward (Table 20) and of these, 7 were under the age of 16 years (Table 21). A total of 30 children had been detained under the Mental Health (NI) Order 1986 (Table 22) and of these, 17 were under 16 years (Table 23). A small number of hospitals had 'time out' rooms which were designated for use as part of behavioural management therapies. Where 'time out' had occurred, this was not always recorded in the child's file. There was also a lack of clarity among staff about the purpose of the provision. This raised general concerns about the restriction of children's liberty while in hospital and the need for clear policies, procedures and training to inform practice in this area.

6.14 *Where a hospital has a designated facility or makes use of behaviour management techniques that restrict the liberty of children:*

- ***the hospital should establish an appropriate policy which conforms to the Department's guidance on 'The Use of Restraint and Seclusion in Residential and other Settings' (DHSSPS 2005);***

- *there should be clear procedures for staff covering the use of techniques to restrict the liberty of children, including an agreed level of staff training and supervision, as well as the recording of use and the circumstances surrounding this in children's case files;*
- *where there are designated time out areas in the hospital, the Trust should seek guidance on the physical aspects to ensure that this conforms with best practice guidance;*
- *senior management in the Trust should review policy and procedures to ensure that these do not breach the child's human rights; and*
- *parents should be given information about restriction of liberty; they should consent to the methods used and be fully informed of any incidents involving their child.*

Group support for children, parents and siblings

6.15 The inspection identified group work as a potential area for development in the support of children in hospital and their families. Examples were found of group work initiatives for children and young people in hospital and these were commended. As has already been noted in 6.1, however, families can feel a sense of isolation when they have a disabled or very ill child who requires an extended period in hospital. A number of parents reported that they felt they were the only ones in this situation and would have valued the opportunity to talk to and share matters of mutual concern with others who had a similar experience. One such approach to support the parents of neonatal children was commended.

6.16 Other members of the family also have support needs that may go unrecognised when the disabled child is centre stage. Parents and hospital staff reported that the needs of siblings, particularly young siblings often take second place in the midst of daily visits to hospital, frequent meetings and the other issues that arise in the care of the disabled child. When a disabled child is newly born into the family or has acquired a serious injury, the child's brothers and sisters need time and attention to help them make sense of the dramatic change in their lives. It was encouraging to note that some hospitals were in the process of setting up sibling support groups led by social workers and nursing staff.

6.17 Voluntary organisations offer a range of support initiatives and information about these should be provided to children and their families. The opportunity for parents or other family members to meet with others involved with the same hospital, however, can be a valuable additional source of help. Such an approach needs to be supported by staff who are familiar with the children, the hospital and its routines. Hospital based social workers are well placed to take on this role (4.26) both in their own right and as co-workers with members of the multidisciplinary team.

6.18 *Hospitals caring for disabled children should explore whether children, parents and siblings would benefit from group support approaches and, if they wish, ensure that they are linked into hospital based initiatives or the group support approaches of other agencies.*

Bereaved families

6.19 Sadly, there is a high death rate in the most severely disabled children. Of the children considered in the total sample, at least 16 (9%) children had died (Table 24). The death of a child is one of the most devastating events in the lives of families. The Inspection Team commended one Hospital Trust for having established an annual memorial service for families. Some hospitals also demonstrated great sensitivity to cultural issues in the way they handled the death of the child and subsequent arrangements for the family. These initiatives were commended. Whilst most families who had been bereaved valued the sensitivity of hospital staff and had received information about various support groups, some parents reported that they would have benefited from a further period of counselling by social work staff who had knowledge of and contact with the family during their bereavement. Social workers also identified the need for additional time and resources to offer this vital service (see 4.25)

6.20 *When families have suffered the bereavement of a child, professional social work support should be made available for as long as is necessary to meet the needs of the family for support during this difficult time.*

The physical environment

6.21 The Inspection Team visited a large number of wards and hospital based facilities. Many of the findings relating to the physical environment were specific to the hospitals inspected. The following main themes emerged overall:

- children's wards in acute hospitals were generally bright and welcoming. The décor was (or was in the process of becoming) child friendly and in general, there was respect for the dignity and privacy of each child;
- in some cases, single bedrooms were available for young people who were admitted to an all child or mainly adult environment;
- where young people were placed in a 'house' rather than a hospital environment, they preferred this rather than the traditional setting of a hospital;

6.22 Some matters of concern, however, were:

- physical conditions in the mixed age group provision for people with learning disabilities and mental health needs were unacceptable;
- a number of hospitals did not have private rooms where parents could discuss or be given information about their child or where professionals such as social workers could elicit information or provide support to parents in a manner that respected their need for confidentiality and privacy in emotionally charged or distressing situations;
- a significant number of facilities in wards were not easily accessible by children or families with mobility problems;
- there were not always suitable facilities or equipment for families travelling long distances or needing to stay overnight with their child;
- lack of outdoor leisure space for some young mental health patients;
- lack of social space for young people to meet with peers, particularly in the acute sector.

6.23 Appropriate recommendations in respect of these have been made to each of the hospitals concerned.

6.24 *Trusts should ascertain whether any of the above matters apply to their hospitals and seek with parents, children and disability representative groups to identify areas of the physical environment that should be improved.*



7. Education Provision

Standard

Children in hospital are able to access educational support which is matched to their needs and is appropriate to the circumstances of the hospital setting.

7.1 The Inspection identified well established arrangements and practices to meet the educational needs of children and young people across almost all of the hospitals. Some areas for improvement were identified in individual hospitals to ensure that the educational support needs of children and young people would be effectively met. The more general issues are outlined below.

7.2 For children who remained in long stay hospital provision, in general, educational support was accessible as required. Where appropriate, arrangements included daily travel to local schools or access to visiting teachers. In these situations, clear arrangements were followed and support was appropriate and fit for purpose. Of 82 children who received education while in hospital, 53 (65%) received on-site provision (Table 25).

7.3 In the main, the evidence indicated that there was access to good quality provision in almost all of the settings, with some having developed a more integrated and interdisciplinary approach to planning educational and health care provision. It was noted, however, that 13 children aged 4 years and over had received no educational provision and in the case of a further 18 children, it was not known whether they had received any education during their hospital stay (Table 26).

7.4 *All children who experience a long stay in hospital – or frequent hospital admissions – should be able to access an appropriate level of education. Where this is not the case, the care plan should contain an explanation and the appropriate Education and Library Board should be notified with a view to establishing, where this is possible and appropriate, an educational programme for the child.*

7.5 In the best examples observed, children and young people were helped to maintain their school progress, regular contact was maintained by teaching staff with parents and the child's school and there were written reports which recorded the work undertaken and learning achieved by the child. In these situations, teachers and assistants were sensitive to the individual medical needs of the children and young people. They had established harmonious relationships with hospital staff and parents and working arrangements that complemented the hospital's daily routines.

7.6 The factors that contributed to the effective education of children and young people in hospital settings included:

- good teacher-staff relations;
- the establishment of an atmosphere of mutual respect that was conducive to helping children within a medical care setting;
- regular communication between teaching staff and the children's schools;
- written agreements which set out the roles of the teaching and hospital staff and detailed how working practices could promote an integrated approach to the care and education of children and young people;
- time to plan on an interdisciplinary basis;
- an appropriate balance of education and personal social care which assisted children while they were in hospital and during convalescence at home;
- the sharing and discussion of good practice;
- well organised lessons and good management of time; and
- good teaching approaches matched to individual need.

7.7 The inspection demonstrated however, that there was a need to improve the educational service to children and young people in hospital by:

- better liaison between Trusts, Education and Library Boards and their hospital based staff to develop more systematically the policy and guidance necessary to establish a clear focus on the needs of children and young people in hospital from admission to discharge;
- availing of training to promote collaborative working practices;
- regular review of the level of educational support and making adjustments to ensure that provision is sufficient to meet changes in admissions of children;

- exploring the use of information and communication technology as a learning tool and recording and maintaining links between hospital and schools;
- ensuring that parents have full written and location specific information about how their child's educational needs will be met while in hospital;
- including educational needs within the child's care plan;
- ensuring that the process for children and young people who need a statement of special education needs whilst in hospital is carried out efficiently and where possible, temporary educational arrangements are made for the child pending the completion of the statementing process.

7.8 Education and Library Boards should establish a regional forum to enable the above issues to be addressed and promote strategic discussion and consensus to:

- ***inform the development of consistent and cohesive practices in the education of children in hospital; and***
- ***create a framework that will assist hospitals in understanding the nature and importance of educational provision and how appropriate educational support can contribute to the overall wellbeing of children and young people in hospital.***



8. Workforce Planning, Staff Training and Support

Standard

There are sufficient staff with appropriate qualifications, knowledge and expertise to deliver effective services to disabled children and their families.

Workforce planning

8.1 The difficulties of planning services which potentially span several health and social care programmes have already been considered in Part 4.1-5 of this report. Workforce planning for disabled children's services is equally complex, in that more so than any other children's services, the medical, health and social care needs of disabled children require coordinated planning across a wide range of disciplines that provide services both within community and hospital settings. Although there were a number of Boards' and Trusts' documents that addressed workforce planning, these focused on discrete areas of professional practice rather than the strategic and holistic needs of patient or user groups. Even within clinical specialisms, paediatrics is a further specialist area that requires appropriate training across all hospital based disciplines. There were gaps in the multidisciplinary staffing in each of the hospitals inspected. In general, there was an insufficient pool of appropriately qualified staff to meet the needs of disabled children in hospital and the implications of this are clearly far reaching.

8.2 The Department, Boards and Trusts have already identified the need for multidisciplinary workforce planning. The Department is currently taking forward a pilot multidisciplinary workforce planning exercise to address the workforce implications of the Bamford Review (3.1). In view of the fact that part of this pilot will address the needs of child and adolescent mental health services, it is recommended that:

8.3 *As a further multidisciplinary workforce planning pilot initiative, the Department should consider taking forward the findings of this inspection in relation to workforce issues in disabled children's services.*

8.4 In their workforce planning arrangements, Boards and Trusts should identify ways in which professionals should work together to more effectively secure the necessary quality of care for disabled children and their families.

Social Work services

8.5 The need for social work support within hospitals providing services for children and young people has already been identified in Part 4.24-27. Whilst one hospital had not been able on the first trawl to recruit a social worker, in general, there did not appear to be staff recruitment or retention difficulties in hospital based social work services. Where there was no social work support for children and families, or insufficient staff to provide the full range of social work services required, the reasons for this appeared to be linked to lack of appropriate planning, poor recognition of the contribution social workers make to the care of children in hospital and their families, or pressures on resources.

8.6 Boards and Trusts should review workforce planning within Social Services to ensure that priority is given to the needs of disabled children in hospital and their families for adequate social work support.

8.7 The Department's forthcoming regional review of the Social Services workforce should take into account the findings of this inspection in relation to social work workforce issues.

Medical services

8.8 It was acknowledged that there were various and complex medical staffing issues across the region which are in the process of being considered and addressed at different levels outside the remit of the inspection. However the Inspection Team highlighted particular needs for urgent consideration:

- Medical posts in child and adolescent psychiatry to secure the current in-patient services;
- Consultant posts to take forward rehabilitative services to children and young people;

- Dually-trained consultants in child and adolescent psychiatry and learning disability to ensure quality of care in future services for learning disabled children and young people;
- More joint paediatric community and hospital based posts; and
- Consultants to be supported by multidisciplinary teams that are based on the assessed needs of children receiving the service and where necessary, include other medical staff.

8.9 The Department should take account of the above pressures as part of its ongoing assessment of specialist medical workforce needs.

Nursing services

8.10 The Inspection Team found a general shortage of registered children's nurses in all areas, in particular, mental health and learning disability. Nurse workforce planning arrangements varied within hospitals and Trusts. In one Trust an 'over recruitment' policy was in place. Nurse managers, however, in this Trust reported a problem with retention of staff as registered children's nurses left to take up senior posts in other hospitals. This was in contrast to reports from local hospitals where nurse managers stated that the transfer of pre-registration nurse training to Belfast had exacerbated recruitment problems. Managers also considered that students, once qualified, did not return to fill post in local hospitals but preferred to remain in Belfast where career prospects were perceived to be better. In a number of hospitals nurses had been recruited from overseas to cover the shortfall of local staff.

8.11 There were significant recruitment problems in the area of mental health. Pay structures encouraged experienced nursing staff to take up post in community Trusts, thereby creating a gap in service provision in acute facilities. To some extent this may be resolved with the introduction of the 'Agenda for Change', a policy paper published by the Department of Health in 2004 which sets out the Government's workforce plans for number of professional groups, including nurses. The parents of children in mental health facilities and the young people reported that they very much valued the input from registered nursing staff but were aware that staff shortages affected the level of therapeutic interventions available to them. They were also concerned that this might subsequently lengthen their hospital stay as

programmes of care or interventions may take longer to complete. In the regional children's mental health facility, bed capacity had been reduced from 20 to 16 and in learning disability services a significant dependence on bank and agency nursing staff and health care staff was evident. The Department has recently taken forward a recruitment campaign to encourage people to train as mental health nurses. This resulted in a significant increase in the numbers applying to mental health programmes.

8.12 *The Department should continue to support an increased intake into mental health nursing programmes and address shortfall and deficit issues in the children's nursing workforce both within the required disciplines and on a geographical basis.*

8.13 Workforce planning in relation to new builds in the acute sector included assessments of general nursing staff requirements. None of the workforce plans, however, specifically identified the nursing resources required for the management and provision of children's or adolescent services.

8.14 *Business plans for new builds in the acute sector should take account of the nursing resources required for the management and provision of children's and adolescent services.*

AHP services

8.15 Issues to do with the structure and organisation of AHP services that clearly had an impact on the quality of the treatment and care of children were identified in 4.38-42. Future workforce planning must take account of the right of children to receive AHP services that can respond to their individual needs. Planners at strategic and local levels should know what those needs are and be capable of identifying the range of professional expertise and the resource required in the workforce to meet those needs effectively.

8.16 *Boards and Trusts should identify the needs of disabled children including those of children in hospital and the range of AHP expertise required to meet these. The Department should ensure that there is a collaborative approach to multiprofessional AHP workforce planning between the Department, Boards and Trusts that will enable strategic and operational responsibilities to be fulfilled.*

Psychology services

8.17 There is a general shortage of psychologists in all areas of children's services. Some hospitals had no access to services, others had sessional support which was in general not sufficient to meet demands or to provide help and support to children and their families when this was most needed (4.43-44). Although there has been a recent increase in the numbers of psychologists in training this is unlikely to meet current and future need in children's services.

8.18 *The findings of this inspection in relation to psychology services for disabled children in hospital should be taken into account by the Department's workforce planning review of psychology services.*

Pharmacy services

8.19 Paediatric pharmacy is a critical area for future workforce development. The Department's current review of the HPSS workforce will provide an updated review of the pharmacy workforce. In view of the importance, however, of pharmacy services to the care and treatment of children in hospital and to effectively meet the requirements of the recommendation set out in 4.45-6, the Inspection Team made the following recommendations:

8.20 *The Department's pharmacy workforce planning review should contain a recommendation for the development of specialist expertise in paediatric pharmacy services.*

8.21 *The Northern Ireland Centre for Post Graduate Pharmaceutical Education and Training should seek to develop a curriculum to support paediatrics.*

8.22 *In the commissioning, planning and delivery of services, Boards and Trusts should ensure that there is a dedicated pharmacist resource to support clinical paediatric services.*

Staff induction, supervision and appraisal

8.23 Most hospitals had an induction programme for all new staff. There were examples of good general induction information packs and ward specific induction arrangements and information for nurses. This

was commended but did not always exist for other professionals in the hospital team. In a number of situations, doctors' handbooks required to be updated.

8.24 *Up to date induction handbooks should be available for all key professional disciplines within hospitals.*

8.25 Annual appraisal had been established in most hospitals for a range of staff. Some Trusts were commended for having successfully introduced annual appraisal for consultant medical staff. Appraisal was not generally afforded to all disciplines within hospitals.

8.26 A number of Trusts were commended for having introduced national appraisal processes for medical Consultants who also reported that they had opportunities for continuing professional development and, in some cases, peer support. Social workers consistently received regular professional supervision and protected time was set aside for this. The Inspection Team noted that in some cases there were supportive arrangements, such as mentoring, in place for newly qualified nurses. Established nursing staff, however, rarely had formal clinical supervision and protected time had generally not been allocated to support staff in this way. In comparison with the other remaining professions, AHP staff had more regular supervision, although this varied between hospitals and in only a few situations had protocols been developed and protected time allocated to this process. Most psychologists reported that they had access to professional supervision and in some situations, they were able to avail of peer group support.

8.27 Supportive appraisal and clinical supervision arrangements provide an opportunity for reflective practice, specialised learning and professional development.

8.28 *Trusts should establish a policy that supports annual appraisal and protected time for clinical supervision of all professional staff. They should promote the implementation of the policy across all children's services.*

Staff development and training

8.29 Each of the hospitals and their respective Boards had made available a range of training for professional groupings as part of their staff development and annual training programmes. Social workers

had assisted in child protection training within hospitals although in a number of situations front line hospital staff were not familiar with child protection issues, policies and procedures. Social workers had also availed of and contributed to specialist training to improve skills and knowledge in complex clinical areas. Medical staff in each hospital had access to opportunities for continuing professional development. There were also examples of nurse training initiatives aimed at preparing nurses to take on new roles and enabling them to gain knowledge and skills quickly through the shortened branch children's programme. These were commended. In most of the larger hospitals there was evidence of good links with Nurse Education Commissioning Groups, Provider Support Units and the universities.

8.30 In terms of the range of qualifying training available to key professionals in children's services, however, it was noted that there was no AHP undergraduate training module on children and young people with mental health needs (see 4.41). There were also limited training opportunities for individual AHPs working with disabled children. Those that are available are delivered mainly through profession-specific national bodies. This deficit can lead to the feeling of isolation for AHPs working within under resourced services.

8.31 In the key area of multidisciplinary working, including assessment and care planning for children, there were few formal training initiatives. In at least one situation, however, a medical Consultant had introduced the team to a multidisciplinary assessment approach which worked well. This was commended.

8.32 In light of the range of training issues raised by the inspection the following recommendations were made.

8.33 *Boards should ensure that there is an annual training needs analysis to identify the training and development needs of all staff working in children's hospital services. In addition to clinical care and individual staff development needs there should be a continuing emphasis on training in:*

- *child protection;*
- *multidisciplinary assessment and care planning and review;*
- *and*
- *children's rights and safeguarding these in hospital (see 10.13).*

8.34 *Boards should address with the Educational Partnership Forums the matter of AHP undergraduate training in working with children who have mental health needs. Boards and Trusts should also work in partnership with the Department and other relevant agencies to provide post qualifying training programmes for AHPs working with disabled children.*

9. Communication and Information

Standard

The hospital provides accessible and relevant information about its services to disabled children and their families.

9.1 The provision of appropriate and accessible information for service users is an important part of the wider responsibilities of all Trusts. Good information about the range of services available, the Trust's responsibilities and other matters to do with the delivery of services can be empowering for children and their families. Clear communication between professionals and agencies who are responsible for providing services and between professionals and those receiving services, will also help to determine the quality of service experienced by children and their families.

9.2 Professional communication issues between

- Trusts and professional staff;
- hospital staff and children and their families; and
- hospital and community services

were considered in Parts 4 and 5 of this report. The paragraphs to follow are concerned with more general information and how Trusts and hospitals made information available and accessible to children and their families.

Information

9.3 Hospital Trusts' Annual Reports contained information about children's services and included details of new initiatives, developments and the future planning of services. The Annual Reports of community Trusts provided general information about services for disabled children, although these did not always cover the full range of services provided. These reports were generally widely available within hospitals and could also be accessed on Trusts' web-sites.

9.4 The following examples of information initiatives were commended by the Inspection Team:

- displays containing information about medical conditions; community and voluntary services; child protection and disability;
- welcome packs for children and parents;
- in one situation, results of children's survey displayed in a child friendly manner; and
- attractive information booklets for children about the hospital's routines.

9.5 Some parents reported that they would have liked written information for themselves and their children about the various roles of professional staff in the hospital. Where other deficits in information occurred, these were generally related to a lack of suitable information for young people about health and health education matters.

9.6 Hospitals should:

- ***develop information for children, young people and their families about their hospital stay, the roles of professional staff within the hospital and appropriate services available in the community; and***
- ***ensure that appropriate health and health education information is available for young people during their stay in hospital.***

Complaints, access to patient information and consent to treatment

9.7 Most hospitals had information about how to complain, either on poster display or in leaflet form. Within children's services there were few examples of user friendly information explaining how to access information held on the child's case file. Indeed, some of the parents who were interviewed were not aware that they could access their children's records. In situations, however, where parents exercised this right, they were pleasantly surprised at the extent of work undertaken for or on behalf of their children. Information on consent to treatment for children and young people was not widely available.

9.8 Information on complaints, access to personal records and consent to treatment should be sensitively communicated within the general written information given to parents and children.

Communication with children and families

9.9 Most hospitals were able to access people skilled in Makaton and alternative forms of communication. There was generally little information available, however, on the types of assistance available to children and families with communication difficulties or those whose first language was not English. Written information and other forms of media can serve to enlighten families about what is available and to reassure them that their communication needs will be met,

9.10 Hospitals should produce information in leaflet form and other media about the range of assistance available to patients and families who by reasons of disability or ethnicity may experience communication difficulties.



10. Equality and Human Rights

Standard

The Board and Hospitals Trust are fulfilling their statutory duties in respect of requirements under human rights and equality legislation. Human rights and equality principles are integrated into practice within all aspects of services for disabled children.

The rights of children

10.1 The United Nations Convention on the Rights of the Child (the UN Convention) places disabled children firmly within the full implementation of the rights of the Convention.

10.2 Disabled children in hospital experience an added level of dependency. Those responsible for their care and treatment need to give careful consideration to safeguarding and promoting their rights. In summary¹, Article 23 of the UN Convention states that

‘a child with a physical or mental disability should enjoy a full and decent life, in conditions that ensure dignity, promote self-reliance and facilitate the child's active participation in the community. Children with disabilities have the right to special care, designed to ensure that the child receives education, training, healthcare services, rehabilitation services, preparation for employment, and recreation opportunities in a manner conducive to the child's achieving (*sic*) the fullest possible social integration and individual development, including cultural and spiritual development’.

10.3 This is the ultimate standard by which services and those who deliver them must be measured.

10.4 The Disability Discrimination Act 1995 (DDA) promotes the rights of disabled people to access the full range of public services. The Northern Ireland Act 1998 upholds the right of disabled people to be treated equally in all aspects of public life. The life quality of disabled children and their families, however, may at times be more affected by attitudes and disabling environments, rather than a lack of adherence to the letter of the law. Children who have a disability can be particularly vulnerable to unhelpful attitudes and environments that emphasise rather than minimise their dependency.

1 The summary statements of the rights of children under the UN Convention in this part of the report are those drawn up by the Commission for Social Care Inspection (CSCI), the national registration and inspection agency for social care services in England and Wales. The full text of the statements can be found on the CSCI internet site www.csci.org.uk.

Charters for children and young people

10.5 In the main, the Inspection Team found that staff who were immediately involved in the treatment and care of children and young people had a clear child and family focus. The rights of children were respected and valued. Some hospitals had developed Charters for Children which set out the child's rights and what children could expect whilst in hospital. These were commended. Where young people were provided with services, there were no equivalent charters aimed specifically at their age group, although most general hospitals had the DHSS Patient's Charter on display. The needs of young people and their rights can differ in important respects from those of children or adults, for example in areas such as consent to medical treatment and matters to do with the confidentiality of information. It would be helpful to see these rights expressed in the form of a charter developed specifically to address their needs.

10.6 *Where hospitals provide services for young people, they should develop in partnership with young people, a Charter which sets out their rights and how they can expect these to be promoted whilst in hospital.*

Advocacy services

10.7 Article 12 of the UN Convention promotes the rights of children to be heard in all matters affecting them. Some hospitals had established forms of group support for young patients, and 2 hospitals had developed an advocacy service, one of which was a dedicated child advocacy service. This was commended. Disabled children and young people and particularly those in hospital or other care settings can face enormous challenges in getting their voice heard. It is vital that they are provided with support and encouragement to enable this to happen.

10.8 *Hospitals providing children's and young people's services should encourage pro-active approaches, such as advocacy initiatives, which promote the rights of children and young people and enable their voice to be heard in any matters that concern them.*

Play, leisure and social activities

10.9 Article 31 of the UN Convention upholds the right of children to relax and play and enjoy a range of activities, regardless of their circumstances. This is a particular concern when children spend long periods of time in hospital and where the focus on the child's disability or illness may limit or detract from promoting their rights to social and leisure activities. A recommendation in relation to this has already been made in 6.5 of this report.

10.10 Good practice example:

The Royal Belfast Hospital for Sick Children was commended for its commitment to promoting innovative approaches to play. The hospital had established dedicated play specialists in each of the children's wards who provided a range of play and social activities. This helped to alleviate children's worries and distress and enabled procedures to be explained in a child friendly manner. The play specialists were integrated into the multidisciplinary team approach to children's care and used visual and multisensory material to prepare children for treatment and surgery.

Issues impacting on the rights of children

10.11 There was a strong commitment in the hospitals inspected to promoting the rights and equality of disabled children. The full expression of children's rights and equality issues were, however, constrained by the matters presented in Figure 2, which have already been considered in this report.

10.12 *Hospitals caring for children should examine their services for children in the light of the inspection findings and in the context of the need to promote the human rights and equality of disabled children as set out in Figure 2. They should report any shortcomings to their respective Trusts and Boards with a view to agreeing strategies to address these.*

10.13 In general, there was a need for continuous staff training in children's rights and equality issues in order that matters such as those listed in Figure 2 and their implications for children's rights may be readily identified and acted upon by staff. A recommendation to this effect has been made in 8.33.

Figure 2: Inspection findings and implications in terms of the UN Convention¹ on the Rights of the Child

Matters for attention	Paragraph references	UN Convention Extracts from summary statements
Access by children to the full range of expertise necessary to promote their health and the support of families	3.3 8.1	Article 24 Children have the right to the highest attainable standard of health, and to facilities for the treatment of illness and rehabilitation of health
Prolonged admissions of children or young people to specialist mental health or learning disability hospitals and lack of appropriate community care provision.	3.3 – 3.8 3.16-3.17	Article 23 A child with a physical or mental disability should enjoy a full and decent life, in conditions that ensure dignity, promote self-reliance and facilitate the child's active participation in the community
Buildings and institutional practice	3.7 6.21	Article 23 Children have a right to a standard of living adequate for their physical, mental, spiritual, moral and social development.
Children and young people in adult wards	3.9 – 3.14 6.9 – 6.10	Article 3 Administrative measures shall be appropriate to ensure each child such protection and care as is necessary for his or her wellbeing
Use of hospital as a respite placement	3.22- 3.24	Article 23 Children with disabilities have the right to special care, designed to ensure that the child receives healthcare services and recreation opportunities in a manner conducive to the child's achieving the fullest possible social integration and individual development.
Child protection	4.16 –4.22 5.38 –5.41	Article 19 Child protection should include support for the child and their carers, prevention, identification, reporting referral, investigation and treatment.

¹ See footnote on UN Convention summary statements (Page 13).

Matters for attention	Paragraph references	UN Convention Extracts from summary statements
Care planning and review of children	5.4 5.19 5.31–5.33	Article 25 A child placed for care, protection, or treatment of physical or mental health, has the right to periodic review of the treatment provided and all other circumstances relevant to his or her placement.
Addressing 'whole child' needs	5.10– 5.12 5.19	Article 23 Children with disabilities have the right to special care in a manner conducive to the child's achieving the fullest possible social integration and individual development, including cultural and spiritual development.
Involvement of children in care planning and advocacy arrangements	5.17 10.7 –10.8	Article 12 Any child who is capable of forming his or her own views shall be afforded the right to express those views freely in all matters affecting them. The views of the child shall be given due weight in accordance with the age and maturity of the child.
Access to creative therapies	6.4 – 6.5	Article 13 Children have the right to freedom of expression. They have the right to seek, receive and impart information and ideas of all kinds, orally, in writing or in print, through art, or through any other media of the child's choice
Play, leisure and social outlets for children and young people	6.4 - 6.5 10.9	Article 31 Children have the right to rest and leisure, to engage in play and recreational activities appropriate to their age, and to participate fully in cultural life and the arts. Appropriate and equal opportunities shall be encouraged in the provision of cultural, artistic, recreational and leisure activity.
Transport for families and visits home by the child	6.5 6.11– 6.12	Article 9 A child separated from one or both parents has the right to maintain personal relations and direct contact with both parents on a regular basis, unless this is contrary to the child's best interests.

Matters for attention	Paragraph references	UN Convention Extracts from summary statements
Use of time out/restriction of liberty	6.13– 6.14	Article 37 No child shall be deprived of his or her liberty unlawfully or arbitrarily Every child deprived of liberty shall be treated with humanity and respect for the inherent dignity of the human person, and in a manner which takes account of the needs of a person of his or her age.
Access to education	7.3 – 7.8	Article 28 Every child has the right to education. This includes making educational and vocational information and guidance available to children, making higher education accessible to all on the basis of capacity by all appropriate means
Qualifications of staff and professional supervision practice	8.1 8.25 –8.28	Article 3 Institutions, services and facilities responsible for the care and protection of children shall conform with the established standards, particularly for safety, health, the number and suitability of staff, and competent supervision.

Equality Initiatives by Boards and Trusts

10.14 Each Board and Trust had an Approved Equality Scheme and programme to assess the impact of existing and new policies in accordance with Section 75 of the Northern Ireland Act. There had been some form of training in each Board and Trust on these issues. Several initiatives were commended, including:

- equality and human rights road shows;
- board wide forum for sharing good practice in equality and human rights issues;
- multidisciplinary equality steering groups;
- clear emphasis on the mainstreaming of human rights considerations in all areas of policy and practice;
- staff trained in access issues under DDA to conduct internal audits; and
- designated senior staff with responsibility for DDA implementation.

10.15 The Inspection Team noted that groups established by Boards and Trusts to implement the Act had not met for some time and this lack of regular strategic focus on disability had the potential for DDA matters to be approached in a reactive rather than proactive manner.

10.16 *Disability Discrimination Act Implementation Groups should reconvene and meet on a regular basis to identify areas for action and agree strategies for promoting equality in disability issues.*

10.17 There was also scope for a more specific policy emphasis on promoting the rights and equality of disabled children in hospital, particularly those who stay for long periods. This should inform everyday practice in the care of children and the support of families while their child is in hospital.

10.18 *Hospitals caring for children should develop a policy framework which sets out the rights of disabled children and provides guidance for staff on promoting rights and equality based care while the child is in hospital.*



11. Conclusion and Summary of Recommendations

Conclusion

11.1 This inspection has highlighted many areas of good practice in the care of disabled children while they are in hospital. But the care of the child is a continuum that starts with policy makers, commissioners and planners of services and extends beyond the hospital into the community. The care of the child is not just about the child. It's about strengthening and supporting families. It's about ensuring that there are proper clinical, social, educational and cultural networks in place to make the child's hospital stay as effective but as short as possible. The recommendations set out below are aimed at providing 'Care at its Best' at all of these levels. It is important that the Department, Boards and Trusts should now address the findings of this report as part of the pursuit of high quality children's services. The disabled children, their families and their advocates who contributed to the inspection, had an expectation that it would enhance services in the future. They deserve to see that expectation fulfilled.

Summary of the recommendations

THEMES TO INFORM STRATEGIC PLANNING FOR DISABLED CHILDREN

Recommendation	Page
1 Boards should give priority to establishing Tier 4 child and adolescent mental health services. The services should provide for full and intensive multidisciplinary assessment, treatment and care of children in facilities that are specifically designed for specialist interventions (3.4).	12
2 The Departmental Regional CAMHS Development Group should take account of the findings of this inspection to inform strategic planning of services and the development of new inpatient provision for children and young people with mental health needs (3.6).	12

Recommendation	Page
3 In the context of the planned reprovision of regional inpatient services for adults and children with learning disabilities, commissioning Boards should formally recognise the needs of young people as being distinct from those of children or adults and should address these as a matter of urgency. (3.8).	13
4 Boards and Trusts should monitor the numbers of children and young people admitted to adult wards and the length of their stay with a view to determining whether there are sufficient children's specialist inpatient places and community based provision to meet their needs. Where there are deficits these should be addressed in a cross Board coordinated manner (3.13).	14
5 Boards should develop a regionally agreed protocol for referrals of young people aged 14 years and over to hospital and other clinical and community services. This should promote consistent approaches that take account of the young person's age and stage of development and enable appropriate expertise to be available to meet each young person's needs (3.15).	14
6 The 'Children Matter' Task Force should in its Phase 2 implementation consider the impact of impending reductions in children's specialist hospital places on current and planned community residential and other community provision with a view to informing strategic planning for future services to disabled children (3.17).	15
7 The Department should agree a regional policy to address the emerging needs of technology dependent children for community care services, including the skills base required in staff, parents and carers, to ensure minimum delay in progressing care plans for these children (3.21).	16
8 A regional review of respite provision for disabled children should be progressed by the Department without delay as part of the Implementation of the Children Matter Phase 2 initiative (3.24).	17