THE COMMISSIONING ARRANGEMENTS, STRUCTURE, ORGANISATION AND MANAGEMENT OF THE HOSPITAL'S SERVICES

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 (4.5).	 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 (4.5). 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 (4.7). 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 registers of disabled children as a matter of urgency (4.9). In view of the importance of the links between hospital and community services for children who require periods of hospital care, the CSP should include representatives from hospitals providing children's services. (4.11). 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 (4.13). A designated senior manager within Trusts with a lead responsibility for children's services should be established in hospitals providing children's inpatient services to: promote an integrated approach to clinical and social care 	Rec	ommendation P	ag
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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;

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 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 (4.15).

- 15 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 (4.18).
- 16 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 (4.20).
- 17 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 (4.22).
- 18 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 (4.27).
- **19** Patient surveys should take account of the social care support needs of patients and their families (4.28)
- 20 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 (4.30).

Rec	ommendation	Page
21	Trusts should consider establishing joint paediatric and community based medical consultant posts to promote continuity of care for children and their carers (4.32).	27
22	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 (4.35)	28 5
23	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 (4.42).	30
24	Boards and Trusts should establish arrangements to prioritise the timely provision of psychology support services to disabled children and young people in hospital (4.44).	30 I
25	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 (4.46).	31
26	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 (4.49).	
27	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 (4.50).	32
28	Trusts should develop full multidisciplinary audit and monitoring of services for children in hospital (4.53).	33

Recommendation	Page
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The Department's Standards and Guidelines Unit should take forward the development of multidisciplinary standards to inform the care of disabled children in hospital (4.57).

ASSESSMENT AND CARE PLANNING

- 30 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 'Cooperating 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 neonatal children); and
 - discharge arrangements (5.3).

Rec	Acute hospitals providing children's services should establish fast tracking arrangements for children needing frequent admissions to hospital (5.6).	Page 36
32	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 (5.12).	38
33	Hospitals should, as part of the assessment process include a multidisciplinary assessment of risk on each child and young person which addresses the issues outlined in 5.14 (5.15).	39 I
34	Each disabled child should have a 'child centred', focused care plan based on the multidisciplinary assessment which:	40
	• covers the period from admission through to discharge;	
	 takes account of the needs of the 'whole' child - includin 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 professiona with timescales and arrangements for review; and	Ι,
	• 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 (5.19).	
35	As part of each child's care plan, a structured discharge process should be established which:	41
	• identifies a professional to take the lead in planning and coordinating discharge arrangements;	

takes account of the ongoing support needs of children

and families;

Recommendation Page

 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 (5.22).
- Trusts should consider whether it would be helpful to take forward the assessment and care planning recommendations of this report on a regional basis with a view to developing jointly agreed protocols and proformas (5.23).
- 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 (5.25).
- 38 Hospitals should ensure that they are fulfilling the notification 43 requirements of the Children Order. This should apply to all children, including neo-natal 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 (5.28).
- 39 As children and parents may not be aware of the legal requirements regarding notification and the reasons for these, hospitals should liase 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 (5.30).
- 40 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 (5.33).

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41 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 (5.37).
- 42 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 (5.40).
- 43 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 (5.41).
- 44 To assist multidisciplinary working in children's services, hospitals should consider establishing a single continuous record to which all disciplines contribute and which contains the child's multidisciplinary assessment and care plan (5.45).
- **45** Hospitals should establish a policy, in consultation with parents, on the use of the PCHR when children are admitted to hospital (5.47).
- 46 Hospitals should ensure that when files are not in immediate 47 use they are at all times securely stored in accordance with agreed procedures to prevent breach of patient confidentiality (5.49).

THE RANGE AND QUALITY OF SERVICE PROVISION

nec	ommendation	rage
46	The needs of parents and families of disabled children for	49
	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	or
	their child at home (6.2).	

- 47 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 (6.5).
- 48 Hospitals providing children's services should establish 50 arrangements that promote best practice in each of the areas outlined in 6.6 and ensure that the needs of children and their families are addressed in a sensitive manner (6.7).
- **49** 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; and
 - there is a discharge plan to move the child quickly to a suitable alternative placement (6.10).

Recommendation Page

50 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 on ensuring that children and families are not disadvantaged by events outside their control (6.12).

- 51 Where a hospital has a designated facility or makes use of behaviour management techniques to 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 (6.14).
- 52 Hospitals caring for disabled children should explore whether 54 children, parents and siblings would benefit from group support approaches and, if they wish, ensure that they are linked into hospital based or the group support initiatives of other agencies. The needs of parents and siblings for individual support should also be addressed (6.18).

Recommendation Page

53 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 (6.20).

54 Trusts should ascertain whether any of the matters identified 55 in 6.22 apply to their hospitals and seek with parents, children and disability representative groups to identify areas of the physical environment that should be improved (6.24).

EDUCATION PROVISION

- 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 (7.4).
- **56** Education and Library Boards should establish a regional forum to enable the issues identified in 7.7 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 (7.8).

WORKFORCE PLANNING, STAFF TRAINING AND SUPPORT

initiative, the Department should consider taking forward the findings of this inspection in relation to workforce issues in disabled children's services (8.3). 58 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 (8.4). 59 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 (8.6). 60 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 (8.7). 61 The Department should take account of the pressures outlined in 8.8 as part of its ongoing assessment of specialist medical workforce needs (8.9). 62 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 (8.12). 63 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 (8.14). 64 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 allow strategic and operational responsibilities to be fulfilled (8.16).	Reco 57	ommendation As a further multidisciplinary workforce planning pilot	Page 61
should identify ways in which professionals should work together to more effectively secure the necessary quality of care for disabled children and their families (8.4). 59 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 (8.6). 60 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 (8.7). 61 The Department should take account of the pressures outlined in 8.8 as part of its ongoing assessment of specialist medical workforce needs (8.9). 62 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 (8.12). 63 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 (8.14). 64 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 allow strategic and		initiative, the Department should consider taking forward the findings of this inspection in relation to workforce issues in	
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	64	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 allow strategic and	64

Rece 65	ommendation 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 (8.18).	i ge 65
66	The Department's pharmacy workforce planning review should contain a recommendation for the development of specialist expertise in paediatric pharmacy services (8.20).	65
67	The Northern Ireland Centre for Post Graduate Pharmaceutical Education and Training should seek to develop a curriculum to support paediatrics (8.21).	65
68	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 (8.22).	65
69	Up to date induction handbooks should be available for all key professional disciplines within hospitals (8.24).	66
70	Trusts should establish a policy that supports annual appraisal and protected time for the clinical supervision of all professional staff. They should promote the implementation of the policy across all children's services (8.28).	66
71	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:	67
	 child protection; multidisciplinary assessment and care planning and review; and children's rights and safeguarding these in hospital (8.33). 	
72	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 (8.34)	68

COMMUNICATION AND INFORMATION

		nendation spitals should	Page 70
	•	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 (9.6).	,
74	con with	ormation on complaints, access to personal records and . sent to treatment should be sensitively communicated hin the general written information given to parents and dren (9.8).	71
75	oth pati	spitals should produce information in leaflet form and er media about the range of assistance available to ients and families who by reasons of disability or ethnicity y experience communication difficulties (9.10).	71
EQU	IALIT	TY AND HUMAN RIGHTS	
76	sho whi	ere hospitals provide services for young people, they uld develop in partnership with young people, a Charter ich sets out their rights and how they can expect these to promoted whilst in hospital (10.6).	74
77	sho initi peo	spitals providing children's and young people's services uld encourage pro-active approaches, such as advocacy atives which promote the rights of children and young ople and enable their voice to be heard in any matters that cern them (10.8).	74
78	for con of con any	spitals caring for children should examine their services children in the light of the inspection findings and in the text of the need to promote the human rights and equality disabled children as set out in Figure 2. They should report a shortcomings to their respective Trusts and Boards with a system of the strategies to address these (10, 12).	75 ,

Recommendation	Pag	g

- 79 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 (10.16).
- 80 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 (10.18).

APPENDIX A

INSPECTION OF SERVICES FOR DISABLED CHILDREN IN NORTHERN IRELAND

1. INTRODUCTION

- 1.1 The Children Order 1995 sets out the responsibilities of Boards and Trusts to provide services to children in need and their families. The powers and duties under the Children Order require disabled children to be treated as children first and to have access to a range of generic and specialist service provision in their own homes and in local communities.
- **1.2** This inspection is the first regional inspection of services for disabled children in Northern Ireland and will focus mainly on the provision of social care services. Health and education services are also vital, however, to ensuring that disabled children gain maximum benefits within the full range of life situations. The Children Order empowers Trusts to combine assessments under the Order with those under existing health and education legislation affecting disabled children. The inspection will therefore consider the extent to which social care services promote multidisciplinary and integrated approaches to care planning and assessment in partnership with children, parents and voluntary agencies.
- **1.3** A multidisciplinary team will be established to take forward the inspection which will be conducted in two stages. The first stage will consider children with disabilities who have been accommodated in hospital for a consecutive period of at least three months. The second stage¹ will consider services for disabled children in the community.

2. AIMS AND OBJECTIVES

- **2.1** The aim of the inspection is to assess the extent to which social care services for disabled children meet statutory requirements and reflect standards of best practice.
- **2.2** The objectives are to:
- a) consider the structure, organisation and management of services for disabled children;
- 1 This has been deferred indefinitely.

- b) determine the extent to which Boards and Trusts are complying with the requirements of the Children Order in respect of identification, assessment and care planning in relation to the social care needs of disabled children;
- c) consider how services engage children and their families in partnership approaches and promote multidisciplinary working with key agencies and professionals;
- d) examine the responsiveness of services to the needs of disabled children, the appropriateness of service provision and the choices available to children and their families; and
- e) assess the extent to which services respect the lifestyle and culture of disabled children and promote equality of social, leisure and life opportunities.

3. SCOPE OF THE INSPECTION AND THE PERIOD COVERED

3.1 Stage 1 of the inspection will consider disabled children who were admitted to hospital for a consecutive period of not less than three months during the period 1 April 2000 to 31 March 2002.

4. STANDARDS

- **4.1** The inspection will consider practice against agreed standards in relation to each of the following:
- the structure, organization and management of services;
- the range and quality of service provision;
- assessment and care planning arrangements, including multidisciplinary and partnership working; and
- communication and information.



5. METHODOLOGY

5.1 A reference group¹ comprising representatives of HSS Boards, Trusts, voluntary agencies, and service users will be established to advise on the inspection process, including the instruments to be used.

5.2 The inspectors will:

- collate pre-inspection baseline data on the number and circumstances of disabled children, who during the target period were admitted to hospital for a period of 3 consecutive months and those who received community care services;
- undertake a census of disabled children who have been in hospital for a period of 3 consecutive months on the first day of the commencement of the Phase 1 fieldwork;
- carry out a desk analysis of current policies and procedures in each HSS Board and Trust;
- interview senior managers and other personnel in Boards and community and hospital Trusts regarding the commissioning, structure, management and organisation of services;
- select for analysis a sample of case files of children currently in hospital or admitted to hospital during target period. A sub sample will be chosen for in depth examination. The inspectors will interview:
 - children;
 - parents, carers and families;
 - staff within the relevant range of disciplines; and
 - key partnership agencies and user representative groupings.

6. FIELDWORK LOCATIONS

6.1 The pre-inspection information returned by Trusts will determine the number of hospital sites to be visited by the Inspection Team. Access to hospital staff, wards and facilities will be arranged directly with the Chief Executive of each Trust.

Coordinators were also appointed from each Board, community and hospital Trust to advise on the standards, assist the pre-inspection data collections and, in the case of the hospitals selected for inspection, coordinate the administrative arrangements for the Inspection Team.
OFFICIAL-SENSITIVE-PERSONAL

APPENDIX B

THE INSPECTION TEAM

Inspection Manager

Mrs Maire McMahon, Assistant Chief Inspector, Social Services Inspectorate, DHSSPS

Project Leader

Ms Jacqui McGarvey, Principal Social Worker, seconded to the Social Services Inspectorate, DHSSPS

Inspection Team

Mrs May Anderson, Sessional Inspector, Social Services Inspectorate, DHSSPS

Ms Una Boylan, Professional Advisor to the Inspection, Allied Health Professions, by contract to Medical and Allied Branch, DHSSPS

Mr Ray Gordon, Lay Assessor

Dr John Hunter, Inspector, Education and Training Inspectorate, DENI

Dr Patricia McDowell, Deputy Principal Statistician, Community information Branch, DHSSPS

Dr Maureen Watson, Senior Medical Officer, Advisor to the Inspection on Medical and Psychology Services, seconded to Medical and Allied Branch, DHSSPS

Mrs Fiona Wright, Specialist Nurse Manager, Children's Nurse Advisor to the Inspection, seconded to Nursing and Midwifery Advisory Group, DHSSPS

Assisted by

Dr Hilary Harrison, Inspector, Social Services Inspectorate, DHSSPS

Mrs Nuala McArdle, Officer for the Allied Health Professions, DHSSPS

Mr Ken Wilson, Inspector, Social Services Inspectorate, DHSSPS

Policy Advisor

Dr Hilary Harrison, Inspector, Social Services Inspectorate, DHSSPS

Reference Group

Mrs Margaret Black, Assistant Director of Social Services, NHSSB

Mrs Arlene Cassidy, Director, PAPA

Ms Jennifer Creegan, Senior Clinical Psychologist, Down and Lisburn Trust

Dr Brid Farrell, Consultant in Public Health, SHSSB

Mrs Arlene Greene, Team Leader, Sensory Support Services, Foyle Trust

Mr Bill Halliday, Director, Equality Commission

Dr Sandi Hutton, Consultant Community Paediatrician, Foyle Trust

Ms Geraldine Kerr, Acting Operations Manager, Sargent Cancer Care for Children NI

Mrs Marina Monteith, Institute of Child Care Research, QUB

Mr Aidan Murray, Assistant Director of Social Services, EHSSB

Dr Janet MacPherson, Consultant Psychiatrist, Muckamore Abbey Hospital

Mrs Nuala McArdle, Officer for the Allied Health Professions, DHSSPS

Ms Tonya McCormack, Regional Children Services Development Manager, The Cedar Foundation

Mr David McDonald, Service User

Mr Brendan McKeever, Facilitator, Family Information Group

Dr Ian McMaster, Medical Officer, DHSSPS

Mrs Theresa Nixon, Assistant Director of Social Services, EHSSB

Mrs Nuala Norris, Contact a Family, NI

Mr Ken Wilson, Inspector, Social Services Inspectorate, DHSSPS

APPENDIX C

REGIONAL MULTIDISCIPLINARY INSPECTION OF SERVICES FOR DISABLED CHILDREN IN HOSPITAL

Draft standards and criteria

Introduction

These standards and criteria have been developed to assist the process of inspection. They provide a draft framework of best practice that will enable the members of the multidisciplinary Inspection Team to consider services for disabled children in a consistent and systematic way, as well as informing the planning and delivery of services. There are seven key standards, each of which is supported by a number of 'criterion' statements. These statements are the components that the inspectors will consider in determining the extent to which services comply with the expectations contained in the standards.

The standards and criteria have been developed in consultation with the inspection reference group and have been informed by the views of disabled children, their families and advocates, HSS Boards' and Trusts' representatives and voluntary agencies, as well as a wide body of literature and research in the field of disability. It is intended that the findings of the inspection will build on this work to establish a comprehensive quality standards framework to inform the future development of services for disabled children.

Terminology

In the field of disability, language is particularly important as it encapsulates current thinking and sensitivities and helps to form attitudes. What is considered to be acceptable language can change over time. It is essential to keep abreast of such changes and the reasons for them. It is vital that language and terminology should at all times respect and reflect the views of disabled children, their families and the organisations that work on their behalf.

The Inspection Team gave careful consideration to the use of the terms 'disabled children' and 'children with a disability' to describe the population of children who are the focus of this inspection. Both terms are in current use and both have validity. Having consulted widely, however, the Inspection Team and the members of the reference group agreed to adopt the term 'disabled children' throughout the inspection

documentation. This was the preferred option of disabled children and their advocates. The term derives from the social model of disability, which highlights and recognises the part society plays in disabling individuals by virtue of its attitudes, social norms and physical barriers.

Finally, as in the Children (NI) Order 1995, the terms 'child' or 'children' are used throughout the documentation to describe children or young people up to the age of 18 years. Where the standards refer to 'family' or 'families', this should be interpreted as including parents, siblings or, where appropriate, extended family and non-relative carers.

Definition of disability

Definitions of disability are many and varied. They tend to change over time to reflect, for example, newly identified conditions, developing clinical knowledge and increasing social awareness. In 2000, a regional project was set up by the four Health Social Services Boards (Boards) to prepare for the establishment by Health and Social Services Trusts (Trusts) of a 'Children with a Disability Register' – a statutory requirement under the Children (NI) Order 1995. Having considered a number of definitions currently in use and consulted widely on this issue, the Inspection Team and the members of the reference group decided that the definition adopted by the 'Register of Children with a Disability Project' should be used (with minor modifications) to describe the children to be included in the inspection. This definition has received wide support throughout Northern Ireland:

'A child/young person is disabled if he/she has a significant* impairment** and without the provision of additional assistance, resources and information, would be disadvantaged/restricted or prevented from participating in the life of the community, both in the manner which might be reasonably expected and in comparison to other children of similar age, respecting individual culture and circumstances'.

*significant

As the definition of disability implies, 'significant' is determined by the impact of the impairment on the quality of life for the child and his/her family being such that the level of help, resources and information required is likely to be greater than that for children or young people of a similar age, culture and circumstances and their families.

**impairment

Impairment is 'a loss or abnormality of a body structure or of a physiological or a psychological function' (World Health Organisation), i.e.

- sensory (hearing and/or visual) impairment
- communication impairment (including language disorder)
- developmental delay
- learning difficulties
- physical impairments
- severe illness
- severe mental health problems
- emotional and behavioural difficulties

Legislation underpinning the standards

In addition to the standards which have been drawn from best practice, policy guidance and professional literature, a number of standards and criteria have been derived from the following main areas of legislation which impose certain statutory duties on Boards and Trusts:

- the Chronically Sick and Disabled Persons (NI) Act 1978;
- the Mental Health (NI) Order 1986;
- the United Nations and Convention on the Rights of the Child 1989;
- the Disability Discrimination Act 1995;
- the Children (NI) Order 1995;
- the Education (NI) Order 1996;
- the Human Rights Act 1998;
- the Northern Ireland Act, Section 75 1998;
- Code of Practice on the Identification and Assessment of Special Educational Needs 1998; and
- the Carers and Direct Payments Act (NI) 2002.

Within the standards, the above legislation is referenced in an abbreviated form e.g. 'The Children Order'.

Values and Principles

A number of important themes have been drawn from the legislation and relevant literature. These are summarised in the following values and principles statements which have informed the development of the standards:

- 1. Disabled children are children first.
- 2. Listening to disabled children and their families is crucial to ensure their full participation when decisions are being made that affect them.
- 3. Disabled children are entitled to express their individuality and to enjoy the opportunities for play, leisure and social activities the same as other children.
- 4. Disabled children are particularly vulnerable due to their disabilities. The design and delivery of services should therefore promote and safeguard their well-being.
- 5. Services should promote the inclusion and full citizenship of disabled children and be provided within an ethos that maximises their life chances, life opportunities and independence.
- 6. Disabled children must not be discriminated against by those planning, providing goods, facilities or services.
- 7. Services should be planned and delivered in ways that respect the personal dignity of disabled children, their social and cultural backgrounds, individual circumstances, and their rights to privacy.
- 8. Boards and Trusts have a statutory responsibility to provide a range of support services that empower disabled children to lead as full a life as possible.
- 9. Disabled children and their families should experience individual assessments of their needs and co-ordinated approaches to meeting these.
- 10. Disabled children have a right not only to equality of access to services, but access to services that best meet their assessed needs.

- 11. A hospital admission can involve physical and emotional stress for disabled children and their families and every effort should be made to minimise this.
- 12. Disabled children should not be admitted to, or remain in hospital unless they are assessed as requiring clinical/medical care.
- 13. When disabled children are in hospital, close links with their families should be encouraged, supported and maintained.

Commissioning arrangements, structure, organisation and management of hospital services

The commissioning arrangements, structure, organisation and management of hospital services promote optimum quality in the planning and the provision of services for disabled children.

- **1.1** The views and aspirations of children and their families influence the structure, organisation and planning of services at all levels in the Board and Trust.
- **1.2** There is an ethos within the Board and Trust that promotes the independence, life quality, life opportunities and life chances of disabled children.
- **1.3** The organisational arrangements within the Board and Trust promote and facilitate a co-ordinated child and family centred approach to the provision of services.
- **1.4** The Board carries out assessments in partnership with the Trust, other agencies and users to identify the health and social care needs of disabled children in the Board's area. Information about unmet need is collated and informs planning within the Board and Trust.
- **1.5** The Board's commissioning arrangements and its Children Services Plan identify need and establish relevant targets to meet the needs of disabled children and their families.

- **1.6** Monitoring and review systems are in place which enable the Board and Trust to assess the effectiveness, efficiency and quality of services and identify any gaps or deficiencies in service provision.
- **1.7** The Board has appropriate policies, procedures and standards which promote multidisciplinary and interagency approaches to the provision of services to disabled children. The Board monitors and reviews the implementation of these by Trusts and other agencies.
- **1.8** The Trust has established policies, procedures and standards for services to disabled children, which are informed by best practice and regulatory requirements. These are implemented, reviewed and amended as necessary.
- **1.9** There are clinical and social care governance systems in place to promote effectiveness of clinical and social care interventions and continuous improvement in all aspects of service provision for disabled children. These include approaches to ensure that:
- a) all staff are involved in multi-disciplinary audit;
- b) standards are set, monitored and reviewed;
- c) evidence based practice is introduced;
- d) there is a process to measure outcomes;
- e) critical incidents are reported and analysed (root cause analysis);
- f) risk assessments are undertaken and risk management arrangements are in place;
- g) complaints are monitored; and
- h) there is a process to encourage cultural change.
- **1.10** The hospital makes effective use of information technology to support the delivery of services.

Assessment and care planning arrangements

The well being of disabled children is promoted through multidisciplinary assessment, care planning and educational arrangements, which enable their needs to be identified and met in a co-ordinated manner.

- **2.1** An appropriate assessment has been completed on each child, which indicates that the necessary criteria for admission to hospital have been met.
- **2.2** A post admission assessment, which includes a risk assessment, has been completed on all disabled children admitted to the hospital.
- **2.3** From admission to discharge there is a multidisciplinary, integrated approach to assessments, care planning and reviews, which draws on the expertise of other agencies, where appropriate.
- **2.4** There is a written plan which represents the disabled child's assessed needs, the actions and services required to address these and the arrangements for review.
- **2.5** Disabled children and their families participate in assessment and care planning. They are encouraged to ask questions and where necessary, are assisted in accessing further information. Their contribution is reflected in the care plan and the decisions taken.
- **2.6** The Trust maintains an up-to-date and confidential patient record on the disabled child which contains the child's assessment, written plan and the contribution of all professionals involved in the child's treatment and care.
- **2.7** The Trust fulfils its duties under the Children Order in respect of the notification of children, who have been in hospital for a period of 3 months, to community care services.

- **2.8** Where children are looked after, the Trust fulfils its duties under the Children Order in respect of:
- 'Looked After Children' reviews;
- comprehensive assessment;
- care planning;
- social work visits;
- complaints and representation;
- aftercare support; and
- reviews by Education and Library Boards of Statements of Special Educational Needs.
- **2.9** The Trust carries out assessments in respect of the services it is empowered to provide under the Chronically Sick and Disabled Person's Order.
- **2.10** In preparation for the introduction of the Carers and Direct Payments Act, the Trust provides information on carers' assessments and the provision of services to carers.
- **2.11** The Trust fulfils its obligations under the Mental Health Order in respect of compulsory admissions of disabled children to hospital.
- **2.12** The Trust fulfils its obligations under the Education Orders in respect of:
- informing Education and Library Boards (ELB) about pre-school children who might have special educational needs;
- contributing medical and social services advice when a ELB is carrying out an assessment of a child's special educational needs; and
- contributing to disabled children's transitional plans.
- **2.13** The Trust has partnership arrangements in place which ensure a smooth transfer for disabled children, and the sharing of information between relevant agencies including:
- hospital to hospital;
- children's to adults' services; and
- hospital to community services.
- **2.14** The Trust ensures that disabled children and their families are aware of and have access to advocacy services.

- **2.15** Children do not remain in hospital when it is clinically appropriate for them to be discharged.
- **2.16** There are effective planning and liaison arrangements in place to support disabled children and their families at the point of discharge from hospital.
- **2.17** Hospital and community staff are clear about respective roles in support of disabled children returning to the community from hospital.

The range and quality of service provision

The hospital provides responsive services that are child friendly and offer choice and flexibility to disabled children and their families.

- **3.1** The hospital is a safe environment for disabled children.
- **3.2** Hospital services are provided in child and family friendly settings.
- **3.3** Early diagnostic and support services are available when the child's disability first becomes evident.
- **3.4** The hospital has effective systems in place which ensure internal referrals are made and appropriate actions are taken to address these.
- **3.5** Efforts are made to reduce the length of time disabled children wait for diagnostic, assessment, and treatment services.
- **3.6** Efforts are made to minimise the physical and emotional stress which many disabled children experience in hospital.
- **3.7** Families are supported and assisted in maintaining links with their child in hospital. There are appropriate facilities and visiting routines to enable this to happen.

- **3.8** The range and quality of service provision evidence that:
- a) disabled children are respected as individuals with their own needs, wishes and feelings. They are involved in decisions about their treatment and procedures. Consent is sought appropriately;
- b) personal care and treatment routines are delivered in sensitive ways that respect the child's dignity and privacy;
- c) families are valued as having a unique knowledge of their child's needs;
- d) the needs of families, including those of other children in the family are recognised and addressed; and
- e) information regarding the child's condition is discussed with the child and the family, as appropriate.
- **3.9** When aids, adaptations and transport are required, these are suited to the individual needs of the disabled child and are provided in a timely manner.
- **3.10** Disabled children in hospital have access to and are encouraged to participate in appropriate play, social activities and educational programmes.
- **3.11** The care provided to children in hospital minimises the effects of their disabilities and as far as possible enables children and their families to maintain their typical patterns of living.

Education provision

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.

4.1 Effective arrangements are in place to ensure that the relevant Education and Library Board, or its designated service provider, is informed of the need for educational support for a child on admission to hospital.

- **4.2** Links are established between the education providers and the child's school, which ensure that information in respect of the child's curriculum is available to assist the planning of an appropriate educational programme in the hospital setting.
- **4.3** The quality of educational provision supports the child's school programme and enables him/her to maintain progress and keep up–to–date with the work of his/her peers.
- **4.4** Arrangements for educational provision are integrated into the hospital setting and implemented in a collaborative manner by both hospital and education staff.
- **4.5** On discharge from hospital, an education report is available which informs arrangements for the child's continuing education.

Workforce planning, training and support

There are sufficient staff with appropriate qualifications, knowledge and expertise to deliver effective services to disabled children and their families.

- **5.1** The Board and Trust have a workforce planning strategy which meets present need and addresses the future needs of services for disabled children.
- **5.2** The Board and Trust, through contracts and service level agreements, ensure that contracted services have an appropriate human resources strategy.
- **5.3** Staff providing services for disabled children are:
- employed in appropriate numbers;
- subject to PECS and other checks to determine their suitability;
- appropriately qualified; and
- have sufficient knowledge and expertise.
- **5.4** The Trust has a development plan for staff working in services for disabled children based on an analysis of individual training needs and uni/multidisciplinary requirements.

- **5.5** Young disabled people, the families of disabled children and other service users with relevant experience, are involved in the ongoing training and development of staff.
- **5.6** The Trust has in place arrangements for staff:
- induction;
- supervision;
- support and consultation;
- appraisal; and
- performance management and review.
- **5.7** Disabled children and their families consider that staff are skilled in working with them.
- **5.8** Managers have established systems to monitor the quality of service delivery and this information is used to inform training plans.

Communication and information

The hospital provides accessible and relevant information about its services to disabled children and their families.

- **6.1** The hospital publishes up-to-date information about the full range of services available to disabled children.
- **6.2** The hospital has written information which explains the rights and responsibilities of families in relation to their child's hospital care. This information is provided for families in accessible formats.
- **6.3** Appropriate information is provided for disabled children about their hospital stay. The information takes account of linguistic and cultural factors and the needs of children and families with communication difficulties.

- **6.4** Disabled children and their families consider that the information they receive is timely, accessible, appropriate and contains what they need to know about individual assessment, treatment and care arrangements and the services of other relevant agencies.
- **6.5** Hospital staff are aware of the services for disabled children provided by the community Trust and other agencies. They share this information with children and their families and encourage them to make use of relevant services.
- **6.6** Staff are trained in communicating with disabled children and members of their families who are disabled and have access to specialist help in communication, when required.
- **6.7** The hospital provides information for disabled children and their families about how to access personal information held on file or computer.
- **6.8** The hospital provides information for disabled children and their families about how to complain or make representations. Children and families who express concerns about their treatment or care are listened to and facilitated to resolve the concern, or where appropriate, assisted in accessing the complaints and representations procedures.

Equality and Human Rights

The Board and Trust are fulfilling their statutory duties in respect of human rights and equality legislative requirements. Human rights and equality principles are integrated into practice within all aspects of services for disabled children.

- **7.1** The rights of disabled children under the UN Convention on the Rights of the Child and the Human Rights Act are respected, valued and promoted.
- **7.2** All relevant policies have been subject to appropriate consultation in accordance with Section 75 of the Northern Ireland Act.

- **7.3** Appropriate provision has been made for the specific needs of disabled children in line with Section 21 of the Disability Discrimination Act.
- **7.4** Service providers do not treat disabled children less favourably than others who do not have a disability, unless there is justification for this as set out in Section 24(1) of the Disability Discrimination Act.
- **7.5** The social circumstances of disabled children, their gender, sexual orientation, religious belief, political opinion, racial group and age are recognised and respected in planning and delivery of services.
- **7.6** There is consideration and respect for the diversities arising from differing cultural community identities and there is consideration of these in the provision of services to disabled children.

APPENDIX D

PROFILE OF CHILDREN WITH HOSPITAL STAYS OF 3 MONTHS OR MORE

Technical Note: Due to the effects of rounding, the percentages in some tables may not add to 100.

Table 1 Children with hospital (1) stays of 3 months or more

	Male	Female	All	
Altnagelvin	4	4	8	5%
Antrim	6	3	9	5%
Belvoir Park	3	3	6	3%
Craigavon	1	4	5	3%
Daisy Hill		2	2	1%
Forster Green	17	13	30	17%
Gransha		1	1	1%
Longstone	1	2	3	2%
Mater		1	1	1%
Muckamore	26	11	37	21%
Musgrave Park	1	0	1	1%
Royal Group of Hospitals	19	19	38	22%
St Luke's	1	1	2	1%
Stradreagh	3	1	4	2%
Ulster Hospital	3	4	7	4%
Young People's Centre	7	11	18	10%
Lagan Valley		1	1	1%
All hospitals	92	81	173	100%
	53%	47%	100%	

⁽¹⁾ For children who stayed in more than one hospital, the table shows the hospital to which they were most recently admitted

Table 2 Gender and age at most recent admission

	Male	Female	All	
Birth - 11 months	21	27	48	28%
1-4 years	5	7	12	7%
5-10 years	22	6	28	16%
11-15 years	29	31	60	35%
16-17 years	15	10	25	14%
Total	92	81	173	100%
	53%	47%	100%	

Table 3 Religion

	Male	Female	All	
Catholic	37	38	75	43%
Protestant	24	26	50	29%
No Denomination	9	3	12	7%
Other religions	2	2	4	2%
Not known	20	12	32	18%
Total	92	81	173	100%
	53%	47%	100%	

Table 4 Ethnic origin

	Male	Female	All	
White	80	65	145	84%
Other	1	2	3	2%
Not known	11	14	25	14%
Total	92	81	173	100%
	53%	47%	100%	

Table 5 Trusts in which children resided at time of admission

Hospital of admission							
Trust	Forster Green	YPC	Muckamore	Royal	Other	All	
Armagh & Dungannon	1	0	2	3	6	12	7%
Causeway	0	0	1	1	1	3	2%
Craigavon & Banbridge	1	0	0	2	4	7	4%
Down Lisburn	6	2	4	2	1	15	9%
Foyle	0	1	0	0	12	13	8%
Homefirst	6	1	7	11	7	32	18%
Newry & Mourne	1	0	1	3	3	8	5%
North & West Belfast	4	7	8	6	3	28	16%
South & East Belfast	5	5	10	3	3	26	15%
Sperrin Lakeland	2	1	0	5	2	10	6%
UCHT	3	1	2	2	8	16	9%
Other	1	0	2	0	0	3	2%
Total	30	18	37	38	50	173	100%

Table 6 Length of most recent admission (children who have been discharged)

	Male	Female	All	
Under 3 months (1)	1	1	2	1%
3-5 months	47	34	81	59%
6-11 months	10	18	28	20%
1 year - under 2 years	6	10	16	12%
2 years - under 3 years	2	2	4	3%
3 years - under 4 years	2	0	2	1%
4 years - under 5 years	0	1	1	1%
5 years and over	1	0	1	1%
Not Known	0	2	2	1%
Total	69	68	137	100%
	50%	50%	100%	

⁽¹⁾ These children were included in the survey because they had previous admissions of 3 months or longer

Table 7 Number of previous admissions (1) (2)

	Male	Female	All	
In hospital continuously since birth	12	17	29	17%
No previous admissions	55	40	95	55%
One previous admission	11	16	27	16%
Two previous admissions	5	4	9	5%
Three previous admissions	0	2	2	1%
Four or more previous admissions	4	1	5	3%
Not known	5	1	6	3%
Total	92	81	173	100%
	53%	47%	100%	

⁽¹⁾ Previous admissions to other hospitals are included where known

Table 8 Children who had been in hospital since birth

Length of Stay	Died	Discharged	All	
3-5 months	4	23	27	93%
13 months	0	1	1	3%
24 months	1	0	1	3%
Total	5	24	29	100%
	17%	83%	100%	

^{(2) 29} children had been in hospital continuously or almost continuously since birth. For children who had been out of hospital for short periods, some hospitals recorded this as one continuous stay.

Table 9 Admissions to regional and other hospitals (1)

	Male	Female	All	
Forster Green	17	13	30	17%
Muckamore	26	11	37	21%
Royal Group of Hospitals	19	19	38	22%
Young People's Centre	7	11	18	10%
Other hospitals	23	27	50	29%
All hospitals	92	81	173	100%
	53%	47%	100%	

⁽¹⁾ For children who stayed in more than one hospital, the table shows the hospital to which they were most recently admitted

Table 10 Types of disability (1)

Disability	Male	Female	All	
Sensory (visual or hearing) impairment	8	10	18	10%
Physical disability	18	29	47	27%
Severe or chronic illness	27	22	49	28%
Learning disability	41	27	68	39%
Developmental delay	41	30	71	41%
Behavioural disorder	42	18	60	35%
Emotional disorder	26	28	54	31%
Mental illness	10	14	24	14%
Communication disorder	25	11	36	21%
Challenging behaviour	43	24	67	39%
Life limiting illness	13	10	23	13%
Traumatic brain injury	4	3	7	4%
Other disabilities ⁽²⁾				
Epilepsy	5	4	9	5%
Drug misuse	1	0	1	1%
Hydrocephalus	1	1	2	1%
Spina bifida	1	0	1	1%
Burns	2	0	2	1%
Cerebral palsy	1	0	1	1%
Chronic lung disease	1	0	1	1%
Chronic ventilator dependency	1	0	1	1%
Seizures	1	0	1	1%
Prematurity	1	0	1	1%
Spinal muscular atrophy	1	4	5	3%
Intestinal obstruction	1	0	1	1%
Congenital heart disease	1	2	3	2%
Severe apneas	1	2		2%
Small bowel insufficiency	1	0	1	1%
Physical disability	0	1	1	1%
Spinal and head injuries	2	0	2	1%
URTI	2	0	2	1%
Total	92	81	173	
	53%	47%	100%	

⁽¹⁾ Many children had multiple disabilities

⁽²⁾ Where more than one disability was included at 'other disabilities', only the first one has been shown

Table 11 Most important reason for admission

Reason	Male	Female	All	
Challenging behaviour	34	4	38	22%
Personal care	0	2	2	1%
Management problems	5	4	9	5%
Risk to others	3	4	7	4%
Risk to self	4	20	24	14%
Planned respite	0	0	0	0%
Emergency respite	4	4	8	5%
Emotional difficulties	3	2	5	3%
In hospital since birth	10	18	28	16%
Intensive care	8	7	15	9%
Surgery	2	6	8	5%
Appropriate equipment not available in				
the community	0	0	0	0%
Appropriate care not available in the community	6	4	10	6%
Physical illness	4	1	5	3%
Other reasons	3	5	8	5%
Missing	6	0	6	3%
Total	92	81	173	100

Table 12 Hospitals included (1)

	Male	Female	All	
Altnagelvin	4	4	8	5%
Antrim	6	3	9	5%
Forster Green	17	13	30	17%
Longstone	1	2	3	2%
Muckamore	26	11	37	21%
Royal Group of Hospitals	19	19	38	22%
St Luke's	1	1	2	1%
Young People's Centre	7	11	18	10%
All hospitals in the sample	81	64	145	84%
Other hospitals	11	17	28	16%
All hospitals	92	81	173	100%
	53%	47%	100%	

⁽¹⁾ For children who stayed in more than one hospital, the table shows the hospital to which they were most recently admitted

Table 13 Hospital settings

	Number of Children	
Learning Disability Hospitals ⁽¹⁾	44	25%
Mental Health Hospitals or Psychiatric Units of other Hospitals (2)	51	29%
Other Hospitals	78	45%
All Hospitals	173	100%

- (1) Muckamore Abbey, Stradreagh and Longstone Hospitals
- (2) Forster Green (Child and Family Centre only), Young People's Centre, Mater Hospital
- (Psychiatric Unit), Gransha Hospital, Lagan Valley (Department of Psychiatry) and St Luke's

Table 14 Hospital ward

	Children	
Stayed exclusively in children's ward during entire stay	136	79%
Did not stay exclusively in children's ward during entire stay	31	18%
Spent some time in Intensive Care Unit	6	3%
Total	173	100%

Table 15 Hospitals where children stayed in adult wards or wards accommodating adult patients

		Age on admiss	ion to hospital	
Hospital	1-4 years	11-15 years	16-17 years	All
Forster Green ⁽¹⁾		2		2
Gransha			1	1
Lagan Valley			1	1
Longstone			2	2
Mater			1	1
Muckamore		9	11	20
Musgrave Park			1	1
St Luke's		1	1	2
Stradreagh	⁽²⁾ 1			1
Total	1	12	18	31

- (1) Excludes Child and Family Centre
- (2) See paragraph 3.9 of the main report

Table 16 Formal notification to Community Trust of the child's hospital admission of more than 3 months

Yes – formally notified:		
Within one week of admission	11	6%
1 week – 1 month after admission	14	8%
1-3 months after admission	11	6%
3-6 months after admission	7	4%
6-12 months after admission	1	1%
1-2 years after admission	1	1%
3-4 years after admission	1	1%
Date not known	8	5%
All formal notifications	54	32%
No need - Community Trust already aware/admission arranged by		
Community Trust	35	20%
Original admission before introduction of Children Order	2	1%
Notified during previous admission	5	3%
Notified prior to admission (but no previous admission at date stated)	4	2%
Not notified	36	21%
Not known	37	21%
Total	173	100%

Table 17 Formal notification for children who had been in hospital since birth

Notified	10
Not notified	16
Not known	3
Total	29

Table 18 Children looked after at time of admission (1)

	Male	Female	All	
Looked after	24	22	46	27%
Not looked after	40	49	89	51%
Not Known	28	10	38	22%
Total	92	81	173	100%
	53%	47%	100%	

(1) This table is based on responses from hospital staff. Hospital and Community Trust staff responses did not always agree.

Table 19 Children remaining in hospital – reasons for not being discharged

	Male	Female	All
Appropriate care not available	6	3	9
Appropriate equipment not available in the community	0	1	1
Appropriate care not available, breakdown of previous placement, no other placement available	1	0	1
Appropriate care not available, no fostering placement after more than 2 years	1	0	1
Appropriate care/equipment not available and other reasons	4	5	9
Continuing assessment, treatment or both	8	3	11
No reason given	3	1	4
Total	23	13	36

Table 20 Children who stayed in a secure (locked) ward or facility at any time since admission

		Children	
Stayed in secure ward		17	10%
Did not stay in secure ward		153	88%
Not Known		3	2%
Total 17	'3	100%	

Table 21 Age and gender of children who stayed in a secure ward or facility

		Age on admission	
	11-15 years	16-17 years	All
Male	3	6	9
Female	4	4	8
Total	7	10	17

Table 22 Children detained (under the Mental Health (NI) Order, 1986) at any time during their stay

	Children	
Detained	30	17%
Not detained	136	79%
Not Known	7	4%
Total	173	100%

Table 23 Age and Gender of children detained (under the Mental Health (NI) Order, 1986)

		Age on admission	
Gender	11-15 years	16-17 years	All
Male	7	8	15
Female	10	5	15
Total	17	13	30

Table 24 Number of children who died

	Male	Female	All	
Deceased	10	6	16	9%
Alive	66	56	122	71%
Not known	16	19	35	20%
Total	92	81	173	100%
	53%	47%	100%	

Table 25 Location of educational provision

Provision	Male	Female	All	
Off-site	17	8	25	30%
On-site	27	26	53	65%
Both	1	1	2	2%
Not known	1	1	2	2%
Total	46	36	82	100%
	56%	44%	100%	

Table 26 Educational provision during hospital stays (1)

	Male	Female	All	
Some educational provision	46	36	82	73%
No educational provision	5	8	13	12%
Not Known	15	3	18	16%
Total	66	47	113	100%
	58%	42%	100%	

(1) Table includes only children aged over 4 years at time of admission

Notes

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Notes

Produced by

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October 2005

Ref 110/05

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LIS-1450

INQUIRY INTO HISTORICAL INSTITUTIONAL ABUSE 1922 TO 1995 Module 13 - Lissue Hospital

Witness Statement of Dr Kevin McCoy

- 1. I have been informed that Dr Roger McAuley, a former consultant child psychiatrist at the Royal Belfast Hospital for Sick Children and the Child Psychiatry Unit at Lissue has indicated to the HIA Inquiry that the DHSS's Social Work Advisory Group (SWAG) and/or the Social Services Inspectorate (SSI) carried out inspections of Lissue Child Psychiatry Unit. I have read the relevant extract from the transcript of Dr McAuley's evidence to the HIA Inquiry.
- 2. As the Inquiry is aware from my previous statements, I joined SWAG in 1972 and held senior positions in SWAG and SSI from 1973 until my retirement as Chief Inspector, SSI in November 2000. I understand that the Lissue Child Psychiatry Unit was in operation from 1971 to 1989. I can confirm that at no stage during this period did SWAG or SSI carry out an inspection of Lissue Children's Hospital or any services associated with the hospital.

Signed

Verir Ur. Car.

Dr Kevin McCoy

Date 5th May 2016

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

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

- 47. Please see response to Question 8 above.
- 48. In the Belfast Hospital Management Committee Annual Report for 1971, Dr McSorley was named as allocated to Lissue Hospital within the visiting team. That report noted:
 - "The system of Management Rounds established in 1965 continued until October 1971 when, because of continuing civic unrest, it was decided to defer further visits until March 1972."
 - See Exhibit X (Belfast Hospital Management Committee Annual Report 1971).
- 49. The Board therefore believes that it was likely Lissue was visited on behalf of the Belfast Hospital Management Committee, however no reports of such visits have been found. It is noted that the 1972 Annual Report of the Committee is silent in relation to the issue of Management Rounds. See **Exhibit 11.** From discussion with former members of staff of the Northern Ireland Hospital Authority and another Hospital Management Committee, the Board believes that these visits were predominantly for the purposes of familiarisation.
- 50. The composition and structure of the Belfast Hospital Management Committee is detailed within their Annual Reports exhibited as outlined above. Beneath the Management Committee sat a series of committees that specialised in particular areas. This included, in particular, committees comprised of Doctors, and Nurses, who would have been concerned with the day to day running of the hospitals.

CHAPTER VII

Management Rounds

The system of Management Rounds established in 1965 continued until October 1971 when, because of continuing civic unrest, it was decided to defer further visits until March 1972.

Visiting Teams were established and allocated as follows:

R.V.H.

	7 162.					
	Mr. P. R. D. Clarendor	1				Main Block
	Mr. G. L. Cotton .					Out-Patient Centre
	Mrs. M. Wilson .					
	Mr. H. Crothers .					
	Mr. B. G. Harkin .		•		•	Eye and Ear Clinic M. & C.C.
	Mr. J. Crymble (died 1:	5/12/	71)			Throne
	Mr. R. J. Nesbitt .		,			Haypark
	Mr. Brian Morton					Quin House
	Mr. H. G. Steele .	15	. 8	9		K.E.B.
			•		•	C.S.H.
	Mr. J. C. Creaney					Killowen
$R_{\cdot \cdot}$	М.Н.					
	Mr. F. M. R. Byers					R.M.H.
	Professor C. H. G. Mac				•	Bostock House
	Mr. T. N. McCann	arec	402	•	•	Musson House
	Mrs. M. Wilson .					Laboratories
	Dr. T. C. Crossin .					Laboratories
R	B.H.S.C.					
	Dr. W. R. N. Galbraith					DDHAG
					•	R.B.H.S.C.
	Dr. M. MacSorley				•	Lissue
	Mr. J. M. McAuley	•		Ç.		School of Dentistry
	Mr. T. N. McCann			•	•	Broadway Complex
	Mrs. G. Wheeler .	•	•	•	•	

All groups had representation at the Works and the Finance and Establishment Committees.

The Chairman and Vice-Chairman are ex officio members of all Teams.

CHAPTER VIII

Honours List

Honorary Appointments

- Miss R. C. Perkes, S.R.N., S.C.M., M.T.D., has been awarded the O.B.E. and has also been re-elected National President of the Royal College of Midwives for one further year.
- Miss M. K. Robb, S.R.N., S.C.M., R.S.C.N., O.N.C., NURSING ADMIN. CERT. (R.C.N.) and Miss M. H. Hudson, M.B.E., S.R.N., S.C.M., R.S.C.N. have been appointed as Officers (Sisters) of the Order of St. John.
- Dr. J. F. Pantridge, M.C., M.D., F.R.C.P., F.A.C.C., has been appointed as Honorary Professor in Cardiology to the Queen's University, Belfast.
- Dr. M. G. Nelson, M.D., F.R.C.P., F.R.C.P.I., F.R.C.PATH., D.T.M. & H. has been appointed as Honorary Professor in Haematology to the Queen's University, Belfast.
- Dr. G. F. Adams, M.D., F.R.C.P., has been appointed as Honorary Professor in Geriatrics to the Queen's University, Belfast.
- Rev. R. D. E. Gallagher, M.A., B.D., has been awarded the Degree of Doctor of Divinity.
- Mr. G. D. L. Smyth, M.D., F.R.C.S., D.L.O., has obtained the Degree of D.Sc. from the Queen's University, Belfast.
- Mr. T. L. Kennedy, M.B., M.S., F.R.C.S., and Mr. W. J. Hurt, A.I.I.P., were awarded silver medals in the B.M.A. annual competition for Medical Photography. Mr. Hurt was technically responsible for the film of Mr. Kennedy performing a selective Gastric Vagotomy operation.

- 51. The Royal Belfast Hospital for Sick Children also had a Matron, who would have visited Lissue Hospital. Following reorganisation it is believed that the Matron in charge would have been attached to Lisburn District. The Board is aware that Dr Nelson recalls such visits.
- 52. No records have been located by the Board in relation to any visits to Lissue undertaken by the Eastern Health and Social Services Board after it assumed responsibility in 1973. However the Board believes, having spoken to relevant staff, that the Area Executive Team visited on an annual basis.
- 53. Whilst not directly related to the running of the Lissue Unit, the Board believes that the Royal College of Psychiatrists visited the Royal Belfast Hospital for Sick Children, including the Child Psychiatry Unit at Lissue, every three years to examine the educational content of training and professional development of doctors. The Board believes that the visits from the Royal College of Psychiatrists lasted in or around two days during which members of the College would have met and talked with staff.
- 54. Similarly, it is known that following its establishment in 1983, the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC) became the nursing profession's regulatory body and National Boards were set up in each country of the United Kingdom, including Northern Ireland, to monitor the quality of nursing and midwifery education courses, and to maintain the training records of students on these courses. The Board is aware that from an EHSSB memo dated 10 June 1988 from Ms. A Grant, Director of Nursing Services to Mr. R Lyons, Assistant Group Administrator that " *The National Board Inspection of Jan/Feb 1987 withdrew approval as a nurse teaching unit as the philosophy of care was seen as restrictive and "custodial". The structure and layout of Lissue was not seen as well suited for its present use.*" **Exhibit 12.**

Q10 How was Lissue funded?

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

- 20. The Inquiry is aware that there was a school on site, by whom was it regulated and inspected?
- 20.1 The school at Lissue³⁴ was established by the South Eastern Education and Library Board and was subject to periodic inspection by the then Northern Ireland Department for Education's Inspectorate.
- 21. The Inquiry is aware that a television documentary was made in relation to Lissue. Please provide a copy of the same.
- 21.1 The Department believes that the above request refers to a BBC 2 Horizon production entitled "Breaking in Children", broadcast on 12 October 1981 and featuring the work of a consultant child psychiatrist based at the Royal Victoria Hospital and Lissue Children's Hospital. The Department does not have a copy of the documentary but has referred the HIAI to sources from which it may be obtained.
- 22. The Inquiry is aware that a historical review was carried out into Child Safeguarding Issues (the Stinson Review). How was that review received and were any steps taken by the Department on receipt of the same?
- 22.1 The steps taken by the Department on receipt of the Stinson Review need to be viewed in the context of other major work undertaken by the Department, Boards and Trusts to identify potential cases of historical abuse against children and adults mental health and learning disability hospitals. The Stinson Review contributed to the Department's strategy in taking this forward.
- 22.2 In 2005, a former patient in Muckamore Abbey Hospital made a complaint alleging sexual abuse some 30 years earlier. That complaint was exhaustively investigated in a process that was commissioned by what was then the EHSSB and which involved the police, including professionally-monitored interviews with patients and the scrutiny of almost 300 files of patients who had been in Muckamore Abbey. There were no prosecutions arising from this investigation.
- 22.3 Following this exercise, which was largely into the abuse of patients by other patients, the Department asked HSC Trusts to conduct a wider retrospective sampling exercise across adults' and children's files from all Mental Health (MH) and Learning Disability (LD) hospitals across NI (covering the period 1985-2005). This was in order to determine whether there was any evidence

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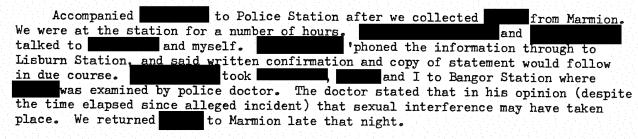
³⁴ See page 130 of Annex A which provides details of the school.

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LS 71

Marmion Children's Home, Church Road, Holywood

March 1st 1983



March 2nd

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

March 2nd 1953

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

We called at house in and then to we left a note for with Snr., asking to call at James Street the next day if convenient.

March 3rd

Called at James Street. I explained what had happened to at Tissue. It is at 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 1953

Called with 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 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.

Page 62

- 1 come on duty.
- 2 Q. Okay. You will be glad to know I am getting to my last
- 3 two. There was an incident of peer sexual abuse in 1983
- 4 -- do you remember that -- where a boy said he had been
- 5 sexually --
- 6 A. What date?
- 7 Q. 1983.
- 8 A. We got sexually abused children as patients.
- 9 Q. No, but that a sexual abuse actually happened in Lissue.
- 10 You don't remember that?
- 11 A. No.
- 12 Q. LS8 was called back off holiday to help in the
- investigation of it.
- 14 A. I don't know anything about it.
- 15 Q. You don't remember that. Okay. The last thing was just
- that we know that the National Board removed approval
- from Lissue to be a teaching establishment for nurses.
- 18 Do you remember that?
- 19 A. No.
- 20 Q. No.
- 21 A. Sorry. He would send me on -- to the nursing on the
- 22 Lisburn Road, there for lectures --
- 23 Q. Right.
- 24 A. -- but it was for different things, like how you would
- deal if you were -- somebody dead and how would you talk



OFFICIAL-SENSITIVE-PERSONAL MINISTRY OF HEALTH AND SOCIAL SENSITIVE-PERSONAL

FSS4(US) Prench

Dundonald House Upper Newtownards Road Belfast BT4 3SF

Telex 74578

Telephone 0232 (Belfast) 650111 can

The Chief Administrative Officer of each Health and Social Services Board

Please reply to The Secretary
Your reference

Our reference Al034/73 Circular Ref No HSS4(OS) 1/7

Date 30 October 1973

Dear Sir

MOTTFICATION OF UFTOWARD LIVELTS 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 Einistry 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 Moci Services Roard should therefore arrange for a telephone message to be sent HSS4(OS) Branch, Dundonald House, Upper Newtownards Road, Belfast BTM 35F, (telephone Belfast 650111 extension 397) as soon as possible after the occurrency such untoward event, with the following information:
 - a) the nature of the occurrence (ie whether an unauthorised absence, a accident or a sudden, unexpected or unnatural death);
 - b) a brief description of the circumstances of the event;
 - c) the name of the patientinvolved 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 locati of the event;
 - e) the date and time of the occurrence; and
 - f) whether the patient's relatives, the RUC and the Finistry of Home Affairs, as appropriate, have been informed of the event.
- 3. To enable the necessary information to be furnished to the Ministry, a Health and Social Services Board should ask the psychiatric and special car hospitals within its area to notify the Board by telephone, in the first plof the details of an untoward event immediately its occurrence becomes known and the social carried carried and the social carried c

Yours faithfully

L. lo. Gillia

AND SECRET SERVICES

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RECTIVED

SECTORAL

SE

MissLamb, CANO

Dr McKenna, CAMO

/LRM

2 4 MAR 1983

Child Psychiatric Unit, Lissue Hospital

I am attaching a copy of Miss Acheson's Report on the Investigation she has carried out into the nursing service in the Child Psychiatric Unit of Lissue Hospital.

I should be glad to have your advice when you have had the opportunity to read the Report. It will probably be benificial for us to have a further discussion. I have not copied the Appendices from the view point of economy but these would be available for information at any time.

It would seem that a certain strain is being placed on the nursing staff of the unit because of the recent tendency to admitchildren over the age of 14 years. I understand that children of 16 and over have been treated in the unit as day patients. It goes without saying that the needs of adolescents of this age are vastly different to those of younger children.

Greelyn N. D Lamb

LISBURN DISTRICT

CONFIDENTIAL

INVESTIGATORY NURSING REPORT - CHILD PSYCHIATRY UNIT, LISSUE HOSPITAL

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

The allegation, made by LS71 who had been an in-patient in the Unit from until stated that he had been sexually assaulted by another patient on three occasions during this time. The assault was alleged to have taken place in his room at night.

NURSING INVESTIGATION

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

- 1. to establish the facts surrounding the allegation in as far as this could be done within the Unit and on the basis of the information available at the time,
- 2. to protect the children currently in the Unit by seeking to establish elements of risk to which they could be subject with a view to taking action on any risks found.

GEOGRAPHY OF THE UNIT

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

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

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

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

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

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

- 2 -

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

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

DAY TO DAY MANAGEMENT OF THE UNIT

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

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

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

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

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

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

AGE GROUP OF CHILDREN

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

NURSE STAFFING

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

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

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

RECRUITMENT POLICY

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

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

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

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

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

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

(See Appendix 4)

STAFF QUALIFICATIONS AND EXPERIENCE

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

Of the other 15 trained nurses on the staff

1.7	hold	R.M.N.	registrations
3	hold	S.R.N. and S.C	.м.
1	holds	S.R.N. and R.M	.N. "
1	holds	R.S.C.N. & S.R	.N. "
1	holds	R.S.C.N.	registration
1	holds	R.N.M.S.	11

Transport of the state of the s

l holds S.R.N.

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

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

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

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

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

STAFF WASTAGE AND SICKNESS/ABSENTEEISM RATES

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

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

STAFF RELATIONSHIPS AND MORALE

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

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

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

DUTY ROTAS

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

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

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

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

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

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

OTHER NURSING POLICIES

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

- 1. The grades of staff to be rostered at all times.
- 2. Rules to be observed if a change of duty becomes necessary for any member of staff.
- 3. Overtime.
- 4. The ratio of male staff which may be rostered. (See Appendices 6, 7, 8 and 9)

SECURITY STAFF

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

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

COMMUNICATIONS

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

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

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

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

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

SUMMARY

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

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

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

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

OFFICIAL-SENSITIVE-PERSONAL

- 7 -

LIS-1422

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

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

- The philosophy of the Unit permits a degree of freedom and encourages independence and the development of a good "self image" in the child - this means an element of risk which must be accepted.
- 2. The policies and practices in the Unit were adequate but there was a failure in performance by the staff at post at the time of the incident.
- 3. An element of each could exist.
- 4. The more recent tendency to admit over 14 year old children is stretching the Unit beyond that with which it can be expected to cope.
- (A) In completing this investigation I have sought to ensure that nursing staff fully understand their role and responsibilities.
- (B) Since the police enquiries are not yet complete I have not taken any action to counsel staff on this particular incident.

DISTRICT ADMINISTRATIVE NURSING OFFICER

Page 92

- 1 period had to work with didn't help them make that
- 2 happen.
- It is interesting, because it appears an exception
- 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
- a building, if you ask someone, "Can I speak to who is
- 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
- 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:

Eastern Health and Social Services Board

Lisburn Unit of Management

PRIVATE AND CONFIDENTIAL

The Area General Administrator, Eastern Health and Social Services Board, 65 University Street, BELFAST, BT7 1HN



Lisburn Health Centre Linenhall Street Lisburn BT28 1LU Tel.: Lisburn 2733

Our Ref:

Your Ref: AC 28/83/67

30th May, 1984.

Dear Sir,

Untoward Event - Lissue Hospital

I refer to your letter of 29th March, 1984 and I would first of all apologise for the delay in replying. We have been endeavouring to obtain a report from the Consultant concerned but, as this is not yet available, I would now wish to offer the following information as requested and, hopefully, the Consultant's report can be sent at a later stage.

- 1. The Nature of the Alleged Assaults.

 It is understood that, following the interview of LS 71 by a Social Worker and particularly following a telephone message received by Mr. R. Bunting, Assistant Director of Social Services, on 2nd March 1983, it appears that buggery by another patient in the Child Psychiatry Unit constitutes the nature of the alleged assaults.
- 2. The D.A.N.O.'s reappraisal of the Nursing Service in the Child Psychiatry Unit.
 A full report of her investigation was sent to the Chief Administrative Nursing Officer by the D.A.N.O. and, in summary, -
 - (a) It was considered that policies were sound and that there was adequate provision for the nursing care of all children brought into the Unit.
 - (b) That an element of risk did exist within the philosophy which had to be accepted.
 - (c) That the recent (at that time) tendency to admit children over 14 years was stretching the Unit beyond that with which it could cope.
 - (d) That in completing the investigations, D.A.N.O. had sought to ensure that nursing staff fully understood their role and responsibilities.

-over-

The Area General Administrator

-2-

30th May, 1984.

3. Whether there was any evidence of staff negligence or ignorance of procedures.

It was concluded that staff were fully aware of all procedures and there was no indication of any staff negligence.

It is 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 different needs of the various groups.

4. Steps taken to remedy the situation.

Following discussion with Consultant Medical Staff it was agreed to institute a change in admission policy so as to ensure that older children would not be admitted.

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.

Yours faithfully,

GROUP ADMINISTRATOR

W. S. HEANEY

MissLamb, CANO

Dr McKenna, CAMO

/LRM

2 4 MAR 1983

Child Psychiatric Unit, Lissue Hospital

I am attaching a copy of Miss Acheson's Report on the Investigation she has carried out into the nursing service in the Child Psychiatric Unit of Lissue Hospital.

I should be glad to have your advice when you have had the opportunity to read the Report. It will probably be benificial for us to have a further discussion. I have not copied the Appendices from the view point of economy but these would be available for information at any time.

It would seem that a certain strain is being placed on the nursing staff of the unit because of the recent tendency to admitchildren over the age of 14 years. I understand that children of 16 and over have been treated in the unit as day patients. It goes without saying that the needs of adolescents of this age are vastly different to those of younger children.

Greelyn N. D Lamb

LISBURN DISTRICT

CONFIDENTIAL

INVESTIGATORY NURSING REPORT - CHILD PSYCHIATRY UNIT, LISSUE HOSPITAL

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

The allegation, made by LS71 who had been an in-patient in the Unit from until stated that he had been sexually assaulted by another patient on three occasions during this time. The assault was alleged to have taken place in his room at night.

NURSING INVESTIGATION

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

- 1. to establish the facts surrounding the allegation in as far as this could be done within the Unit and on the basis of the information available at the time,
- 2. to protect the children currently in the Unit by seeking to establish elements of risk to which they could be subject with a view to taking action on any risks found.

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

GEOGRAPHY OF THE UNIT

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

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

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

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

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

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

- 2 -

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

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

DAY TO DAY MANAGEMENT OF THE UNIT

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

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

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

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

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

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

AGE GROUP OF CHILDREN

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

NURSE STAFFING

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

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

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

RECRUITMENT POLICY

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

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

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

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

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

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

(See Appendix 4)

STAFF QUALIFICATIONS AND EXPERIENCE

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

Of the other 15 trained nurses on the staff

1.7	hold	R.M.N.	registrations
3	hold	S.R.N. and S.C	.м.
1	holds	S.R.N. and R.M	.N. "
1	holds	R.S.C.N. & S.R	.N. "
1	holds	R.S.C.N.	registration
1	holds	R.N.M.S.	11

Transport of the state of the s

l holds S.R.N.

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

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

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

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

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

STAFF WASTAGE AND SICKNESS/ABSENTEEISM RATES

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

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

STAFF RELATIONSHIPS AND MORALE

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

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

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

DUTY ROTAS

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

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

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

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OFFICIAL-SENSITIVE-PERSONAL

- 7 -

LIS-1422

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DISTRICT ADMINISTRATIVE NURSING OFFICER

MissLamb, CANO

Dr McKenna, CAMO

/LRM

2 4 MAR 1983

Child Psychiatric Unit, Lissue Hospital

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Greelyn N. D Lamb

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- 1 A. Yes.
- 2 Q. You obviously agreed to that.
- 3 A. Yes.
- 4 Q. It probably suited your purposes as well, if I might
- 5 suggest, because the teaching staff, as you say, were
- 6 happy. The older children were presenting more
- 7 difficult management issues.
- 8 A. Oh, very much more. Firstly, they were physically more
- 9 developed and able and stronger. So that was
- 10 a difficulty in itself.
- 11 Q. 1987 you were transferring to Forster Green or there was
- 12 discussions about it. You will recall that you and
- I looked earlier at a document which was a memo that was
- being sent to the -- I think it is at 226 -- a memo that
- was being sent by Miss Grant, who was the Director of
- Nursing Services, to Mr Lyons in response to a letter
- sent by three consultants. I was asking was that you,
- Dr McAuley and I thought it might have been Dr Barcroft,
- but, in fact, we have located the letter in the
- bundle of papers that we have, and it is at 12708. It
- is written to Dr Greer, who was Acting Chief
- 22 Administrative Medical Officer, on 27th May 1988. It is
- signed by, as you suspected, Dr Kennedy --
- 24 A. Uh-huh.
- 25 Q. -- yourself and Dr McAuley. I don't know if you have

1173 1073

To DANO, FOR INFORMATION The Royal Belfast Hospital for Sick Children

CHILD PSYCHIATRY LEPARTMENT

Bellast BT12 6BE Northern Ireland, telephon€40503

Ext 3550/2100

To:

All Members of Staff

Date: 29 March 1983

morne

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.

Dr W McC Nelson

Child Psychiatry, RBHSC and Lissue House.

Page 149

- children than the younger staff. Is that your
- 2 recollection?
- 3 A. I can't say it is.
- 4 Q. And I just wondered what you recalled about inspections.
- 5 A. The only one that really stands out for me is a nursing
- 6 inspection where Staff Nurse -- I don't know what grade
- 7 the person was -- but Nurse LS 100 , who is now I think
- 8 the senior nurse in Northern Ireland.
- 9 Q. The Chief Nursing Officer?
- 10 A. Yes.
- 11 Q. I think he certainly became that. I don't know whether
- 12 he still is or not.
- 13 A. He certainly did one inspection at Lissue.
- 14 Q. Do you have any recollection of people from Social
- 15 Services, Social Services Inspectorate or the Social
- Work Advisory Group coming?
- 17 A. No. I don't -- I don't remember that inspection at all
- 18 --
- 19 Q. I take --
- 20 A. -- if it occurred.
- 21 Q. Or the Northern Ireland Health Advisory Service?
- 22 A. No. No, I don't.
- 23 Q. There was -- we have seen a report of the Mental Health
- 24 Commission coming in 1987. Do you recall that?
- 25 A. No.

hospitals⁹. This was replicated in Section 70 of the Health Services Act (Northern Ireland) 1971¹⁰. Article 50 of the 1972 Order contained a more general power of inspection of "any home for persons in need or other premises in which a person is or is proposed to be accommodated under arrangements made by the Ministry"¹¹. It is of note the more widely drafted Article 50 power was not directed specifically towards hospitals, rather any arrangement under the 1972 Order. Dr Harrison has described this as a backstop power¹².

- 2.4. There is no information available to suggest the power to inspect was ever used other than in a Social Services led inspection of services for disabled children in 2005¹³. Dr McAuley, who retired in 2000, whilst giving oral evidence dealing with the various groups that inspected Lissue, referred to the Mental Health Tribunal and Royal College of Psychiatrists and suggested that there was Social Services Inspectorate (SSI) or Social Work Advisory Group inspection of Lissue¹⁴. He had not raised this issue within his statement. Dr Nelson when asked in oral evidence did not have any recollection of SSI or SWAG attending at Lissue¹⁵. Dr McCoy who retired as Chief Inspector of SSI in 2000 has subsequently confirmed that neither SSI nor SWAG inspected Lissue. Dr Nelson suggested he recalled an inspection by Martin Bradley, who subsequently became the Chief Nursing officer. Mr Bradley has subsequently provided a statement in which he suggests he did not lead or carry out any inspection of Lissue and does not in fact recall ever visiting it.
- 2.5. It is of note the former Chief Medical Officer in his statement to the Inquiry 16 confirmed the role of the Department was more by way of

⁹ Section 63 at LIS-9034.

¹⁰ LIS-9096.

¹¹ LIS-9142.

¹² Day 200 Page 24 should read, "backstop" rather than "stopgap".

¹³ LIS-795.

¹⁴ Day 201, page 101.

¹⁵ Day 201, page 149.

¹⁶ LIS-696

- 37. It is known that following the establishment of the Mental Health Commission, Miss Lyons, Secretary, wrote to the Lisburn Unit of Management on 24 November 1986 to advise of an intended visit to Lissue Hospital on 5 January 1987 by two members of the Commission, Dr B G Scally and Mrs J M Eve. The letter opens:
 - "You will be aware that the Mental Health Commission will be undertaking a programme of visits to hospitals whereby it is intended that each will be visited by some members of the Commission at least once per year."
- 38. The letter also makes it clear that as part of their visit private interviews with patients will be undertaken, and their files are to be made available at the times of their interviews. In responding, Mr Heaney, Group Administrator of EHSSB, noted that all parents/guardians of all patients were notified of the visit and offered the opportunity to meet with the Commission members. He recorded that no parent had indicated a wish for such a facility. A copy of these letters is found at **Exhibit 7.**
- 39. A report is available from a visit of J Eve of the Mental Health Commission to Lissue Hospital at **Exhibit 8**. While the report appears to be undated, the Board believes that it is likely this followed the visit in January 1987. Issues raised by the Commissioners are recorded thus:
 - "The Commissioners commented favourably on the multi-disciplinary approach and on the obvious harmony between the various professional disciplines.

 The only doubt raised concerned the adequacy of staffing in view of the high turnover and high occupancy rates..."
- 40. A statistical return provided by Lissue to the Mental Health Commission on 8

 December 1986 is at **Exhibit 9.**
- 41. While it is noted that the Commission indicated an intention to visit at least once per year, to date the Board has not identified any later reports of visits by the Mental Health Commission to Lissue Hospital. However, it is also noted that the Child Psychiatry service moved off this site on 28 February 1989.

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 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

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.

MENTAL HEALTH COMMISSION FOR NORTHERN IRELAND

HOSPITAL REPORT (Confidential) Future Visits Recommendation regular visit Future visit visit in 6 mths visit in 3 mths 4 urgent revisit Board Area Northern Board Southern 3 Eastern Western Date 5 January 1987 Date 0 50 Hospital (code) Hospital/wxix...Lissue Type of provision: Type pt mental illness mental handicap mixed hospital 500+ beds hospital 500 beds Size unit 100+ beds unit 50 - 100 beds unit - 50 beds hospital Type nursing home Hospital home for person in need other Status statutory voluntary hospital private Total number of patients 17 + 3 day patients No pts

Total number of detained patients	,	0	1	7
Names of Visiting Commissioners	No det	pts		
Dr Scally (Team Leader) Mrs Eve		0	0	0
(Reporter)				

from 9.30 am to 2.45 pm Time of visit:

Type of visit: day early morning night

)

announced unannounced Visit

Announced

REPORT

1.	Detention of in-patients for 48 hours (art 7(2))	,
	Comments on use/policy:	
	N/A	
2.	Is the availability of Pt II Doctors always satisfactory?	
	Always 1	Pt II
	Usually 2 Not often 3	1
	Never 4	·
	N/A 5	
	If no, please specify:	
		•
3.	Admissions from courts	
	(1) Number of art 42 remands for report etc	No/42
	(2) Number of art 43 remands for treatment	No/43
	(3) Number of convicted persons subject to hospital order under art 44	No/44
	(4) Number of convicted persons subject to interim hospital order under art 45	No/45
	The only 'court' admissions are of children who are subject to a fit person or place of safety order under the Children and Young Persons legislation.	
4.	Use of guardianship	
	Comments:	
	N/A.	
		1

Consent to treatment			
(1) Arts 63 and 64 N/A			
Is there (if appropriate) a form 21 or each detained patient?	22 for Yes No N/A	2 3	Consent 1
Are all the forms completed satisfactor	ily?		
	Yes No N/A	2 3	Consent 2
Is there an adequate flagging system for renewal/Art 67 review reports?	r		Consent 3
·	Yes No	2	
Comments:			·
N/A - except where parental rights have and authority given to social services.	been r	removed	
	:		
(2) Urgent treatment (art 68)			
Is a complete/accurate central record kept and monitored?	Yes No	2	Art 68
If yes, who monitors:		L	
f no. comments:			<u> </u>

Treatment prais for patrents			
Is there a wrîtten multi-disciplinary each patient?	programme	for	
A formal written plan is not kept. The MD team keeps notes based on	Always	1	
discussion at 2 x ½ day ward rounds	Sometimes	2	3
each week. The MD team comprises medical, psychology, nursing, teaching and social work staff.	Never ig	3	*
Is there a nursing process for each p	atient?		
This emanates from ward rounds.	Always	1	
	Sometimes	2	1
	Never	3	
Is there a medical formulation recordand explicit form for each patient?	ed in a cle	ar	
	Always	1	
	Sometimes	2	
	Never	3	1
Does the unit operate a "key worker" co-ordinate the individual's programme		_	
Keyworker is not always medical.	Always	1	
·	Sometimes	2	7
	Never	3	1
Are treatments which could be distress which are not specified under Article Aversion Therapy, Behaviour Modificat: carefully monitored and understood by BMP - modified by the full time clini psychologist - always written. TO - used by nursing staff/corridor (not room) for a few minutes.	64 eg Time ion Program staff?	Out,	1
After-care plans for patients			
Are individual follow-up treatment plant prior to discharge? The inpatient unit usually follows up for a month. They may be referred to outpatient unit for child psychiatric guidance. There is extensive liaison various outside bodies, eg social serves there a written policy/set of processions.	patients an Yes No	specified 1 2	
	Yes	1	
	No	2	
Comments:			

7.

No N/A

8.	Patien ^a	ts'	mone	y
8.	Patien	ts'	mone	١

Are capable detained patients allowed to handle money?

Yes

Money

3

Comments on administration/policy/use of rewards:

There is a seclusion policy laid down by No the Area Nursing Team but seclusion is never

Pocket money is kept on ward by nurses by ledger card system. It is usually issued daily. There is liaison with patients on this matter and with social services who provide money for children in care. Money is spent on sweets and on outings.

9. Seclusion policy

If yes,

)

Is seclusion used

Yes

used.

Seclusion 1

2

Are instances of seclusion recorded on the wards:

Always

Never N/A

Usually

Not often

3

Seclusion 2

Seclusion 3

centrally recorded accurately

Always

Usually Not often

3 4

5

monitored adequately

Always

Never

N/A

Never

N/A

Usually

3

4

Seclusion 4

Not often

Comments on seclusion policy/practice:		
Comments on seclusion rooms:		
Are voluntary patients nursed on locked wards	?	
If yes - give names of wards	Yes 1 No 2	Locked
Does the hospital have a written policy for nursing informal patients in secure provisions	s? 	
	Yes 1 No 2 N/A 3	Secure policy
Comments on use of de facto detention etc: Some wards are <u>lockable</u> to keep children <u>out</u> times. Absconders are catered for by staff to		1

10.

11. Mental Health Review Tribunals

Are patients aware of and do they exercise their right of appeal?

12. Staff training re Mental Health Order

Are staff given satisfactory training

satisfactory 1
not satisfactory 2
not covered 3

Comments:

Nursing staff - $2 \times \frac{1}{2}$ day study sessions. They can also attend weekly training sessions run by the child psychiatrist for medical/nursing staff.

Social workers - were given opportunity to attend training courses.

13. Patients Rights (art 27)

Was a notice concerning the visit on display on the wards? Yes No Were leaflets on patients' rights available, if so where? Yes From nurses. No Were patients advised of the Commissioners' visit? orally All parents were informed. 2 in writing both not informed N/A

Staff training

Notice

Leaflets

Pt advised

To whom has the duty for informing pate of their rights been delegated?	ients orally		
	nurses	1	Inf rights
	admin	2	
	other (specify)	3	
	more than]	. 4	
	no policy	5	<u> </u>
Were ward staff seen to be aware of pat	tients'		
rights?	all	1	Staff/rights
	most	2	
	some	3	
	few	4	
	none	5	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
Is patients' state of understanding and for possible further action recorded?	l need		
	Always	1	Pt understands
	Mostly	2	
	Occasionally	3	
	Never	4	
	N/A	5	
	,	1_1	
Comments on patients' awareness of righthose who have communication difficulti	ts, particular	L	•
	ts, particular	L	•
those who have communication difficulti	ts, particular	L	
those who have communication difficulti	ts, particular	l⊸i ly	
those who have communication difficulti	ts, particular es:	l⊸i ly	
those who have communication difficulti	ts, particular es:	l⊸i ly	
those who have communication difficulti	ts, particular es:	l⊸i ly	
those who have communication difficulti	ts, particular es:	l⊸i ly	
those who have communication difficulti	ts, particular es:	l⊸i ly	
those who have communication difficulti	ts, particular es:	l⊸i ly	
those who have communication difficulti	ts, particular es:	l⊸i ly	
those who have communication difficulti	ts, particular es:	l⊸i ly	
those who have communication difficulti	locked/unlo	l⊸i ly	

	i			
Number of detained patients interviewed		Pt	, 	
- at patients' request:		1		
- at Commissioners' request:		2		
Total patients interviewed:		3		
Number of complaints received:		4		
How many voluntary patients interviewed:		5		
Were any patients unavailable during the vis	it? Yes 1 No 2 N/A 3	Det p	pt	

General Comments on Interviews

(Please list separately the names of patients seen, with notes on individual interviews. In the case of a complaint, complete a separate complaint form for each).

General Comments on Ward Visits

1. The Psychiatric Unit

The unit is small, having 2 seating areas, a dining-room, some 4-bedded wards and some single rooms. Children are encouraged to bring their possessions and to put up pictures etc. Many go home alternate weekends, therefore, not as much use is made of this facility as might be.

There are 2 family flats with cooking facilities. These are used in particular for non-accidental injury cases.

A school with 4 classrooms and 5 teachers is attached to the unit and caters for children from 5-13, usually in conjunction with the child's own school.

Recreational facilities include secluded open-air play-area and room for indoor activities such as snooker, darts etc.

The children were seen at lunch and in school and were happy to talk with us.

2. Paediatric Unit

Although we were not scheduled to visit this unit we took the opportunity to visit the wards. They are used mainly as mental handicap wards and provide important respite facilities. The wards are large, bright and cheerful and there are indoor and outdoor play facilities.

Assessment and Treatment

Some of the children are admitted for assessment and stay for a short period only at Lissue. Others are there on a longer-term basis for treatment. The average stay is 2 months; some are less than 2 weeks, some over one year. The majority are boys.

General Comments on Wards Visits continued

The emphasis is on involving the whole family, including parents, siblings, grand-parents, uncles and aunts, as appropriate. The unit has a closed circuit video unit which is used to record interviews with families. One member of the multi-disciplinary team conducts the interview which can be watched then, or later, by the others so that a co-ordinated approach can be planned.

One psychiatrist insists that parents give an undertaking of regular contact and participation (see copy attached of relevant form) on a weekly basis at the least.

The ward records kept for each child are detailed and extensive.

FINAL MEETING BETWEEN COMMISSIONERS AND SENIOR STAFF

(All the points raised should be recorded and included in the subsequent letter to the hospital).

Issues raised by Commissioners

The Commissioners commented favourably on the multi-disciplinary approach and on the obvious harmony between the various professional disciplines.

The only doubt raised concerned the adequacy of staffing in view of the high turnover and high occupancy rates (see figures provided in advance).

Issues raised by staff

)

- 1. The role of nursing staff when apprehending absconders.
 - Children do run away from time to time. The doors are not locked. It is hoped to contain such children by maintaining close supervision but this is not always possible. Nursing staff queried whether it should not be the responsibility of social workers to look for the children and bring them back. It appears that, at present, whoever is available is used.
- 2. The future of the paediatric unit
 - A decision is expected in mid-February on the future of the unit which tends to be used for mental handicap cases though not designated as such. The staff share parental concern that respite facilities may not be so freely available when the unit is moved to Purdysburn (probably).
- Similar doubts exist about the future of the school as a result of the move.

Issues to be checked on next visit

Signed	J Eve
	·

- 37. It is known that following the establishment of the Mental Health Commission, Miss Lyons, Secretary, wrote to the Lisburn Unit of Management on 24 November 1986 to advise of an intended visit to Lissue Hospital on 5 January 1987 by two members of the Commission, Dr B G Scally and Mrs J M Eve. The letter opens:
 - "You will be aware that the Mental Health Commission will be undertaking a programme of visits to hospitals whereby it is intended that each will be visited by some members of the Commission at least once per year."
- 38. The letter also makes it clear that as part of their visit private interviews with patients will be undertaken, and their files are to be made available at the times of their interviews. In responding, Mr Heaney, Group Administrator of EHSSB, noted that all parents/guardians of all patients were notified of the visit and offered the opportunity to meet with the Commission members. He recorded that no parent had indicated a wish for such a facility. A copy of these letters is found at **Exhibit 7.**
- 39. A report is available from a visit of J Eve of the Mental Health Commission to Lissue Hospital at **Exhibit 8**. While the report appears to be undated, the Board believes that it is likely this followed the visit in January 1987. Issues raised by the Commissioners are recorded thus:
 - "The Commissioners commented favourably on the multi-disciplinary approach and on the obvious harmony between the various professional disciplines.

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- 40. A statistical return provided by Lissue to the Mental Health Commission on 8

 December 1986 is at **Exhibit 9.**
- 41. While it is noted that the Commission indicated an intention to visit at least once per year, to date the Board has not identified any later reports of visits by the Mental Health Commission to Lissue Hospital. However, it is also noted that the Child Psychiatry service moved off this site on 28 February 1989.

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- Similar doubts exist about the future of the school as a result of the move.

Issues to be checked on next visit

Signed	J Eve	
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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." 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

MENTAL HEALTH COMMISSION FOR NORTHERN IRELAND

HOSPITAL REPORT (Confidential) Future Visits Recommendation regular visit Future visit visit in 6 mths visit in 3 mths 4 urgent revisit Board Area Northern Board Southern 3 Eastern Western Date 5 January 1987 Date 0 50 Hospital (code) Hospital/wxix...Lissue Type of provision: Type pt mental illness mental handicap mixed hospital 500+ beds hospital 500 beds Size unit 100+ beds unit 50 - 100 beds unit - 50 beds hospital Type nursing home Hospital home for person in need other Status statutory voluntary hospital private Total number of patients 17 + 3 day patients No pts

Total number of detained patients	,	0	1	7
Names of Visiting Commissioners	No det	pts		
Dr Scally (Team Leader) Mrs Eve		0	0	0
(Reporter)				

from 9.30 am to 2.45 pm Time of visit:

Type of visit: day early morning night

)

announced unannounced Visit

Announced

REPORT

1.	Detention of in-patients for 48 hours (art 7(2))	,
	Comments on use/policy:	
	N/A	
2.	Is the availability of Pt II Doctors always satisfactory?	
	Always 1	Pt II
	Usually 2 Not often 3	1 .
	Never 4	·
	N/A 5	
	If no, please specify:	
з.	Admissions from courts	
	(1) Number of art 42 remands for report etc	No/42
	(2) Number of art 43 remands for treatment	No/43
	(3) Number of convicted persons subject to hospital order under art 44	No/44
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	The only 'court' admissions are of children who are subject to a fit person or place of safety order under the Children and Young Persons legislation.	
4.	Use of guardianship	
	Comments:	
	N/A.	
		1

Consent to treatment				
(1) Arts 63 and 64 N/A				
Is there (if appropriate) a form 21 or each detained patient?	22 for Yes No N/A	2 3		Consent 1
Are all the forms completed satisfactor	ily?			
	Yes No N/A	2 3		Consent 2
Is there an adequate flagging system for renewal/Art 67 review reports?	r			Consent 3
	Yes No	2		
Comments:				·
N/A - except where parental rights have and authority given to social services.	been r	removed		
	:			
(2) Urgent treatment (art 68)				
Is a complete/accurate central record kept and monitored?	Yes No	2		Art 68
If yes, who monitors:				
f no. comments:			Ì	<u> </u>

Treatment prais for patrents			
Is there a wrîtten multi-disciplinary each patient?	programme	for	
A formal written plan is not kept. The MD team keeps notes based on	Always	1	
discussion at 2 x ½ day ward rounds	Sometimes	2	3
each week. The MD team comprises medical, psychology, nursing, teaching and social work staff.	Never g	3	*
Is there a nursing process for each p	atient?		
This emanates from ward rounds.	Always	1	
	Sometimes	2	1
	Never	3	
Is there a medical formulation recordand explicit form for each patient?	ed in a cle	ar	
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Keyworker is not always medical.	Always	1	
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Are individual follow-up treatment plant prior to discharge? The inpatient unit usually follows up for a month. They may be referred to outpatient unit for child psychiatric guidance. There is extensive liaison various outside bodies, eg social serves there a written policy/set of processions.	patients an Yes No	specified	
is there a written policy/set of proce	Yes	1	
	No	2	
Comments:			

7.

No N/A

8.	Patient	ts'	mone	y
8.	Patien	ts'	mone	١

Are capable detained patients allowed to handle money?

Yes

Money

3

Comments on administration/policy/use of rewards:

There is a seclusion policy laid down by No the Area Nursing Team but seclusion is never

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9. Seclusion policy

If yes,

)

Is seclusion used

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Seclusion 1

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Are instances of seclusion recorded on the wards:

Always

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Usually

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3

Seclusion 2

Seclusion 3

centrally recorded accurately

Always

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monitored adequately

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Never

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N/A

Usually

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4

Seclusion 4

Not often

Comments on seclusion policy/practice:		
Comments on seclusion rooms:		
Are voluntary patients nursed on locked wards	?	
If yes - give names of wards	Yes 1 No 2	Locked
Does the hospital have a written policy for nursing informal patients in secure provisions	s? 	
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	Always	1	Pt understands
	Mostly	2	
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	Never	4	
	N/A	5	
Comments on patients' awareness of right those who have communication difficulties		ly	
			•
,			
Ward Visits			
Ward Visits	locked/unlo	cked*	
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Ward Visits	locked/unlo	cked*	
Ward Visits	locked/unlo	cked*	
Ward Visits	locked/unlo	cked*	,
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	i			
Number of detained patients interviewed		Pt		-
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Were any patients unavailable during the vis	it? Yes 1 No 2 N/A 3	Det p	ot	

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(Please list separately the names of patients seen, with notes on individual interviews. In the case of a complaint, complete a separate complaint form for each).

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There are 2 family flats with cooking facilities. These are used in particular for non-accidental injury cases.

A school with 4 classrooms and 5 teachers is attached to the unit and caters for children from 5-13, usually in conjunction with the child's own school.

Recreational facilities include secluded open-air play-area and room for indoor activities such as snooker, darts etc.

The children were seen at lunch and in school and were happy to talk with us.

2. Paediatric Unit

Although we were not scheduled to visit this unit we took the opportunity to visit the wards. They are used mainly as mental handicap wards and provide important respite facilities. The wards are large, bright and cheerful and there are indoor and outdoor play facilities.

Assessment and Treatment

Some of the children are admitted for assessment and stay for a short period only at Lissue. Others are there on a longer-term basis for treatment. The average stay is 2 months; some are less than 2 weeks, some over one year. The majority are boys.

General Comments on Wards Visits continued

The emphasis is on involving the whole family, including parents, siblings, grand-parents, uncles and aunts, as appropriate. The unit has a closed circuit video unit which is used to record interviews with families. One member of the multi-disciplinary team conducts the interview which can be watched then, or later, by the others so that a co-ordinated approach can be planned.

One psychiatrist insists that parents give an undertaking of regular contact and participation (see copy attached of relevant form) on a weekly basis at the least.

The ward records kept for each child are detailed and extensive.

FINAL MEETING BETWEEN COMMISSIONERS AND SENIOR STAFF

(All the points raised should be recorded and included in the subsequent letter to the hospital).

Issues raised by Commissioners

The Commissioners commented favourably on the multi-disciplinary approach and on the obvious harmony between the various professional disciplines.

The only doubt raised concerned the adequacy of staffing in view of the high turnover and high occupancy rates (see figures provided in advance).

Issues raised by staff

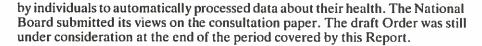
)

- 1. The role of nursing staff when apprehending absconders.
 - Children do run away from time to time. The doors are not locked. It is hoped to contain such children by maintaining close supervision but this is not always possible. Nursing staff queried whether it should not be the responsibility of social workers to look for the children and bring them back. It appears that, at present, whoever is available is used.
- 2. The future of the paediatric unit
 - A decision is expected in mid-February on the future of the unit which tends to be used for mental handicap cases though not designated as such. The staff share parental concern that respite facilities may not be so freely available when the unit is moved to Purdysburn (probably).
- Similar doubts exist about the future of the school as a result of the move.

Issues to be checked on next visit

Signed	J Eve





2.6.18 Review of Standing Orders

Revised Standing Orders for meetings of the National Board and its Committees were agreed at the Board's May 1986 meeting.

2.7 Inspection of Training Facilities

2.7.1 Training Facilities Inspected during 1985–86

Institutions at which courses of training for registration and/or courses of further training under the provisions of Section 6(1)(a) of the 1979 Act are provided must be approved by the National Board. To this end inspection and approval procedures constitute an important part of the Board's work.

During the period under review the following training facilities were inspected by officers of the National Board:

Training Institution	Location of Training Facilities	Date of Inspection
Northern Ireland College of Midwifery	Royal Maternity Hospital, Belfast	August 1986
	Wards 4, 5 and 15 of the Maternity Unit, Altnagelvin Hospital Londonderry (re- inspection)	October 1986
	Neo-natal Intensive Care Unit (formerly called the Special Care Baby Unit), Altnagelvin Hospital, Londonderry (re-inspection)	January 1987
	Maternity Unit, The Mid- Ulster Hospital, Magherafelt, Co. Londonderry	January 1987
	Jubilee Maternity Hospital, Belfast	March/April 1987
-	Genito-Unrinary Medicine Clinic, Altnagelvin Hospital, Londonderry (approved as a training area associated with the Family Planning Nursing Course)	January 1987
Northern Area College of Nursing	Ward First Floor South, Braid Valley Hospital, Ballymena, Co. Antrim (re-inspection)	June 1986
	Children's Surgical Ward, Waveney Hospital, Ballymena, Co. Antrim (re-inspection)	December 1986
	Children's Ward, The Mid- Ulster Hospital, Magherafelt, Co. Londonderry (re-inspection)	January 1987

Lissue Hospital, Lisburn, Co. Antrim January/February 1987 2.7.2

2.7.3

- a. Treatments that could be distressing for patients such as as Time Out and Behaviour Modification Programmes were carefully monitored and understood by staff.
- b. Seclusion was not used in Lissue.
- c. Some wards were lockable to keep children out at certain times and absconders were catered for by staff relocation.
- d. Staff were given satisfactory training. The report states "nursing staff $2 \times \frac{1}{2}$ day study sessions. They can also attend training sessions run by the child psychiatrist for medical/nursing staff. Social workers were given opportunity to attend training courses."
- 5.12. In the HSCB's submission, there is a strong parallel between the evidence given by former members of staff in Lissue and the recordings made in the Mental Health Commission report dated January 1987. In the HSCB's submission this demonstrates that weight should be given to the evidence of former staff members by the Inquiry.

National Board for Nursing, Midwifery and Health Visiting (1987)

- 5.13. Although the report has not yet been found, it is known through Minutes of the National Board for Nursing, Midwifery and Health Visiting for Northern Ireland ("the National Board") that an Inspection of Lissue Hospital was undertaken by that Board in January 1987. The minutes indicate that in 1987 the National Board accepted recommendations of their Education Committee and Mental Health Nursing Committee that neither the psychiatric ward nor the paediatric ward in Lissue Hospital be approved for nurse training purposes.
- 5.14. The minutes also show that the National Board agreed that further consideration of the Child Psychiatry Unit at Lissue for approval for nurse training purposes would require a number of matters to be addressed,

including a review of the policies and procedures for the nursing management of the children with particular attention to the need for a philosophy on which to base nursing care; the need for the current pattern of excessive door locking; and the supervision of children who abscond from the Unit.⁷⁴

- 5.15. On the evidence available, it is not known whether Lissue was re-inspected by the National Board and/or if it regained approval for nurse training before its closure in February 1989.⁷⁵ However, the documents show that on 8 April 1987⁷⁶ the Education Committee considered that their grave concerns should be drawn to the attention of the Area Board (the Eastern Health and Social Services Board) and their meeting on 9 December 1987⁷⁷ records receipt of a letter from the Chief Administrator, EHSSB and members noted that many of the items raised had been dealt with.
- 5.16. The National Board's withdrawal of approval for nurse training in 1987 is also referenced in an EHSSB memo dated 10 June 1988 from Ms. A Grant, Director of Nursing Services to Mr. R Lyons, Assistant Group Administrator in which Ms. Grant said:

"The National Board Inspection of Jan/Feb 1987 withdrew approval as a nurse teaching unit as the philosophy of care was seen as restrictive and "custodial". The structure and layout of Lissue was not seen as well suited for its present use."⁷⁸

5.17. In her evidence to the Inquiry on Day 200, Mary Hinds said:

"I think the term "custodial" is in relation to the use of locked rooms or locked doors. I don't know that for sure, because I haven't got the complete report. If ...

⁷⁴ LIS 1091

⁷⁵ Day 200, page 121

⁷⁶ LIS 1088

⁷⁷ LIS 1103

⁷⁸ LIS 226-227

the National Board seen practices that were inappropriate by way, for example, of restraint, I think they would have made mention of those..."

5.18. However, when Ms. Doherty pointed out certain likely limitations of the National Board's minutes, Mary Hinds agreed that the minutes could be read 'the other way round". When suggested to Mary Hinds by Ms Doherty that it would be a huge decision to remove nurse training approval, this was accepted.⁷⁹.

Stinson, Devlin & Jacob Review Reports (2009)

- 5.19. In 2008 allegations were made by LS 69 of abuse by a number of staff at Lissue Hospital. LS 69 had been an inpatient at Lissue during defined periods in 1987 and 1988. She also had admissions to Forster Green Hospital for periods of time in 1989 and 1990.
- 5.20. Arising from these allegations, a complaint was made to police and a strategy meeting was held between Belfast Trust and the PSNI after which Belfast Trust submitted a Serious Adverse Incident report to the Department of Health and notified the Eastern Health and Social Service Board (EHSSB)⁸⁰.
- 5.21. Thereafter, Strategy Discussions took place involving the EHSSB, Belfast Health and Social Services Trust, South Eastern Health and Social Services Trust and the police. Among the decisions taken by the strategy group was that the EHSSB would take the lead on the investigation of historic complaints in Lissue and Forster Green Hospitals.

⁷⁹ Day 200, page 120, lines 8-17

⁸⁰ LIS 106

Southern Health and Social Services Board - Area Strategic Plan 1987 - 19

Receipt was noted of the SH&SSB Area Strategic Plan 1987 - 1992.

Noted.

5.4 Southern Health and Social Services Board
Appointment to the Area Nursing Advisory Committee

It was reported that four nominations for appointment to the Area Nursing Advisory Committee had been forwarded to the Southern Health and Social Services Board on behalf of the National Board.

Noted.

5.5 DHSS (NI) Proposals to amend the Colouring Matter in Food Regulations (Northern Ireland) 1973

Receipt was noted of the above, copies of which had been distributed to a training institutions. Any comments received would be collated and a reply formulated to the DHSS (NI).

Agreed.

6.0 FINANCE AND GENERAL PURPOSES COMMITTEE

6.1 Unconfirmed Minutes of the Meeting held on 16 April 1987 (F&GP/2/87)

(Open Session)

Copies of the Minutes had been circulated.

Mr Coyne presented the Minutes.

It was noted that there were no recommendations arising from the Open Session but Mr Coyne drew members' attention to Minute 4.9 "Information Processing Equipment", and commented that this item was related to a recommendation arising from the Closed Session, Minute 11.1.

The National Board adopted the Minutes of the Finance and General Purposes Committee.

7.0 EDUCATION COMMITTEE

7.1 Unconfirmed Minutes of the Meeting held on 8 April 1987 (EC/2/87)

Copies of the Minutes and Summary of Recommendations etc. had been circulated.

Mr Darcy presented the Minutes.

7.1.1 Inspection of Clinical Facilities - Paediatric Unit, Lissue Hospital, Lisburn - January 1987 (Minute 6.3.1.1)

It was agreed to recommend to the National Board that the Paediatric Unit at Lissue Hospital be not approved for training purposes.

8.0 M

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LIS-1088

It was also agreed to recommend that further consideration of the Unit for approval would require particular conditions to be met as listed at paras 7.2.1 - 7.2.4 of the Report.

In addition it was agreed that the additional points arising, presented at sub-section 7.3 of the Report, be referred to the relevant authorities for consideration.

It was further agreed to recommend to the National Board that the Committee's grave concern about a number of points arising from the hospital as a whole listed at paras 1.14.6 - 1.14.10 in the Report be drawn to the attention of the Area Board and the relevant College of Nursing.

Agreed.

In reply to a member's enquiry, it was reported that the Unit had not been utilized for nurse training during the past six years.

7.1.2 Integrated Scheme of Training for Parts 1 and 8 of the Register (Minute 6.3.1.2)

It was agreed to recommend to the National Board that the Belfast Northern College of Nursing be permitted to proceed with curriculum planning in respect of the above course.

Agreed.

7.1.3 Report of the Re-inspection of Ward 3, Mid-Ulster Hospital, Magherafelt - March 1987 (Minute 6.3.4.1)

It was agreed to recommend to the National Board that Ward 3, the Mid-Ulster Hospital be approved as an area for nurse training purposes.

It was also agreed that attention be drawn to the points arising from the re-inspection detailed at para 10.10.2 in the report.

Agreed.

The National Board adopted the Minutes of the Education Committee.

8.0 MIDWIFERY COMMITTEE

8.1 Unconfirmed Minutes of the Meeting held on 25 March 1987 - MC/2/87

Copies of the Minutes and Summary of Recommendations etc. had been circulated.

Miss E Duffin presented the Minutes.

8.1.1 Report of the Inspection of Clinical Facilities at the Maternity Unit, Mid-Ulster Hospital, Magherafelt (Minute 6.3.1.2)

It was agreed to recommend to the National Board that the Ground Floor Maternity Unit, the Labour Ward, and the Ante-natal Clinic be approved for training purposes.

(b) Teaching Staff Expertise

That the Committee were concerned by the reference in the Training Committee's letter to a lack of expertise on the part considered that there may be a need to seek information specifically about what measures were being taken to rectify

(c) Proposals to resolve the difficulties

Finally the Committee noted that the response did not appear to deal with the problems highlighted in the Report, in terms of proposals for their resolution.

After consideration members agreed the Education Committee's proposal that a composite response be forwarded to the Director of Nurse Education outlining the above issues which concerned both Committees.

Agreed.

(ii) Copy of a letter dated 7 October 1987 from the Chief Administrator containing the response of the Eastern Health and Social Services to the above Report had been circulated.

It was noted that the Education Committee had requested that a covering letter should be sent to the Eastern Health and Social Services Board with the Report stressing the concern of the Committee to the problem areas contained therein. It was commented that it was encouraging to see that the EH&SSB had dealt with the issues promptly.

Noted.

(iii) Receipt was noted of a letter dated 12 October 1987 from the Director of Nurse Education of the Belfast Northern College of Report.

Noted.

4.4 Entry to Training Requirements - Rule 16 (Minute 4.8)

It was reported that to date clarification had not been received from the UKCC in relation to the query regarding Rule 16, although it was understood that it had been discussed at their meeting on 20 November 1987. Concern was expressed by members at the delay in receiving clarification as this issue had been referred to the UKCC in July 1987.

The Chief Executive Officer reported that at a meeting of the Chief Executive Officers of the UKCC and other National Boards there was definite indication that this clarification would be forthcoming in the near future.

Noted.

fr McCabe arrived at this point in the meeting (10.30 a.m.).

- 51. The Royal Belfast Hospital for Sick Children also had a Matron, who would have visited Lissue Hospital. Following reorganisation it is believed that the Matron in charge would have been attached to Lisburn District. The Board is aware that Dr Nelson recalls such visits.
- 52. No records have been located by the Board in relation to any visits to Lissue undertaken by the Eastern Health and Social Services Board after it assumed responsibility in 1973. However the Board believes, having spoken to relevant staff, that the Area Executive Team visited on an annual basis.
- 53. Whilst not directly related to the running of the Lissue Unit, the Board believes that the Royal College of Psychiatrists visited the Royal Belfast Hospital for Sick Children, including the Child Psychiatry Unit at Lissue, every three years to examine the educational content of training and professional development of doctors. The Board believes that the visits from the Royal College of Psychiatrists lasted in or around two days during which members of the College would have met and talked with staff.
- 54. Similarly, it is known that following its establishment in 1983, the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC) became the nursing profession's regulatory body and National Boards were set up in each country of the United Kingdom, including Northern Ireland, to monitor the quality of nursing and midwifery education courses, and to maintain the training records of students on these courses. The Board is aware that from an EHSSB memo dated 10 June 1988 from Ms. A Grant, Director of Nursing Services to Mr. R Lyons, Assistant Group Administrator that " *The National Board Inspection of Jan/Feb 1987 withdrew approval as a nurse teaching unit as the philosophy of care was seen as restrictive and "custodial". The structure and layout of Lissue was not seen as well suited for its present use.*" **Exhibit 12.**

Q10 How was Lissue funded?

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

A20

EASTERN HEALTH AND SOCIAL SERVICES BOARD

MEMORANDUM

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

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

10 June 1988

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

 ${\rm I}$ will only comment on those paragraphs which include a nursing item in the above letter.

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

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

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

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

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

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

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

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

Continued/....

3P 077

OFFICIAL-SENSITIVE-PERSONAL

LIS-1090

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

Copies of the above Report had been circulated whilst a paper detailing amendments for Sections 10.0, 10.1 and 11.6 of the Report were tabled.

LS 107 reported on the background to this issue.

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

Accordingly it was agreed to recommend to the National Board that the Report of the Working $\overline{\text{Group be approved}}$.

Agreed.

6.2 Local Training Committee Minutes

Receipt was noted of the following:-

- (i) College of Mental Health Nursing...... February 1987
- (iii) Western Area College of Nursing......24 February 1987

6.3 Colleges of Nursing

6.3.1 College of Mental Health Nursing

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

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

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

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

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

OFFICIAL-SENSITIVE-PERSONAL

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

- 1.0 Policies and procedures for the nursing management of the children should be reviewed, and in this context particular attention should be given to:-
 - 1.1 the need for a philosophy on which to base nursing care
 - 1.2 the need for the current pattern of excessive door locking
 - 1.3 the supervision of children who abscond from the Unit

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

- 2.0 The practice of storing non-medicinal material in the medicine storage cupboard should be discontinued, and the security light should be functioning (Ref. Page 25, Item 12.4).
- 3.0 The policy for secure storage of video tapes should by clarified (Ref. Page 26, Item 12.6).
- 4.0 Copies of appropriate nurse training programmes should be available in the Unit (Ref. Page 26, Item 13.1).
- 5.0 Learning objectives and teaching/learning processes designed to facilitate their achievement should be developed as a joint exercise by staff from the Unit and staff from the College of Nursing (Ref. Pages 26 and 27, Item 13.3).
- 6.0 An adequate clinical teaching service should be provided by the College of Mental Health Nursing (Ref. Page 28, Item 13.4).

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

Agreed.

6.3.1.2 <u>Inspection of Clinical Facilities</u>, Ward 11, Holywell Hospital - Training Committee Response

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

Noted.

Page 83 1 recommend to the National Board that the Child Psychiatry Unit at Lissue Hospital be not approved for 2. nurse training purposes." 3 If we can go on to say that: 4 "It was also agreed to recommend that further 5 consideration of the unit for approval would require the 6 under-listed conditions to be met and be subject to a satisfactory re-inspection. 8 9 Policies and procedures for the nursing management of the children should be reviewed and in 10 this context particular attention should be given to: 11 1.1. The need for a philosophy on which to base 12 13 nursing care. 1.2. The need for the current pattern of excessive 14 15 door locking. The supervision of children who abscond from 16 the unit." 17 18 Then there's storage of medicines, videotapes. "Copies of the appropriate nursing training 19 programme should be available in the unit", 20 2.1 which suggests they weren't. 22 "Learning objectives and teaching/learning processes designed to facilitate their achievement should be 23 24 developed. 25 An adequate clinical teaching service."

- 1 From the Inquiry's viewpoint rather than the
- 2 clinical teaching aspect --
- 3 A. Uh-huh.
- 4 Q. -- of these minutes it is clear that this is the basis
- on which -- I have forgotten the name -- Miss Grant --
- 6 A. Uh-huh.
- 7 Q. -- formed the view that the philosophy was in some way
- 8 custodial because of the locking of the doors.
- 9 A. It is all I can assume from these minutes, because
- 10 unfortunately we don't have the complete report,
- although we do continue to look for it. I think if it
- was anything more, if it was about individual nursing
- practice that they seen that they felt was inappropriate
- or harmful, I think the National Board would have made
- note of it, given they have made note of other issues of
- 16 concern in their minute, but that's my assumption.
- Because I don't have the full report, I can't be sure.
- 18 Q. But certainly there must have been something in the
- 19 inspection --
- 20 A. Uh-huh.
- 21 Q. -- about the locking of doors that caused them a degree
- of concern.
- 23 A. Yes. I mean, it's noted there. I think what is also
- interesting is the Mental Health Commission went into
- Lissue the same month and the same year and their

to Mr Brown, who was the Unit Administrator.

2.

Now the response to that or a response to that is at 226, which is the memo that you and I were looking at, and that's from Miss Grant to Mr Lyons. She is dealing with the paragraph numbers. She is commenting on those paragraphs, which included nursing item in above letter. She scrolls on down through it. Then she says -- it is recorded that:

"The National Board inspection of

January/February 1987 withdrew approval as a nurse

teaching unit as the philosophy of care was seen as

restrictive and custodial. The structure and layout of

Lissue was not seen as well suited for its present use."

Now I pause there to say that we have never located the National Board inspection report and as late as ten minutes ago the researcher that the Inquiry has engaged, who has been trying to locate it all day today in PRONI, has been unable to locate it. He has managed to find an annual report of the National Board of Nursing which refers to it, and we have seen minutes from the National Board and we can look at that at 1090. You will see at the bottom of that page at 6.31:

"Colleges of Nursing.

College of Mental Health Nursing.

Inspection of clinical facilities -- Child

- the list of teaching hospitals and there was a memo that
- we looked at at LIS226. I think you also had the
- 3 opportunity to look at the report, which I think is at
- 4 1416. Sorry. That's a different report. I beg your
- 5 pardon. We don't have -- I was explaining to you that
- 6 we don't actually have --
- 7 A. Uh-huh. Uh-huh.
- 8 Q. -- the report from The National Nursing Board that led
- 9 them to withdraw --
- 10 A. Uh-huh.
- 11 Q. -- approval for Lissue as a teaching hospital for
- 12 nurses. So you were unaware of that. You were unaware
- 13 -- I mean, when you were talking to me, you said that it
- was complete news to you.
- 15 A. Uh-huh.
- 16 Q. You do remember nurses -- student nurses being in Lissue
- and then that suddenly stopping, but nobody ever
- 18 explained to you as one of the consultants in charge of
- 19 this unit why that happened.
- 20 A. Yes. I mean, I would say several things about that. We
- 21 weren't -- the consultants certainly weren't made aware
- of that report, which would have at least allowed us to
- at least monitor and look at the situation and try to
- help to ensure that the points that were being raised,
- critical points that were being raised, would have been

- 1 A. -- on an enuretic alarm system.
- 2 Q. Well, in paragraph -- sorry. At paragraph 6 here you
- just talk about the kind of records that were kept.
- 4 Then in paragraph 7 you go on to what you term
- 5 general issues and concerns about the Child Psychiatry
- 6 Unit. You say that:
- 7 "The interests of different line managements
- 8 resulted sometimes in a lack of empathy with the overall
- 9 purposes of the unit. As already mentioned, issues
- 10 regarding the building were dealt directly by Eastern
- 11 Health & Social Services Board. Medics were the
- responsibility of the Health Board. Social workers were
- managed by North & West Belfast District, nurses managed
- by Lisburn & Down District, and psychologists by The
- Royal Group of Hospitals. The different Trusts were
- always looking to cut staff. In other words, there was
- 17 little cohesive caring for our service, as might have
- occurred if we had operated under one Trust."
- 19 We have been looking at documents yesterday --
- 20 A. Uh-huh.
- 21 Q. -- which suggested that the Department --
- 22 A. Uh-huh.
- 23 Q. -- had, in fact -- whenever the 1973 reorganisation --
- 24 A. Uh-huh.
- 25 Q. -- was taking place, The Ministry of Health was being

5. Conclusion.

- 5.1. The Inquiry has now heard the evidence in relation to this module. The DoH has not sought to directly challenge any complainant in relation to abuse. The DoH regrets any abuse that did occur and condemns both the perpetrators and any others who by act or omission allowed abuse to take place.
- 5.2. The DoH submits that in view of the very different legislative and contextual background to this module, involving a children's hospital, the Department acted appropriately at all times. From 1973 in particular, having delegated the power to provide inter alia hospitals to the Health and Social Care Boards, it is not a failing of the Department not to have inspected Lissue Hospital. This was a multidisciplinary, consultant led unit and staff were subject to professional codes of conduct and obligations requiring them to report inappropriate care. Daily children's meetings and multidisciplinary meetings were held. Children went home regularly at weekends and families attended regularly, not only to visit, but also to be involved in family therapy. Families had the opportunity to stay on site. It is suggested that no evidence has been presented to the Inquiry to suggest that the practices of the MHLG, later the DHSSPS, in respect of children's hospitals were contrary to accepted practices in other jurisdictions.

Dated this 13th day of May 2016.

Bar Library

strategic planning and policy. It is submitted that whilst the Department does not appear to have exercised the wide power under Article 50 the 1972 Order, this is not a failing given the nature of Lissue as a hospital and the factors outlined below.

- 2.6. Unlike children's homes, Lissue was a hospital with many layers of oversight. The psychiatric unit was a multidisciplinary, consultant led unit, with daily attendance by doctors, nurses, social workers, psychologists and consultant psychiatrists. This resulted in significant layers of oversight and consideration of the practices and procedures by medical professionals who were registrants of their professional bodies, with a professional code and duty to identify acts or omissions of concern and report these. This was confirmed by a former member of the nursing staff¹⁷.
- 2.7. Unlike children in children's homes who had been removed from the care of parents and did not often have the benefit of stable supportive families, the children in Lissue went home frequently. Many went home every weekend, families were encouraged to visit during the week and many families took part in family therapy sessions. There was also provision on site for parents to stay. HIA3 confirmed that his mother and father came to visit him during the week and he would get home at weekends. HIA3's mother spoke to staff about a complaint HIA3 had made to her that staff had used the term "angry" in a report written 18 about her son. This parental interaction provided a significant opportunity for children to report any abuse, albeit within the social and cultural context of the time parents might have been less likely to believe a child's complaint or to challenge medical professionals.
- 2.8. Multidisciplinary team meetings were held every day of the week¹⁹ and two half-day ward rounds held weekly. Dr Nelson, one of the two

¹⁷ LS81 Day 198 Page 99

¹⁸ Day 199 Page 18.

¹⁹ Dr McAuley Day 201 Page 107.

5. Conclusion.

- 5.1. The Inquiry has now heard the evidence in relation to this module. The DoH has not sought to directly challenge any complainant in relation to abuse. The DoH regrets any abuse that did occur and condemns both the perpetrators and any others who by act or omission allowed abuse to take place.
- 5.2. The DoH submits that in view of the very different legislative and contextual background to this module, involving a children's hospital, the Department acted appropriately at all times. From 1973 in particular, having delegated the power to provide inter alia hospitals to the Health and Social Care Boards, it is not a failing of the Department not to have inspected Lissue Hospital. This was a multidisciplinary, consultant led unit and staff were subject to professional codes of conduct and obligations requiring them to report inappropriate care. Daily children's meetings and multidisciplinary meetings were held. Children went home regularly at weekends and families attended regularly, not only to visit, but also to be involved in family therapy. Families had the opportunity to stay on site. It is suggested that no evidence has been presented to the Inquiry to suggest that the practices of the MHLG, later the DHSSPS, in respect of children's hospitals were contrary to accepted practices in other jurisdictions.

Dated this 13th day of May 2016.

Bar Library

consultant psychiatrists, visited Lissue every day at different times of the day and at night, including unannounced visits during which he discussed issues with staff and toured the unit²⁰.

- 2.9. The nature of the treatment itself involved psychiatrists speaking to the children to identify issues or factors that might be of concern and to address these. Children also attended a 'children's meeting' every morning with nursing staff and at times a psychologist and registrar. During these meetings children were encouraged to discuss problems and occurrences the previous day²¹.
- 2.10. Lissue Hospital was also visited by the Belfast Hospital Management Committee and later the Area Executive Team of the EHSSB. Ms. Mary Hinds for the Health and Social Care Board suggested in oral evidence that whilst there was no written evidence available the "Health and Social Care Board and Public Health Authority view is that there would have been inspections carried out on Lissue at Board Level." ²²
- 2.11. The Mental Health Commission for Northern Ireland established by the Mental Health (Northern Ireland) Order 1986²³ pursuant to its duty to "keep under review the care and treatment of patients" visited Lissue in 1987 as part of an intended programme of annual visits to each hospital by the Commission²⁴.
- 2.12. Dr Harrison in oral evidence intimated that inspection per se is ultimately a blunt instrument and that unless inappropriate practice had been observed or information communicated to inspectors it is

²⁰ Day 201 Page 132.

²¹ Day 199 page 44.

²² Day 200 page 79.

²³ Article 85 (not section 20 as referred to at LIS-794).

²⁴ LIS-088.

unlikely any abusive practices would have been identified²⁵. In the case of Lissue where there was a multidisciplinary team of professionals who were tasked to build up trust with the children to enable them to share fears and concerns, this is particularly true. It must be more likely that disclosures or observations of abuse would in the first instance have been made to or noted by these people with whom children were familiar and who themselves were familiar with accepted standards of practice.

-

²⁵ Day 200 Page 28.

- this information last week. So we are happy to call
- 2 those files in from PRONI and look at them and see if
- 3 there's any relevant information, but, as I say, I'm
- 4 very doubtful.
- 5 Q. Unfortunately, although there may have been Board
- 6 inspections or even departmental visits to Lissue, we
- 7 have no records of those in existence currently. Isn't
- 8 that right?
- 9 A. That's right.
- 10 Q. The only report of any inspection or visit is that of
- the Mental Health Commission from 1987?
- 12 A. That's it.
- 13 Q. Is it possible -- I mean, I think we were having this
- discussion as well about inspections and what
- inspections could be expected to ascertain, and I think
- 16 you describe it as a blunt instrument in saying if
- an inspection is being carried out, it is unlikely that
- abusive practices might come to light. Really they come
- 19 to light as a result of complaints being made.
- 20 A. Well, complaints or those who are being abused learning
- 21 to trust the people whom they are in contact with. If
- 22 you take Lissue as an example, if, for example, the
- 23 Hospital Advisory Service had visited there, that would
- have been perhaps a one-day visit by professionals, who
- 25 would have been unknown to the patients, but those

- 2. While I was working with Dr McCune, he, I and other colleagues that had worked in Lissue influenced the development of the child and adolescent mental health nurse training course at Purdysburn School of Nursing. This programme commenced in 1990, which later transferred into Queen's University and has been registered by the Nursing and Midwifery Council (Nursing and Midwifery regulation body) as a recognised course. Upon completion of that course you are considered a specialist nurse. I hold that qualification since April 1992 and it is registered on my statement of entry with the NMC. I was commissioned to lead the review of Child and Adolescent Mental Health with Mr Charles Bamford, and within NI. I also had involvement in strategic planning in the scoping and preparation for the design of the current regional provision within NI.
- 3. My line manager upon commencing employment in Lissue 1984 was LS 21 I recall that LS 78 had just left the ward when I was arriving. We were divided into teams so there was one senior staff member that you would have been managed by LS 21 was my team manager.
- 4. I recall my period as a nurse in Lissue with fondness. It was a proactive experience working with Dr McAuley and Dr Nelson. They were implementing new models of practice. Dr McAuley used a behavioural model and Dr Nelson a family therapeutic model. These required different approaches with different children, and they were both of their time. Many of the techniques were new and innovative at that time in relation to the video undertaking with families, with their consent etc. From an academic model perspective I recall using the work of Michael Rutter and Dr Minuchin, and these models would also have been implemented nationally across the United Kingdom. I also recall student doctors and nurses in the Unit, as well as other disciplines working together with families in a multidisciplinary way.
- 5. There were some of the Multi Disciplinary Team (MDT) in Lissue and some came from the Royal Hospital in Belfast. There was a movement of professional staff between the two hospitals to support the children who were admitted or attending as day patients to the ward. There were weekly significant meetings of the MDT.

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

- 13. Communication between the different disciplines of the MDT was very good in my experience. I recall raising queries about the implementation of plans, for example time out, with Dr McAuley, who was always receptive and helpful, as was Dr Nelson. Each would have taken the time to talk through the matter raised.
- 14. There were some occasions where I observed what I perceived was a misapplication of a behavioural technique, this was in relation to time out. This had two aspects: first, a move to implement time out first before using a diversionary technique and secondly, to extend the time the child was in time out waiting until the child was quiet prior to counting that time within the 1 min per year application of time out. Although the extension of time was for minutes longer I still shared this information with senior staff, the aim of which was to clarify seek consistency of approach and not expect the patient/child to remain any longer in time out than was prescribed by their age and the medical team. When I had such concerns I brought this to the attention of senior staff. This would then have been discussed with the Nurse in question and I would have been aware of their practice modifying, thus resolving the issue. I did not consider what I witnessed as abusive practice or this I would have reported, and never saw time out being extended to significant periods.
- 15. Another issue that would arise with time out related to the specific child and whether the timing of the time out should commence when the child was not yet quiet. For some children this had the potential to extend the time unduly in my view. This issue was raised with Dr McAuley, who was very receptive and engagement would then ensure the modification of the technique to suit the needs and presentation of that particular child.

- 59. From 1973, the nursing staff came under the control of Lisburn District (under EHSSB), who took on administrative responsibility for the hospital after reorganisation. Clinical links were maintained however with the parent hospital, RBHSC, which following reorganisation fell within the North West Belfast District (also EHSSB). Medical staff continued to be employed by that District. In 1984, there was a reorganization of hospitals and the North and West Belfast District was replaced by the Royal Group of Hospitals and a separate Community Management Unit for the North and West Belfast area (source: Richard Clarke's book entitled "The Royal Victoria Hospital Belfast, a history 1797-1997", page 141).
- 60. By 31 December 1983 it is known from **Exhibit 13** that the full staff complement in Lissue was described thus:
 - "Consultant medical staff responsibility for both specialities is provided by consultants with commitments both at this hospital and at the Royal Belfast Hospital for Sick Children. In addition, general practitioners have sessional commitments. Of the 39 nursing staff in post at 31 December 1983, 24 (61.5%) were trained nurses. There were 30 ancillary and general staff, 2 professional and technical staff and 2 clerical staff, making a staff complement for the hospital of 73 persons."
- 61. These 73 staff did not include the medical staff that were employed through RBHSC, as it will be noted that numbers of doctors are not detailed. It is known that the Child Psychiatry Unit at Lissue was a Consultant led unit. The Board is aware that Dr Nelson recalls visiting on an almost daily basis, even for short periods, at varying times. Dr McAuley, who was appointed in 1976, himself recalls that he would have attended Lissue Hospital once a week. They each recall a weekly ward round undertaken with the multi-disciplinary team. Daily cover would have been provided by doctors at Registrar level. In addition, the statistic of 73 staff does not include the social workers and psychologists who worked in Lissue, or the teaching staff who taught the pupils in the school on site.
- 62. It should also be noted that these 73 staff covered both units at the Lissue site, which in 1983 had 20 beds each, making a total of 40 beds. For that year it is

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

3.1 There were 2 Units in Lissue Hospital;

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

- 3.2 The Unit was located in an old country mansion. The rooms were spread over an area accessed by corridors and this was never completely satisfactory in facilitating children's whereabouts it on occasions stretched nursing resources.
- 3.3 The Unit was established to provide for a maximum of 20 inpatients and 5 day patients, and accepted children up to 14 years of age.
- 3.4 A school was provided for the Unit by South Eastern Education and Library Board (S.E.E.L.B.)

3.5 Staffing:

- 3.5.1 Staffing provision for the Unit roughly followed the Royal College of Psychiatrists recommended levels set out in around 1971.
- 3.5.2 Consultants in Child and Adolescent Psychiatry. Between 1976 and 1978 there were 3 consultants visiting the Unit. Dr Nelson attended many times each week 1 of his visits being for a complete morning multidisciplinary meeting (M.D.M). Dr Barcroft and I attended for one mornings M.D.M. and usually on at least 1 other occasion each week, in order to discuss cases or work directly with cases. After 1978 Dr Barcroft left to take up a job in England. His input to Lissue was not replaced.
- 3.5.3 A medically qualified psychiatric Trainee attended the Unit on a full time basis and normally each trainee remained for a 6 month period.
- 3.5.4 Nursing Staff. The Unit was staffed with S.R.N. and S.E.N. nurses. This always included a nurse at Charge Nurse/Sister grade.
- 3.5.5 A Social Worker was based full time at the Unit and as well as working with children and families would have liased with Social Services when required.
- 3.5.6 A Psychologist was based full time at Lissue and worked with children and families.
- 3.5.7 For several years (until 1978) there was also an Occupational Therapist whose work was largely child focused. The post was not replaced when this person moved to another job.
- 3.5.8 Overall a Multi Disciplinary ethos was in place see below.

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

- 9. My memory is that I was expected to record the implementation of a model of care that had been prescribed by the consultant in charge. At the MDT that is where the plan would have been modified. That was the expected practice. Any changes to the plan should have been recorded in the notes. If I was working with someone with encopresis the plan should have been evident, so that as key nurse if I was not on the Ward other Nurses could be aware of the plan and what was expected, intended, in the management of that child. For a child with encopresis, this would have psychological, nutritional, fluid intake and toileting elements or factors.
- 10.I recall that I would have been specifically assigned to four children as key Nurse at a time. A second Nurse would also have been assigned, with a health care support person making up a core team of three for each four patients. I do not recall difficulties with staffing while I was there; in fact this was a considered a good staff, patient ratio. We of course had occasions when staff members were sick when alternative plans had to be made to cover care for their patients care needs, but short staffing is not a prevailing memory I have during my time in Lissue between 1984 to 1986.
- 11. As regards records in Lissue, I recall that each section of the MDT kept their notes separately, in different cabinets in the one room, during the admission.

 There were other diary type books that information was recorded in. I cannot recall exactly what types, but I do remember other logs. I also recall people were advised not to write into the book. If it was relevant to a specific child it needed to be recorded in their notes.
- 12. There was a manual on the ward, with printed out copies of guidance that you would be expected to read and be up to date on. I recall that when I started, I spent the first few days having the time to read that folder; this was part of an induction period. If you later had any doubt you would be directed back to the office to refresh your knowledge and practice. Other training involved a planned

- 1 Q. You have heard -- we have heard -- the Inquiry has heard
- that staff generally were rough with children.
- 3 A. Generally?
- 4 Q. Rough with children.
- 5 A. That's not --
- 6 Q. I mean, grabbing them by the neck or by the hair,
- 7 pulling them by the arm.
- 8 A. No, no, no, no, no. Not my experience, nor would I have
- 9 tolerated it.
- 10 Q. Just turning to another matter, which is about staffing
- levels, paragraph 25 you say that there were fifteen to
- twenty-five children in the unit at any time. We know
- that would have included the five day patients --
- 14 A. Yes.
- 15 Q. -- although some record that we saw at the start of
- looking at this model showed in one case there was
- twenty-one in-patients in Lissue.
- 18 A. Yes.
- 19 Q. You remember that? It would have been mid-'80s I think.
- 20 A. Yes.
- 21 Q. At any stage in Lissue did you consider the staffing
- levels to be inadequate?
- 23 A. There were times when staff reduction through leave or
- legitimate -- pregnancies and then holiday -- so there
- were occasions -- and sickness, of course -- there were

- occasions when I had concerns, and I passed this on to
- 2 my own manager, line manager, that I had worried that
- 3 perhaps our resources were being stretched with the
- 4 admission of a new individual with the potential for
- 5 violence. That was my greatest worry, bringing in
- 6 children who were potentially likely to intensify the
- 7 ambience.
- 8 Q. One of the suggestions that we have seen -- the Inquiry
- 9 has seen is as time went on, Lissue was used by Social
- 10 Services to place those children who could not be
- 11 contained in a children's home or couldn't be contained
- in their own home and really were not perhaps
- psychiatric patients as such. Would that have been your
- 14 experience, that -- I am using very emotive language and
- I don't mean to, but was Lissue something of a dumping
- 16 ground for some children, do you think?
- 17 A. I would not have been happy with that, and I am trying
- 18 to remember if that -- if a child in a children's home
- 19 setting had been proving difficult, the first thing
- 20 would have been to refer that to The Adolescent and
- 21 Child Psychiatry Department at RBHSC, where
- a determination would have been made whether this child
- is psychiatrically, emotionally out of control and
- 24 needing help. In that case it would be a legitimate
- 25 resource to use the in-patient unit. I don't --

is, therefore, not possible to detect retrospectively any sustained period of children requiring supervision at the same time, not getting the care they needed. However, the notes made on individual children provide an indication of the concerns felt by nursing staff and the impact on children may be assessed by the level of misbehaviour and gratuitous violence noted during the Review of their case records. Further details are provided at Appendix 9.

The following addresses issues relating to staffing and supervision levels from the 4 cases within this category. Two girls aged 10 and 13 and two boys aged 9 and 14 were identified by staff as requiring higher levels of supervision than staffing levels permitted. The implication for the supervision of children and their care are evident from these records, which may not fully reflect the position given that only a small sample of cases was reviewed:

Issues

Apart from being noted on the files was any recognition given by management to the concerns raised by staff in 1979 and 1980 regarding staffing levels? When one considers the high level of restraint used at time which took up considerable staffing resources and the complexity of children's needs the staffing complement needs to be given particular attention when considering the overall findings of this review.

There is no record on the case files of a response from the Director of Nursing to Dr. A's letter.

Were the staffing levels at Lissue and Forster Green Hospitals at a level to provide the required level of supervision given that staffing levels were raised over a period of years?

6.1.6 Staff / Child Relationships.

There were 2 girls aged 8 and 14 (Child A and Child H) about whom the records suggested issues relating to the appropriateness of the staff/child relationship (see Appendix 10). These are set out below in some detail. There is no indication of management oversight of case files which potentially would have brought the potential risks associated with the situations to the attention of the staff member so that safer practices could be promoted to minimize the risk of complaint.

The need for management oversight of records as a tool to monitor practice is not evident in these cases or in others. Neither is there any sense that comments such as those recorded in respect of an 8 year old child were subject to closer scrutiny. The practice in the case of a 14 year old girl of undertaking therapeutic work on a long practitioner basis in her bedroom late at night is also one which managers should have reviewed to asses how safer practices could have been employed to protect both the staff and patient.

- 1 because we were talking about what would be the
- 2 requisite number of nurses per patient bed. You have
- 3 estimated I think it was just over one.
- 4 A. I think when -- on the information I've got available,
- 5 and it was of its day, I have estimated that they
- 6 probably had about 1.13 nurses per bed. In today's
- 7 language that would be equivalent to a surgical ward,
- 8 and I think you have to bear in mind this was
- 9 a children's intensive care unit, not in the way we
- think of an intensive care unit in a hospital, but
- 11 that's actually what it was. The modern equivalent is a
- staffing ratio of about 3.3 nurses per bed.
- 13 Q. So although in 1987 the Mental Health Commission wasn't
- actually looking at it in those terms --
- 15 A. Yes.
- 16 Q. -- they were correctly identifying that there was
- inadequate staff levels?
- 18 A. I think again based on the information I have their
- visit was in 1987, and if I recall documents, there was
- an indication that the occupancy rate was going up, and
- if they were also admitting more acutely ill or other
- admissions to the unit in an environment where there
- were multiple care models, that would be bound to have
- 24 a stress on staff.
- 25 Q. Well, in paragraph 39 of your statement you believe that

FINAL MEETING BETWEEN COMMISSIONERS AND SENIOR STAFF

(All the points raised should be recorded and included in the subsequent letter to the hospital).

Issues raised by Commissioners

The Commissioners commented favourably on the multi-disciplinary approach and on the obvious harmony between the various professional disciplines.

The only doubt raised concerned the adequacy of staffing in view of the high turnover and high occupancy rates (see figures provided in advance).

Issues raised by staff

)

- 1. The role of nursing staff when apprehending absconders.
 - Children do run away from time to time. The doors are not locked. It is hoped to contain such children by maintaining close supervision but this is not always possible. Nursing staff queried whether it should not be the responsibility of social workers to look for the children and bring them back. It appears that, at present, whoever is available is used.
- 2. The future of the paediatric unit
 - A decision is expected in mid-February on the future of the unit which tends to be used for mental handicap cases though not designated as such. The staff share parental concern that respite facilities may not be so freely available when the unit is moved to Purdysburn (probably).
- Similar doubts exist about the future of the school as a result of the move.

Issues to be checked on next visit

Signed	J Eve
	·

STAFF RELATIONSHIPS AND MORALE

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

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

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

DUTY ROTAS

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

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

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

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

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

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

OTHER NURSING POLICIES

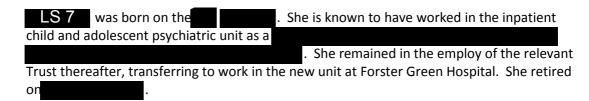
In addition to the policies already referred to there are clear written policies on

- 1. The grades of staff to be rostered at all times.
- 2. Rules to be observed if a change of duty becomes necessary for any member of staff.
- 3. Overtime.
- 4. The ratio of male staff which may be rostered. (See Appendices 6, 7, 8 and 9)

Information held by HSCB in relation to staff:

HIA 172

1. LS 7

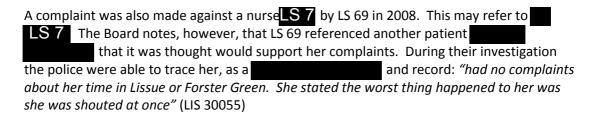


She had 19 years' service working with children with mental health difficulties. Her records have been reviewed on microfiche and no disciplinary action or complaints made against her during her employment in Lissue are recorded on her personnel file. Records have not yet been located for her employment in Forster Green.

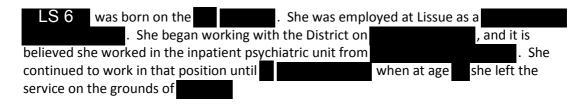
Complaints have been made against her to the police.

On 27th January 1994, she made a statement denying allegations made against her by HIA 172: "All of the allegations [HIA 172] has made against me are definitely untrue". She also described how staff policy was "to be calm and in control to show an example to the children and to give them tender loving care and counselling following a child's outburst" (sic) (LIS 31239)

The police interviewed her again on 9 June 2015. She co-operated with their investigations and again denied the allegations made against her by both HIA 172 and HIA 38.



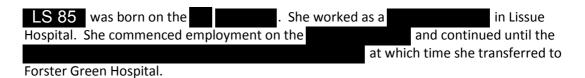
2. LS 6



She had 17 years' service working with children with mental health difficulties. Her records have been reviewed on microfiche and no disciplinary action or complaints made against her during her employment in Lissue are recorded on her personnel file.

On 27th January 1994 she made a statement to police denying allegations made against her by HIA 172. (LIS 31241)

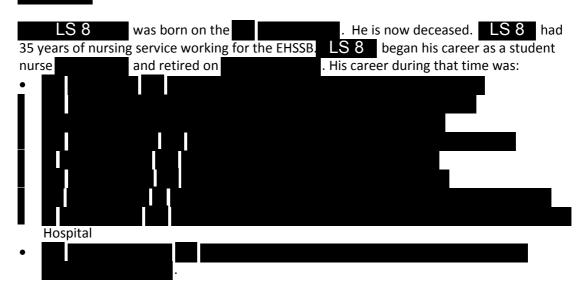
3. LS 85



Records have not yet been located for this member of staff.

She was interviewed by police in connection with a complaint by HIA 172 on 27th January 1994 and made a statement denying the allegation. She also noted: "I have never saw any other member of staff ill-treating [HIA 171] or assaulting him" (sic) (LIS 31236)

4. LS 8



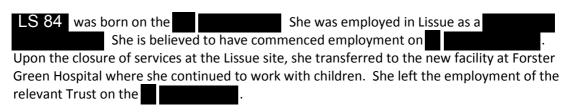
His records have been reviewed and no disciplinary action or complaints made against him during his 35 year career are noted on his personnel file.

He was interviewed by police on 27th January 1994 in connection with a complaint made against him by HIA 172. He denied the allegations stating: "I am shocked at these allegations and I have never treated [HIA 172] or any other child in such a fashion as [HIA 172] describes." He also noted that he was not personally responsible for nursing children following a promotion to Nursing Officer in 1975. (LIS 31237)

The Chief Executive wrote on 15th December 1994:

"I would like to take this opportunity to thank you for your service which has extended over the past 35 years and to wish you a long and enjoyable retirement."





Records have not yet been located for this member of staff.

She was interviewed by police on 27th January 1994 in connection with a complaint made by HIA 172. She denied the alleged incident and stated: "At no time would I ever have treated any child in the manner in which [HIA 172] describes". (LIS 31238)

Other information:

In the context of an investigation of complaints to police by HIA 172 and HIA 38, the Board notes the comments offered to police in 2015 by other members of staff from Lissue Hospital at LIS 31332 – 31333. None of them described witnessing abuse of patients in the hospital.

HIA 119

6. LS 34

The HR files for the LS 34 who worked in Lissue confirmed that she was employed in Lissue as a subsequent employment has not been identifiable from the available records, however a suggestion appears that she may have moved to .

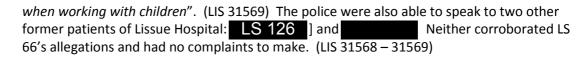
Limited records were available, but those that are available did not include any disciplinary action or complaints made against her during her employment in Lissue recorded on her personnel file

HIA 220

7. LS 21

LS 21 was placed on precautionary suspension in May 1993 following LS 66's complaints to police concerning abuse alleged to have taken place 14 years previously. By letter dated 10th August 1993, LS 21 was informed that the precautionary suspension had been lifted and it was confirmed that the RUC had recommended no prosecution. No prosecution was subsequently directed by the Director of Public Prosecution in October 1993, with the relevant Trust informed on 19th October 1993.

Police enquiries at that time had included interviews with other members of staff at Lissue Hospital. The police summarised: "None of these could provide any corroboration of LS 66's allegation but instead painted a very good picture LS 21 character and practice



During 1995, there were reports of concern about LS 21 performance in relation to his managerial duties including lateness and dependability. These were discussed with him. On one view, the events of 1993 had a significant impact on LS 21 and impacted on his working capabilities.

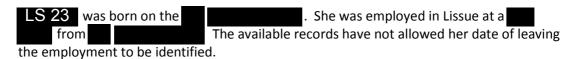
LS 21 was placed in precautionary suspension for a second time in April 1996 due to (i)

LS 21 subsequently applied for and was granted early retirement in July 1996 on occupational health grounds. In writing to confirm the acceptance of his application for early retirement on 9 July 1996 the Director of Human Resources noted: "I would very much like to thank you for the service you have given to the Trust and indeed to Forster Green over a long number of years. I know this recent period has been very difficult for you but hope that your health improves significantly now and that you will enjoy a long retirement."

8. LS 22

Her records have been reviewed on microfiche and no disciplinary action or complaints made against her during her employment in Lissue are recorded on her personnel file. Absence forms were noted, and a form extending her probationary period as it was considered that he suffered from problems of an emotional nature and she had been less than discrete about it.

9. LS 23

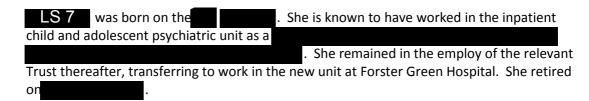


Her available records have been reviewed on microfiche and no disciplinary action or complaints made against her during her employment in Lissue are recorded on her personnel file.

Information held by HSCB in relation to staff:

HIA 172

1. LS 7

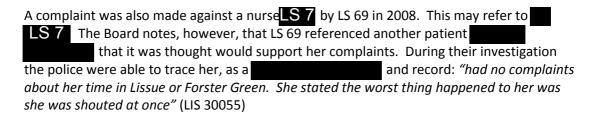


She had 19 years' service working with children with mental health difficulties. Her records have been reviewed on microfiche and no disciplinary action or complaints made against her during her employment in Lissue are recorded on her personnel file. Records have not yet been located for her employment in Forster Green.

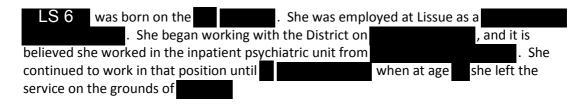
Complaints have been made against her to the police.

On 27th January 1994, she made a statement denying allegations made against her by HIA 172: "All of the allegations [HIA 172] has made against me are definitely untrue". She also described how staff policy was "to be calm and in control to show an example to the children and to give them tender loving care and counselling following a child's outburst" (sic) (LIS 31239)

The police interviewed her again on 9 June 2015. She co-operated with their investigations and again denied the allegations made against her by both HIA 172 and HIA 38.



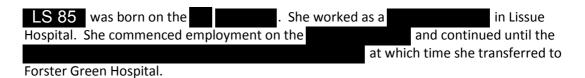
2. LS 6



She had 17 years' service working with children with mental health difficulties. Her records have been reviewed on microfiche and no disciplinary action or complaints made against her during her employment in Lissue are recorded on her personnel file.

On 27th January 1994 she made a statement to police denying allegations made against her by HIA 172. (LIS 31241)

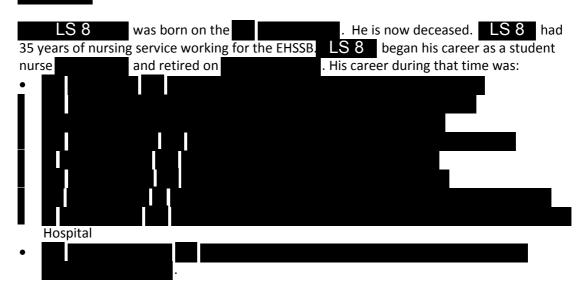
3. LS 85



Records have not yet been located for this member of staff.

She was interviewed by police in connection with a complaint by HIA 172 on 27th January 1994 and made a statement denying the allegation. She also noted: "I have never saw any other member of staff ill-treating [HIA 171] or assaulting him" (sic) (LIS 31236)

4. LS 8



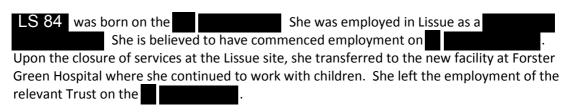
His records have been reviewed and no disciplinary action or complaints made against him during his 35 year career are noted on his personnel file.

He was interviewed by police on 27th January 1994 in connection with a complaint made against him by HIA 172. He denied the allegations stating: "I am shocked at these allegations and I have never treated [HIA 172] or any other child in such a fashion as [HIA 172] describes." He also noted that he was not personally responsible for nursing children following a promotion to Nursing Officer in 1975. (LIS 31237)

The Chief Executive wrote on 15th December 1994:

"I would like to take this opportunity to thank you for your service which has extended over the past 35 years and to wish you a long and enjoyable retirement."





Records have not yet been located for this member of staff.

She was interviewed by police on 27th January 1994 in connection with a complaint made by HIA 172. She denied the alleged incident and stated: "At no time would I ever have treated any child in the manner in which [HIA 172] describes". (LIS 31238)

Other information:

In the context of an investigation of complaints to police by HIA 172 and HIA 38, the Board notes the comments offered to police in 2015 by other members of staff from Lissue Hospital at LIS 31332 – 31333. None of them described witnessing abuse of patients in the hospital.

HIA 119

6. LS 34

The HR files for the LS 34 who worked in Lissue confirmed that she was employed in Lissue as a subsequent employment has not been identifiable from the available records, however a suggestion appears that she may have moved to .

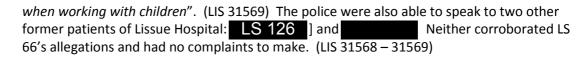
Limited records were available, but those that are available did not include any disciplinary action or complaints made against her during her employment in Lissue recorded on her personnel file

HIA 220

7. LS 21

LS 21 was placed on precautionary suspension in May 1993 following LS 66's complaints to police concerning abuse alleged to have taken place 14 years previously. By letter dated 10th August 1993, LS 21 was informed that the precautionary suspension had been lifted and it was confirmed that the RUC had recommended no prosecution. No prosecution was subsequently directed by the Director of Public Prosecution in October 1993, with the relevant Trust informed on 19th October 1993.

Police enquiries at that time had included interviews with other members of staff at Lissue Hospital. The police summarised: "None of these could provide any corroboration of LS 66's allegation but instead painted a very good picture LS 21 character and practice



During 1995, there were reports of concern about LS 21 performance in relation to his managerial duties including lateness and dependability. These were discussed with him. On one view, the events of 1993 had a significant impact on LS 21 and impacted on his working capabilities.

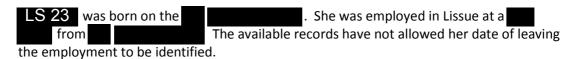
LS 21 was placed in precautionary suspension for a second time in April 1996 due to (i)

LS 21 subsequently applied for and was granted early retirement in July 1996 on occupational health grounds. In writing to confirm the acceptance of his application for early retirement on 9 July 1996 the Director of Human Resources noted: "I would very much like to thank you for the service you have given to the Trust and indeed to Forster Green over a long number of years. I know this recent period has been very difficult for you but hope that your health improves significantly now and that you will enjoy a long retirement."

8. LS 22

Her records have been reviewed on microfiche and no disciplinary action or complaints made against her during her employment in Lissue are recorded on her personnel file. Absence forms were noted, and a form extending her probationary period as it was considered that he suffered from problems of an emotional nature and she had been less than discrete about it.

9. LS 23



Her available records have been reviewed on microfiche and no disciplinary action or complaints made against her during her employment in Lissue are recorded on her personnel file.

Page 74 impossible for him -- for you to have put ice in a bath 1 without somebody being suspicious as to what you were 2. 3 doing. 4 He says: "That there is a question you asked me earlier on 5 and it is simple -- that more simple. When ..." 6 He goes on to talk about: 7 "What we have heard over the years of abuse in 8 9 different institutes, they were turning a blind eye, and it was quite easy in the 1970s to turn a blind eye 10 because The Troubles of Northern Ireland were in full 11 flow. So every day on the news in the '70s, '80s was 12 13 occupied by a police officer being killed, a prison officer, a civilian. So the whole of Northern Ireland's 14 15 focus with on The Troubles. Their focus wasn't on 16 protecting children from pure evil. 17 He got quite angry when I told him that you were 18 upset at the police interview. In response to that he said: 19 20 "What about my life? Upset? My whole life has been 21 totally destroyed by the Lissue Hospital and the 22 institutes that were supposed to protect children, and he was upset?" 23 24 He got quite upset when I suggested to him that you 25 had been upset at the police interview.

- inappropriately towards children?
- 2 A. No.
- 3 Q. Or did you ever have any other member of staff come as
- 4 their line manager to say that anything untoward had
- 5 occurred?
- 6 A. No.
- 7 Q. Well, LS21, you will be glad to know that that's all
- I want to ask you, but before I hand you over to the
- 9 Panel is there anything else that you would like the
- 10 opportunity to say about Lissue, about any -- either
- about the allegations that have been made against you
- 12 personally or about any of the general matters that we
- 13 have been looking at?
- 14 A. My whole experience of this is one of shock and anxiety,
- 15 concern. What we are describing is not my work
- 16 environment experience. When I -- staff arranged
- a dinner for me on my retirement and gave me some
- 18 recognition for my contribution to their training and
- 19 their work practice and their -- yes, their
- 20 relationships. I was proud of that. Now I'm the last
- couple of years feeling I chose the wrong profession.
- 22 Q. LS21, thank you very much. As I say, the Panel may have
- 23 some questions for you.
- 24 A. Thank you.

25

- depending on the level of input, and I am going back to
- 2 that point about a multi-disciplinary team. It's not
- just what I think or he -- it is what we all think and
- 4 throw into the pot in the continual daily interaction
- 5 that we had with each other as a competent team. We
- 6 modified, changed our deliberate interventions in order
- 7 to go along in a more progressively improving way, and
- 8 that was the great thing about that contact that we had
- 9 as a contemporary team. All of us wanted "A child is
- in. We need him out".
- 11 Q. And that was a --
- 12 A. Punishment is not the way.
- 13 Q. It was a collaborative approach to the work.
- 14 A. Collaborative, yes.
- 15 Q. We have heard -- sorry. Just one other question about
- 16 -- I think you have already answered this. Staff did
- intervene if other children were hitting each other, for
- 18 example? They wouldn't have just sat back and recorded
- 19 it?
- 20 A. Inevitably, yes.
- 21 Q. I think you made the point to me that it would have been
- irresponsible not to have done so, because it was
- a volatile situation which would have escalated had they
- 24 not done so.
- 25 A. Yes.

- 7. I never attained the rank of *sister*, but acted up into that role when my colleagues were on holiday or absent due to a bereavement or family illness. I was on the day shift only given my own family commitments.
- 8. The Lissue Unit was unusual in that the staff wore civilian clothes, and never uniforms. We were therefore inclined to pick clothes that were comfortable though smart. A further distinction from my previous nursing experience was that staff being the nursing staff and the medical staff called each other by their first names, rather than a rank and surname. These features were used to make the unit more comfortable for the children under our care.
- 9. The children we cared for were on an in-patient basis numbering around 20 aged from young infants to about 12-14 years. As indicated above at paragraph 6, they had a range of problems and sadly some of the children came from very disturbed and, came from what would now be called, dysfunctional families. Some of the children had been shown no apparent love and their interactions with their parent or parents who called could be quite heartrending. As a member of the nursing staff, I would have participated in the morning meetings with the social workers and doctors and the teachers who provided school facilities at the Unit.
- 10. The children under our care came from all over Northern Ireland.
- 11. As regards any medication these were as prescribed by the 3 doctors who were the general compliment of medical staff in my time both at Lissue and when we moved laterally for economic efficiency to the Old Foster Green Hospital at Saintfield Road, Belfast. The doctors would have prescribed the medication and its dosage. As I became more senior, I was conferred with by some doctors as to whether the dosage was adequate or too much and would certainly have reported back on what impact the medicines were having upon the children. This was in order to assist the doctors to form a clinical

- 1 A. There was LS105 when I was there --
- 2 O. Uh-huh.
- 3 A. -- and they called her Sister LS106
- 4 and LS8, and LS21 --
- 5 O. Uh-huh.
- 6 A. -- and then when LS105 left, LS8 got it, and
- 7 LS106 and LS8 put in for his
- 8 post --
- 9 O. Uh-huh.
- 10 A. -- and LS8 got it and LS106 left. She thought she
- should have got it, and we got new staff in then, and
- then LS21 was up as Charge Nurse.
- 13 Q. Did that whole staff team move on then to Forster Green?
- 14 A. The rest of the -- the rest of the staff stayed.
- 15 Q. Right. What about changes in treatment methods during
- the time you were there? Did you notice any major
- 17 changes?
- 18 A. No, because tablets were very, very good.
- 19 Q. Right. Okay. One last question about weekends. Did
- a lot of the children go home at the weekends?
- 21 A. Yes.
- 22 Q. So you be would left with, what, four or five or
- 23 something like that?
- 24 A. Yes.
- 25 Q. You had a different sort of programme at weekends then,

THE HISTORICAL INSTITUTIONAL ABUSE INQUIRY

STATEMENT OF: LS 7	
Â	
I was born on and am now	
I trained as a nurse at the Belfast City Hospital,	
	1,11
	I was born on and am now

- 3. In about as an experienced nurse, a colleague, who thought that since I was greatly taken by children, that I would be a suitable person to work at the Lissue Unit, also situated at Lisburn, recruited me. While I received no formal training in child psychiatry, I was at that point a very experienced general nurse, with various specific experiences.
- 4. I got married to my late husband and we had children. I very happily enjoy the company of my grandchildren.
- 5. I have never been convicted of any criminal offence whatsoever; I had one complaint made about me in respect of my time at Lissue. I was totally exonerated of any wrongdoing, after investigation.
- 6. I retired in at the age of I was presented with a copy booklet/'scrapbook' of the history of Lissue and the various people and staff I worked with. I thoroughly enjoyed my time working at Lissue and found that we were able, in many instances, to return children to their families. Those who were living with us had various problems such as schizophrenia, anorexia, epilepsy and other behavioural issues.

- 1 A. Normally the individual who was working with the family,
- 2 but on occasion where you would go as an observer that
- 3 would have been a second person, and the key worker
- 4 would have asked the family, "Is it okay for that
- 5 learner to come?"
- 6 Q. Just in terms of key working -- I was going to deal with
- 7 this later -- but from your statement it is clear that
- 8 each child was assigned a member of staff as a key
- 9 worker.
- 10 A. Now there's two key workers. Sorry for the confusion.
- 11 As a nurse you were a key worker within the ward for
- 12 a set number of children, but if you were actually going
- out on a home visit, it was often the social worker or
- indeed the medical person or psychologist that would be
- going out to the home visit, and they were staff from
- 16 The Royal Hospital, and you would have been going out
- with them, because there were two units.
- 18 Q. Can I just check? The reason I ask this is because of
- 19 something we have heard from one of the witnesses. I am
- 20 going to ask you later about some of the staff you
- worked with. Just I am going to use names, but remind
- 22 people that we won't be using those names later on, but
- we heard I think it was yesterday that LS21, not Roger
- McAuley, would have gone on a home visit. Would that
- 25 have been your experience?

- 1 Staff used first names in Lissue. Isn't that right?
- 2 A. Yes.
- 3 Q. They didn't wear a uniform?
- 4 A. That's right.
- 5 Q. Is it possible that a child might have known the first
- 6 name of a member of staff but never got to know the
- 7 surname?
- 8 A. It is likely.
- 9 Q. You also say in paragraph 5 that staff moved between The
- 10 Royal and Lissue and there was --
- 11 A. Now when I say that, that would have been the social
- workers, the psychologist and the consultants and the
- doctors in training.
- 14 Q. But the nursing staff were permanently in Lissue?
- 15 A. Yes.
- 16 Q. They weren't ...? I am not going to ask you about the
- 17 Paediatric Unit. You didn't work or have anything to do
- 18 with the Paediatric Unit. Isn't that right?
- 19 A. The only occasion I would have been asked if they were
- short of staff maybe to assist with meal times, but that
- 21 was very rare.
- 22 Q. I was asking a little bit about handover time. Doing
- 23 the best you can remember, you think that the -- you
- came on shift as a day staff member in or around
- 8 o'clock and that's when the handover took place.

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
- 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

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

- 17. In 1981, the History exhibited at **Exhibit 1** described Lissue in 1971 as offering residential treatment, or "24 hour intensive treatment" of psychological disturbances manifest in children under the direction of the Consultant (Family Therapist), Dr Nelson. Following the appointment of Dr Roger McAuley as Consultant Psychiatrist (Behavioural Therapist) in 1976 it is described: "the previously eclectic milieu changed to absorb a more behaviourist approach which incorporated intensive behaviour modification programmes". This coincided in the same year with the beginning of family admissions, which focussed on the child management skills of the parent. Accommodation was developed from 1977 to allow two families to reside on the site. However, the Board believes that usually just one would be in occupation. Four years later, in January 1980 it is noted: "following a global recognition of the significance of Family Psychopathology in the aetiology of psychological disturbances, the repertoire of treatments extended to include a study of Family Therapy and the development of this alternative approach to psychiatric illness, the main emphasis here being on seeing every member of the child or young person's family".
- 18. Children that were admitted to Lissue were admitted as patients whose treatment plan was led by a Consultant Psychiatrist with the aim of treating emotional or behavioural disturbance, or psychiatric illness. A Consultant Psychiatrist referred patients for admission and supervised their treatment in the Unit during admission. The Board understands this was through ward rounds on a weekly basis.
- 19. An undated contract is at **Exhibit 5** details the expectations upon family members and their involvement in the therapy offered at Lissue. It is important to note the emphasis that is placed on the involvement of the family in this contract, which required parents to agree: that they would spend at least one afternoon or evening per week on the unit; that the whole family would attend once a week for family meetings unless the therapist required otherwise; that while the unit was

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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

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 func-

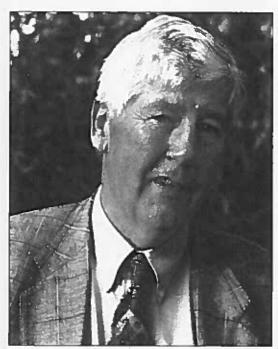
tioned as a convalescent hospital but by 1959 it had become a busy branch facility capable of caring for a wide variety of surgical and medical patients in seventy beds. However, the following ten years saw further change. There had been a slow but steady infiltration of psychiatric patients, and by 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 inpatient 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



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

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.

- 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 Philidelphia, USA, where I visited. This approach included all or

- as many members of the family as possible to attend both outpatients at RBHSC and inpatient / day patient sessions at Lissue.
- 16. A regular Family Therapy teaching course was set up by myself with a senior and very experienced Social Worker in Family Therapy from the Tavistock Clinic in London. This person visited us at the at RBHSC once per month, for over a year. Apart from staff in Belfast and Lissue, we also invited a number of outside professional staff to join this course on a regular basis.
- 17. The main strengths of Lissue were the multidisciplinary team who had the opportunity to observe children and their families closely over the day and night over weeks. Children who were out of control of family or school who would have to have been removed to a place of safety, but without treatment facilities; could both be kept safe and treated in the Lissue situation.
- 18. Also severely, emotionally disturbed children such as those with Anorexia Nervosa which carried significant morbidity, including death. Very depressed and psychotic children who could not be kept safely at home were in a place of safety and also able to be treated.
- 19. The age range at Lissue was always a difficulty ranging from around 0 to 14 years. The main pressure for admissions was from older children and often those with severe behaviour problems. To what extent emotional or mental health difficulties were present in these children, or where we being asked to admit because of their difficult behaviours at home, school and community which could have different origins, not necessarily psychiatric and where no other facility that could manage them, are all examples of what we had to assess.
- 20. Northern Ireland did not have specialised Social Services or residential facilities as you would find in the London area or other parts of mainland UK, such as Newcastle, Liverpool, Glasgow. All units I visited.
- 21. I have been provided with the Stinson, Devlin and Jacobs reports to update me. My response to the allegations in the Stinson report together with my responses

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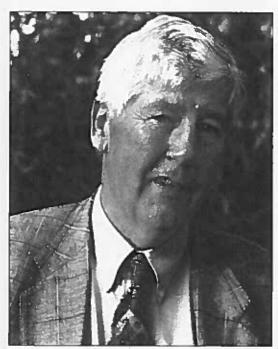
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1

HIA REF: []

NAME: [Dr Roger]McAuley

DATE: [8 March 2016

THE INQUIRY INTO HISTORICAL INSTITUTIONAL ABUSE 1922 TO 1995

Witness Statement of Dr Roger McAuley

- I, Dr. Roger McAuley, will say as follows: -
- 1. My career history is as follows;
- 1.1 Bachelor of Medicine (M.B.) July 1969.
- 1.2 Commenced psychiatric training August 1970. Diploma of Psychological Medicine (D.P.M.) July 1972
- 1.3 Commenced training in child and adolescent psychiatry 1973.
- 1.4 Membership of Royal College of Psychiatrists (M.R.C.Psych) Jan 1974.
- 1.5 Research Fellow Royal Belfast Hospital for Sick Children (R.B.H.S.C.) 1973 1974.
- 1.6 Appointed Consultant in Child and Adolescent Psychiatry April 1976. Job based at both R.B.H.S.C. (outpatient Unit) and at the Child Psychiatry Inpatient Unit at Lissue Hospital.
- 1.7 Doctor of Medicine (M.D.) by thesis, July 1980.
- 1.8 Chairman of British Association of Behavioural and Cognitive Psychotherapy (B.A.B.C.P.) 1985.
- 1.9 Appointed Fellow of the Royal Collage of Psychiatrists (F.R.C.Psch), May 1996.
- 1.10 Retired September 2000. However continued locum work for a further 6 years (between 2 and 3 session per week) at several different Community Trusts.
- 2. I am preparing this statement to assist the Inquiry with their understanding of how psychiatric services were provided to children and their families in Lissue where I was a Consultant Psychiatrist from 1976 until it moved to Forster Green in March 1989. I continued to work until September 2000. I was not aware of the allegations made later and so I have been provided with the Stinson, Devlin and Jacobs Reports to update me in these subsequent developments.

- 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 Philidelphia, USA, where I visited. This approach included all or

- 1 meeting."
- I think also known as ward rounds:
- 3 "Dr Barcroft and I attended for one morning's MDM
- 4 and usually on at least one other occasion each week in
- order to discuss cases or work directly with cases.
- 6 After '78 Dr Barcroft left to take up a job in England.
- 7 His input to Lissue was not replaced."
- 8 I wondered whether his leaving caused problems for
- 9 the unit or for you and Dr Nelson?
- 10 A. Well, in that we would have had more cases each to deal
- 11 with, which meant I suppose occasions at ward round
- meetings and things like that where on occasions more
- fraught, because there were more cases to get through
- each, you know, in terms of the week's activities.
- 15 Q. Am I right in thinking and from speaking to Dr Nelson
- I understand that the ward round meeting would have
- 17 taken about three hours?
- 18 A. Yes. It was -- generally speaking, it was a full
- morning from 9.30 through to lunchtime with a break in
- the middle.
- 21 Q. Paragraph 3.6 then, if we can just move through to that,
- 22 you say that:
- "Patients up to the page of 14 years were in the
- 24 main referred from Out-Patient Service at The Royal
- 25 Belfast Hospital for Sick Children. Other significant

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

3.1 There were 2 Units in Lissue Hospital;

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

- 3.2 The Unit was located in an old country mansion. The rooms were spread over an area accessed by corridors and this was never completely satisfactory in facilitating children's whereabouts it on occasions stretched nursing resources.
- 3.3 The Unit was established to provide for a maximum of 20 inpatients and 5 day patients, and accepted children up to 14 years of age.
- 3.4 A school was provided for the Unit by South Eastern Education and Library Board (S.E.E.L.B.)

3.5 Staffing:

- 3.5.1 Staffing provision for the Unit roughly followed the Royal College of Psychiatrists recommended levels set out in around 1971.
- 3.5.2 Consultants in Child and Adolescent Psychiatry. Between 1976 and 1978 there were 3 consultants visiting the Unit. Dr Nelson attended many times each week 1 of his visits being for a complete morning multidisciplinary meeting (M.D.M). Dr Barcroft and I attended for one mornings M.D.M. and usually on at least 1 other occasion each week, in order to discuss cases or work directly with cases. After 1978 Dr Barcroft left to take up a job in England. His input to Lissue was not replaced.
- 3.5.3 A medically qualified psychiatric Trainee attended the Unit on a full time basis and normally each trainee remained for a 6 month period.
- 3.5.4 Nursing Staff. The Unit was staffed with S.R.N. and S.E.N. nurses. This always included a nurse at Charge Nurse/Sister grade.
- 3.5.5 A Social Worker was based full time at the Unit and as well as working with children and families would have liased with Social Services when required.
- 3.5.6 A Psychologist was based full time at Lissue and worked with children and families.
- 3.5.7 For several years (until 1978) there was also an Occupational Therapist whose work was largely child focused. The post was not replaced when this person moved to another job.
- 3.5.8 Overall a Multi Disciplinary ethos was in place see below.

- 2. While I was working with Dr McCune, he, I and other colleagues that had worked in Lissue influenced the development of the child and adolescent mental health nurse training course at Purdysburn School of Nursing. This programme commenced in 1990, which later transferred into Queen's University and has been registered by the Nursing and Midwifery Council (Nursing and Midwifery regulation body) as a recognised course. Upon completion of that course you are considered a specialist nurse. I hold that qualification since April 1992 and it is registered on my statement of entry with the NMC. I was commissioned to lead the review of Child and Adolescent Mental Health with Mr Charles Bamford, and within NI. I also had involvement in strategic planning in the scoping and preparation for the design of the current regional provision within NI.
- 3. My line manager upon commencing employment in Lissue 1984 was LS 21 I recall that LS 78 had just left the ward when I was arriving. We were divided into teams so there was one senior staff member that you would have been managed by LS 21 was my team manager.
- 4. I recall my period as a nurse in Lissue with fondness. It was a proactive experience working with Dr McAuley and Dr Nelson. They were implementing new models of practice. Dr McAuley used a behavioural model and Dr Nelson a family therapeutic model. These required different approaches with different children, and they were both of their time. Many of the techniques were new and innovative at that time in relation to the video undertaking with families, with their consent etc. From an academic model perspective I recall using the work of Michael Rutter and Dr Minuchin, and these models would also have been implemented nationally across the United Kingdom. I also recall student doctors and nurses in the Unit, as well as other disciplines working together with families in a multidisciplinary way.
- 5. There were some of the Multi Disciplinary Team (MDT) in Lissue and some came from the Royal Hospital in Belfast. There was a movement of professional staff between the two hospitals to support the children who were admitted or attending as day patients to the ward. There were weekly significant meetings of the MDT.

- 1 accepted in the document that I pulled up --
- 2 A. Yes, yes.
- 3 Q. -- that there was a harsh and punitive regime in Lissue.
- 4 A. Uh-huh. Uh-huh.
- 5 Q. First of all, is that your recollection or what can you
- 6 say about that?
- 7 A. I think, as I mentioned, Lissue was a Child Psychiatry
- 8 Unit for children with a mixture of issues or problems,
- 9 if you like, emotional problems, school problems,
- anorexia, and then you had children who had conduct
- 11 problems, which is still within the world of child
- 12 psychiatry. We were dealing with these sort of children
- who are very aggressive, very disruptive, very
- 14 non-compliant, sometimes very sexually active, not very
- responsive to counselling. So they need some management
- that is able to help them begin to manage themselves, if
- 17 possible, and to some extent that regime, that
- 18 behavioural modification regime was used in Lissue
- 19 generally. It was particularly applicable for children
- with conduct problems who maybe came to the attention
- 21 more than others because of their behaviour, but by and
- large the ethos seemed to work well for other children
- of a more neurotic kind of problem or more emotional
- 24 problems, and the people when I was working there in
- general thought this is a reasonable way to be

PRIVATE

extremely well behaved to get into that room. You were only allowed 10 to 15 minutes to watch the train go round.

- 20. My mum and dad came up to visit a couple of times. When my parents came they were given the best china cups and were told that it was for my best that I was in there.
- 21. I only got home every few weeks for one night or two nights. When I visited home Dad said I was always lethargic and tired like a zombie and not the hyper HIA 38 that went away.
- 22. I have no good memories of Lissue House. There were no good times and no outings. There was a mobile classroom but I don't remember doing any school work. I think the was called LS 50 There was a nice called LS 51 but she might have been at I recall she taught us some which I still remember.
- 23. I didn't get an education at Lissue. Basic numeracy and literacy were taught but I did not learn much.
- 24. I believe there were many children including myself were experimented on in Lissue House. Lissue changed me. The experiences had effect on the rest of my life and I didn't have the life I was supposed to have. I know I was supposed to be something better than I became.

Fallowfield Special School, Lurgan (1981 – 1986 approximately)

25. I understand that my parents received a letter which stated that I was misdiagnosed and that Lissue House was wrong for me but that I still needed some form of educational help. I was at home for about 6 to 8 weeks before I was sent to Fallowfield in Lurgan. I was there from 11 to 16 (from 1981 to 1986). I believe I was moved to Fallowfield on the recommendation of Lissue

HIA 38

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

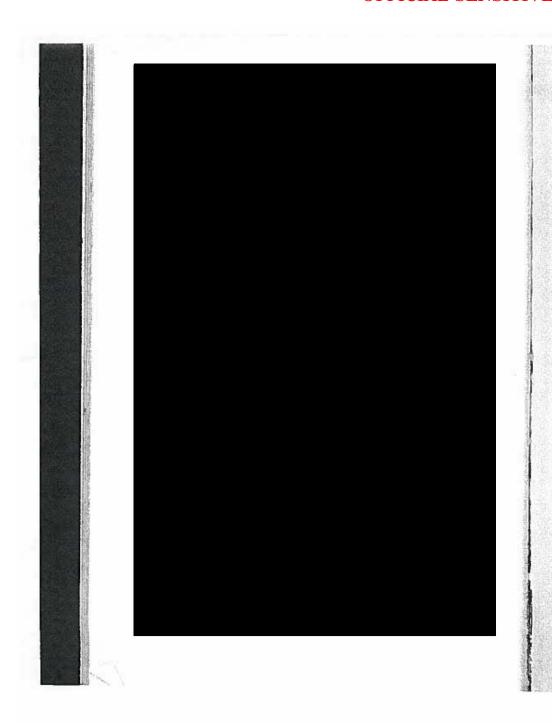
- 142. The Board intends to continually reflect upon the issue of systemic failings as the evidence unfolds and, in so doing, the Board is mindful that some of the allegations and complaints relating to Lissue date back to the 1970s.
- 143. Since then, there have been significant changes in legislation, policy and procedures on how to respond to and investigate allegations of child abuse. Some of these changes reflect recommendations from Inquiries, Case Management Reviews, societal change and increased knowledge and awareness over time about the nature of abuse and its consequences on children. The Board intends to exercise caution when trying to interpret historic events so that they are considered, so far as is possible, by reference not only to practice, policies and procedures extant at the relevant time but also in the context of children receiving medical and nursing care as part of a Consultant-led multi-disciplinary team.

Q24. Any other relevant information you wish to make the HIA Inquiry aware of in respect of Lissue.

- 144. During their training, doctors seeking to specialise in Child Psychiatry and working towards a Consultant's post would almost certainly have spent periods of time in the Child Psychiatry Unit at Lissue Hospital during its years of operation. It has come to the Boards attention that Dr Roderick Morrison Fraser ("Dr Morris Fraser") was a Senior Registrar in the Royal Belfast Hospital for Sick Children and is described as having been employed by the Northern Ireland Hospital Authority as a child psychiatrist from 1 August 1970. Drs Nelson and McAuley recall that as part of his work Dr Fraser would have spent periods at Lissue. The Inquiry may wish to note:
 - a. In August 1971 Dr Fraser took a 13 year old boy, that he was involved with through the Scouts, to London. The boy subsequently complained that Dr Fraser indecently assaulted him during this stay;

- b. On 17 May 1972 Dr Fraser pleaded guilty to a charge of indecent assault at Bow Street Magistrates' Court in London;
- c. This was referred to the General Medical Council where Dr Fraser was found guilty of serious professional misconduct. In determining what sanction to employ the GMC considered the circumstances during sittings on 16-21 July 1973, 11-13 March 1974, 15-18 July 1974 and 14-16 July 1975. It appears that the matter was subsequently concluded without sanction. See Exhibit 51
- d. During this period it is believed that Dr Morris continued to work in Belfast.
 Recollections from staff at the time suggest that the Northern Ireland Hospital Authority was not aware of the allegation or conviction in 1972;
- e. In or around May 1973 Dr Fraser was charged as one of eight people connected to the abuse of boys on an international scale. This was reported in the local press and came to the attention of the Northern Ireland Hospital Authority on the same day that Dr Fraser was due to interview for a post as Consultant in Child Psychiatry. The interview was cancelled. Dr Fraser did not work within Child Psychiatry in Northern Ireland or at Lissue hospital following this.
- 145. Following media attention in relation to events at Lissue Hospital, statements were made by Minister Poots in the Northern Ireland Assembly and during appearances before the Committee for Health, Social Services and Public Safety ("the Health Committee") as follows:
 - a. 26 October 2011 Appearance before the Health Committee
 - b. 7 November 2011 Statement to the Northern Ireland Assembly;
 - c. 18 January 2012 Appearance before the Health Committee.
- 146. From 2008, the Board and Health and Social Services Trusts in Northern Ireland have been undertaking a period of self-examination through the EHSSB Historic Case Review (including the Devlin Report, Jacobs report), retrospective sampling exercises and the SMG review process. The Board is clear that abuse of children can never be excused, that there can be no room for complacency and that no organisation can ever be completely confident that it does not harbour a person who is a risk to children. In light of this, the Board has and continues to take allegations and criticisms made by former patients of Lissue

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- c. This was referred to the General Medical Council where Dr Fraser was found guilty of serious professional misconduct. In determining what sanction to employ the GMC considered the circumstances during sittings on 16-21 July 1973, 11-13 March 1974, 15-18 July 1974 and 14-16 July 1975. It appears that the matter was subsequently concluded without sanction. See Exhibit 51
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17. Fraser, Roderick Morrison

The Committee proceeded to inquire into the following charge against Roderick Morrison Fraser, registered as of 39 Whitehouse Park, Newtownabbey, Co. Antrim, MB BCh 1965 Belf:-

- "That, being registered under the Medical Acts,

 '(1) Since about August 1, 1970 you have been employed by the Northern Ireland Hospital Authority as a child psychiatrist and in that capacity you have displayed a professional interest in environmental and psychological problems affecting persons living in the disturbed areas of Northern Ireland;
- the mother of of Belfast, then aged 13 years, her consent for you to take her son to London on a visit by representing that such a visit would have a beneficial psychological effect on him;
- '(3) During that visit you indecently assaulted between August 27 and August 30, 1971 at 6 St. Augustin's Mansions, Blomberg Street, London S.W.1;

DISCIPLINARY COMMITTEE [July 16-21, 1973

'(4) In consequence of your conduct as aforesaid on May 17, 1972 at Bow Street Magistrates' Court you pleaded guilty to a charge of indecent assault;'

"And that in relation to the facts alleged you have been guilty of serious professional misconduct."

The practitioner was present and appeared by Mr. A. Whitfield, Counsel, instructed by Messrs. Le Brasseur and Oakley, Solicitors.

Mr. J. G. C. Phillips, Counsel, instructed by the Solicitor to the Council, appeared in order to present evidence of the facts alleged in the charge.

At the instance of Mr. Phillips, the charge was amended by the deletion, from head (2), of the words "by representing that such a visit would have a beneficial psychological effect on him".

The facts in heads (1) to (4) of the charge, as amended, were admitted on behalf of the practitioner and the Chairman thereupon announced that the facts alleged in the amended charge had been proved.

Mr. Phillips adduced evidence as to the circumstances leading up to the facts in the charge and called Detective Constable Samuel Reginald Mack and Detective Inspector Anthony Rich as witnesses.

Mr. Whitfield addressed the Committee by way of mitigation.

At the conclusion of the proceedings the Chairman announced the determination of the Committee as follows:—

"Dr. Fraser: The Committee regard with grave concern the facts which have been admitted and proved against you. After careful consideration they have determined that, having regard to your public expressions of professional interest in environmental and psychological problems affecting young persons living in the disturbed areas of Northern Ireland, your behaviour involved an abuse of your professional position as a specialist in child psychiatry. Further, your behaviour was such as seriously to discredit the profession of which you are a member. The Committee have accordingly judged you to have been

July 16-21, 1973] DISCIPLINARY COMMITTEE

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guilty of serious professional misconduct in relation to the facts proved against you in the charge. They have, however, taken into account the evidence which has been adduced in mitigation, the representations which have been made on your behalf, and the assurances which have been given as to your future conduct. In all the circumstances they have determined to postpone their judgment on the question of suspension or erasure in the first instance for a period of eight months until their meeting in March, 1974. Shortly before that date you will be asked to furnish the Council with the names of professional colleagues and other persons of standing to whom the Council may apply for information, to be given confidentially, as to their knowledge of your conduct in the interval. The names furnished should include those of the consultant psychiatrists who have previously examined you with a view to their again reporting on your condition, with special reference to your fitness to practise. Do you understand?"

Dr. Fraser: "Yes, Sir,"



1000

(No. 200)

30

GENERAL MEDICAL COUNCIL

DISCIPLINARY COMMITTEE

MINUTES OF MEETING, MARCH 11-13, 1974

SIR JOHN RICHARDSON, President, in the Chair

Sir John Biggart Dr. Fry

Sir Brynmur Jones Dr. McAndrew

Dr. HUNTER Dr. Jessop

Dr. Sim

Dr. Trethowan

P. B. B. MAYHEW, Q.C., Legal Assessor R. C. B. GRAY, Assistant Registrar

The cases recorded in these Minutes were heard on the following days:—

March 11 Items 1-5 March 12 Items 6-10

March 13 Item 11

Dr. Trethowan was not present on March 12 and did not adjudicate on Items 6-10.

March 11-13, 1974] DISCIPLINARY COMMITTEE

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1. Fraser, Roderick Morrison

The Committee resumed consideration of the following charge* on which judgment had been postponed in July, 1973 (Minutes, 77–79) against Roderick Morrison Fraser, registered as of 39 Whitehouse Park, Newtownabbey, Co Antrim, MB BCh 1965 Belf:—

"That, being registered under the Medical Acts,

- '(1) Since about August 1, 1970 you have been employed by the Northern Ireland Hospital Authority as a child psychiatrist and in that capacity you have displayed a professional interest in environmental and psychological problems affecting persons living in the disturbed areas of Northern Ireland;
- '(2) In or about August, 1971 you obtained from the mother of of Belfast, then aged 13 years, her consent for you to take her son to London on a visit...;
- '(3) During that visit you indecently assaulted between August 27 and August 30, 1971 at 6 St. Augustin's Mansions, Blomberg Street, London S.W.1;
- '(4) In consequence of your conduct as aforesaid on May 17, 1972 at Bow Street Magistrates' Court you pleaded guilty to a charge of indecent assault;'

"And that in relation to the facts alleged you have been guilty of serious professional misconduct."

The practitioner was present and appeared by Mr. A. Whitfield, Counsel, instructed by Messrs. Le Brasseur and Oakley, Solicitors.

Mr. Whitfield made application for the case to be heard in camera. Strangers, by direction from the Chair, withdrew and Mr. A. P. P. Honigmann, as Solicitor to the Council and Mr. Whitfield addressed the Committee in camera.

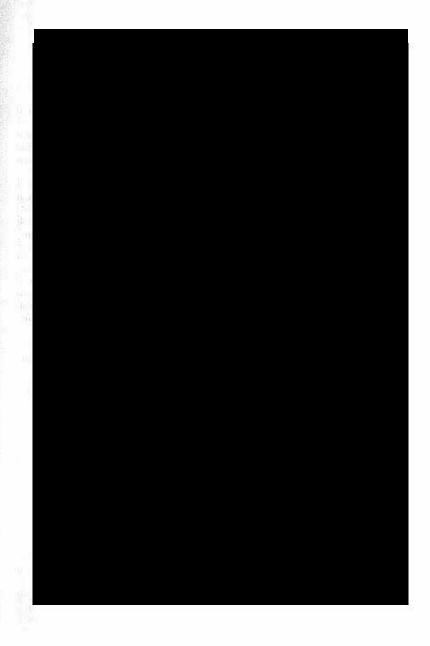
Strangers were then readmitted and the Chairman announced the determination of the Committee as follows:—

The charge as set out above incorporates only the facts which were found proved in July, 1973,

32 DISCIPLINARY COMMITTEE [March 11-13, 1974

"Dr. Fraser: The Committee are unable to feel satisfied that it would yet be proper for them to conclude your isfied that it would yet be proper for them to conclude your case. They have accordingly determined that judgment should be further postponed for a period of four months until their meeting in July, 1974. Shortly before that date you will again be asked to furnish the Council with the names of professional colleagues and other persons of standing to whom the Council may apply for information, to be given confidentially, as to their knowledge of your conduct in the interval. The names furnished should again include those of the consultant psychiatrists who have previously examined you and who can provide further reports on your progress. Do you understand?"

Dr. Fraser: "Yes."





2. Fraser, Roderick Morrison

The Committee resumed consideration of the following charge* on which judgment had been postponed in July, 1973 (Minutes, 77-79) and March, 1974 (Minutes, 31-32) against Roderick Morrison Fraser, registered as of 39 Whitehouse Park, Newtownabbey, Co. Antrim, MB BCh 1965 Belf:—

"That, being registered under the Medical Acts,

'(1) Since about August 1, 1970 you have been employed by the Northern Ireland Hospital Authority as a child psychiatrist and in that capacity you have displayed a professional interest in environmental and psychological problems affecting persons living in the disturbed areas of Northern Ireland;

'(2) In or about August, 1971 you obtained from the mother of the second of Belfast, then aged 13 years, her consent for you to take her son to London on a visit . . . ;

'(3) During that visit you indecently assaulted between August 27 and August 30, 1971 at 6 St Augustin's Mansions, Blomberg Street, London, S.W.1;

July 15-18, 1974] DISCIPLINARY COMMITTEE

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'(4) In consequence of your conduct as aforesaid on May 17, 1972 at Bow Street Magistrates' Court you pleaded guilty to a charge of indecent assault;'

"And that in relation to the facts alleged you have been guilty of serious professional misconduct."

The practitioner was present and appeared by Mr. A. Whitfield, Counsel, instructed by Messrs. Le Brasseur and Oakley, Solicitors.

Mr. Whitfield made application for the case to be heard in camera. Strangers, by direction from the Chair, withdrew and Mr. A. P. P. Honigmann, as Solicitor to the Council, and Mr. Whitfield addressed the Committee in camera.

Mr. Honigmann and Mr. Whitfield then withdrew and the Committee deliberated in camera.

Strangers were then readmitted and the Chairman announced the determination of the Committee as follows:—

"Dr. Fraser: The Committee have noted with satisfaction the evidence which has been presented to them today regarding your conduct and your continued response to treatment since your appearance before them in March, 1974. However, they are not yet satisfied that your case can properly be concluded. They have accordingly determined that judgment on the question of suspension or erasure should be further postponed for a period of twelve months until their meeting in July, 1975. Shortly before that date you will again be asked to furnish the Council with the names of professional colleagues and other persons of standing to whom the Council may apply for information, to be given confidentially, as to their knowledge of your conduct in the interval. The names furnished should again include those of the consultant psychiatrists who have previously examined you and who can provide further reports on your progress. Do you understand?"

Dr. Fraser: "Yes."

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^{*} The charge as set out above incorporates only the facts which were found proved in July, 1973.

1. Fraser, Roderick Morrison

The Committee resumed consideration of the following charge* on which judgment had been postponed in July, 1973 (Minutes, 77-79), March, 1974 (Minutes, 31-32) and July, 1974 (Minutes, 48-49) against Roderick Morrison Fraser, registered as of 39 Whitehouse Park, Newtownabbey, Co. Antrim, MB BCh 1965 Belfast:-

"That, being registered under the Medical Acts,

- '(1) Since about August 1, 1970 you have been employed by the Northern Ireland Hospital Authority as a child psychiatrist and in that capacity you have displayed a professional interest in environmental and psychological problems affecting persons living in the disturbed areas of Northern Ireland:
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- '(4) In consequence of your conduct as aforesaid on May 17, 1972 at Bow Street Magistrates' Court you pleaded guilty to a charge of indecent assault;'
- "And that in relation to the facts alleged you have been guilty of serious professional misconduct."

In July, 1973 the Committee had found proved the facts alleged in the foregoing charge, and had judged the practitioner to have been guilty of serious professional misconduct.

The practitioner was present and appeared by Mr. A. Whitfield, Counsel, instructed by Messrs. Le Brasseur and Oakley, Solicitors.

The Committee acceded to an application by Mr. Whitfield, that the public should be excluded from the resumed inquiry in the case.

July 14-16, 1975] DISCIPLINARY COMMITTEE

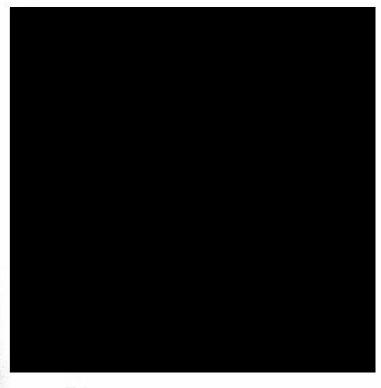
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Mr. A. P. P. Honigmann, as Solicitor to the Council, recalled the position in which the case stood, and referred to evidence received by the Council as to the conduct of the practitioner since the previous hearing.

Mr. Whitfield addressed the Committee.

Strangers were then re-admitted and the Chairman announced the determination of the Committee as follows:

"Dr. Fraser: The evidence as to your continued response to treatment since July, 1974 which has been presented to the Committee today, has enabled them to feel satisfied that it will now be proper to discharge your case. Your case is accordingly now concluded."



^{*} The charge as set out above incorporates only the facts which were found proved in July, 1973.

- with him or had been abused by him in any way?
- 2 A. I don't think there were. The only thing I would say is
- 3 he also worked with the Scouts outside I think. There
- 4 were never any allegations came to light about his
- 5 (inaudible).
- 6 Q. No, no. I just want -- I want to be absolutely clear
- 7 that noone has spoken to the Inquiry --
- 8 A. No, no, no.
- 9 Q. -- and said that they were abused by him in Lissue --
- 10 A. No.
- 11 Q. -- but I just wondered that, you know, this was a man
- 12 who is suddenly revealed --
- 13 A. Uh-huh. Uh-huh.
- 14 Q. -- as having sexually abused a child --
- 15 A. Yes.
- 16 Q. -- and been alleged to have abused others, which we know
- 17 he subsequently pleaded to, but in those circumstances
- I just wondered whether any steps were taken to
- 19 ascertain whether he had been -- had done anything
- 20 untoward while he was in Lissue.
- 21 A. No. I think if it had occurred ten years later, there
- certainly would have been.
- 23 O. Yes.
- 24 A. It's a mark of the times, because the sexual abuse
- allegations all began to, you know, get heated around

- about 1978/'79 and then from that time onwards it was
- 2 increasingly recognised how broadly it was happening.
- 3 Q. That brings me to another allegation. Again I am using
- 4 names ---
- 5 A. Uh-huh.
- 6 Q. -- that can't be used outside. That's the girl LS66.
- 7 You were aware of that allegation about LS21.
- 8 A. Yes, yes.
- 9 Q. You mentioned to me that when he was suspended and he
- 10 came back, he was not the same person and ultimately his
- 11 work deteriorated --
- 12 A. That's right.
- 13 Q. -- to such an extent that he took early retirement.
- 14 A. Uh-huh.
- 15 O. We know that was between 1993 and '96?
- 16 A. Uh-huh.
- 17 Q. You were most surprised by these allegations --
- 18 A. Yes.
- 19 Q. -- in respect of him. Is that right, doctor?
- 20 A. Yes, absolutely. I mean, that amongst other allegations
- 21 -- there were allegations made, for example, that he had
- 22 trailed -- he and another nurse had trailed a child
- along the corridor by the hair and also kicked another
- child, and these things are just -- I mean, that doesn't
- say they didn't occur, but I cannot for the life of me

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

3.1 There were 2 Units in Lissue Hospital;

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

- 3.2 The Unit was located in an old country mansion. The rooms were spread over an area accessed by corridors and this was never completely satisfactory in facilitating children's whereabouts it on occasions stretched nursing resources.
- 3.3 The Unit was established to provide for a maximum of 20 inpatients and 5 day patients, and accepted children up to 14 years of age.
- 3.4 A school was provided for the Unit by South Eastern Education and Library Board (S.E.E.L.B.)

3.5 Staffing:

- 3.5.1 Staffing provision for the Unit roughly followed the Royal College of Psychiatrists recommended levels set out in around 1971.
- 3.5.2 Consultants in Child and Adolescent Psychiatry. Between 1976 and 1978 there were 3 consultants visiting the Unit. Dr Nelson attended many times each week 1 of his visits being for a complete morning multidisciplinary meeting (M.D.M). Dr Barcroft and I attended for one mornings M.D.M. and usually on at least 1 other occasion each week, in order to discuss cases or work directly with cases. After 1978 Dr Barcroft left to take up a job in England. His input to Lissue was not replaced.
- 3.5.3 A medically qualified psychiatric Trainee attended the Unit on a full time basis and normally each trainee remained for a 6 month period.
- 3.5.4 Nursing Staff. The Unit was staffed with S.R.N. and S.E.N. nurses. This always included a nurse at Charge Nurse/Sister grade.
- 3.5.5 A Social Worker was based full time at the Unit and as well as working with children and families would have liased with Social Services when required.
- 3.5.6 A Psychologist was based full time at Lissue and worked with children and families.
- 3.5.7 For several years (until 1978) there was also an Occupational Therapist whose work was largely child focused. The post was not replaced when this person moved to another job.
- 3.5.8 Overall a Multi Disciplinary ethos was in place see below.

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
- 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

- 1 more direct involvement with the child, what was your
- 2 role in respect of them?
- 3 A. Well, it was very much a liaison role certainly with the
- fieldworkers, and with the social workers who worked in
- 5 residential centres it was more of a kind of helping
- for the role in terms of how could we help them implement some
- of the ways that the child had been managed in Lissue.
- 8 Could they do that in their children's home or not?
- 9 What flexibility did they have to undertake some of the
- things that we did and took for granted?
- 11 Q. As I have understood the discussion that we were having,
- 12 your primary function was essentially to work with the
- 13 families --
- 14 A. That's right.
- 15 Q. -- in either family therapy session --
- 16 A. Uh-huh.
- 17 Q. -- or just with the parents on their own to help them to
- 18 learn -- to train the parents how to manage their
- 19 children using the techniques --
- 20 A. Uh-huh.
- 21 Q. -- that Lissue developed essentially.
- 22 A. Uh-huh.
- 23 O. Is that correct?
- 24 A. Yes, yes.
- 25 Q. You also were saying that except for the family therapy

- 1 sessions that children would have attended in Lissue, or
- 2 if you were going on a home visit, when the child might
- 3 have been at home I presume --
- 4 A. Uh-huh.
- 5 Q. -- your role was not to interact with the children as
- 6 such. That was left to the nursing staff in Lissue
- 7 to -- and the teachers to manage them --
- 8 A. Uh-huh.
- 9 Q. -- on a day-to-day basis.
- 10 A. Yes, yes, and also the -- I mean, there's registrars,
- senior registrars in the unit as well who would have had
- individual interviews or individual contact with the
- child or children who were in the unit. So my role was
- more not direct, face-to-face with the children, young
- people, although that did happen at times, but it wasn't
- 16 particularly my role as such.
- 17 Q. I mean, for example, one of the things that I was asking
- 18 you was whether you yourself ever attended the morning
- meetings that the children had between breakfast and
- 20 going to school.
- 21 A. No, no. They were nursing-led.
- 22 Q. Paragraphs 5 and 6 of your statement you talk about
- 23 helping to train parents in the techniques to manage the
- children.
- 25 A. Yes, yes.

- d. Patients were not expected to engage in chores, and chores would not have been given as a punishment. The child/patient would have been expected to keep their bedroom reasonably tidy, as an example clothes not on the floor as a bedroom cupboard was provided.
- e. Bullying was not condoned. Among peers I recall arguments on the Ward; this would have been managed by the staff with the patients/children. The nurse would have engaged with the children involved in the argument, to resolve the issue and re-engage them in co-operative play. If there were serious concerns they were discussed through the MDT meetings.
- f. I had no awareness of peer sexual abuse being a difficulty on the Ward.

 However, I was aware of the need to be vigilant given some of the experiences of the children.

PRIVATE



THE INQUIRY INTO HISTORICAL INSTITUTIONAL ABUSE 1922 TO 1995

WITNESS STATEMENT O HIA 172

HIA 172 will say as follows:-

Personal details

1.	I was born or	ir	l have a	called	Му	
	father was	and we lived	i	. We retu	rned to No	rthern
	Ireland when I was four	. We lived ir		as that is wher	e my fathe	r was
	originally from. According	g to my mother,	my fath	er became very	abusive af	ter he
	and be	came a heavy	drinker.	He eventually	y left us an	ıd my
•	mother was not able to c	ope.				

2.	1 attended	Primary School.	When I	was in F	rimary 1	my mot	her's
	sister encouraged he	r to seek help fro	m social	services	as I was	hyperac	ctive.
	My mother told me th	at I was hard to h	andle. O	n 13 th Ma	y 1980 I v	vas adm	nitted
	to	1 -	was then	transferr	ed to Liss	ue Hos	pital,
	Lishurn						

Lissue Hospital, Lisburn (30/06/1980 to December 1985)

3. The front of the building was for physically disabled children and the nurses wore uniforms. It was the main entrance and it was a lovely part of the building. I was placed in a part of the building at the back of the building where the staff wore ordinary clothes.

HIA 172 PRIVATE 1

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 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 19. I did not drive a I have been asked if I had a called I did not work with a 20. I never worked with a called LS 27 LS 22 **I** remember who was LS 23 She was not called very competent. I remember LS 23

- 1 Staff used first names in Lissue. Isn't that right?
- 2 A. Yes.
- 3 Q. They didn't wear a uniform?
- 4 A. That's right.
- 5 Q. Is it possible that a child might have known the first
- 6 name of a member of staff but never got to know the
- 7 surname?
- 8 A. It is likely.
- 9 Q. You also say in paragraph 5 that staff moved between The
- 10 Royal and Lissue and there was --
- 11 A. Now when I say that, that would have been the social
- workers, the psychologist and the consultants and the
- doctors in training.
- 14 Q. But the nursing staff were permanently in Lissue?
- 15 A. Yes.
- 16 Q. They weren't ...? I am not going to ask you about the
- 17 Paediatric Unit. You didn't work or have anything to do
- 18 with the Paediatric Unit. Isn't that right?
- 19 A. The only occasion I would have been asked if they were
- short of staff maybe to assist with meal times, but that
- 21 was very rare.
- 22 Q. I was asking a little bit about handover time. Doing
- 23 the best you can remember, you think that the -- you
- came on shift as a day staff member in or around
- 8 o'clock and that's when the handover took place.

- 7. I never attained the rank of *sister*, but acted up into that role when my colleagues were on holiday or absent due to a bereavement or family illness. I was on the day shift only given my own family commitments.
- 8. The Lissue Unit was unusual in that the staff wore civilian clothes, and never uniforms. We were therefore inclined to pick clothes that were comfortable though smart. A further distinction from my previous nursing experience was that staff being the nursing staff and the medical staff called each other by their first names, rather than a rank and surname. These features were used to make the unit more comfortable for the children under our care.
- 9. The children we cared for were on an in-patient basis numbering around 20 aged from young infants to about 12-14 years. As indicated above at paragraph 6, they had a range of problems and sadly some of the children came from very disturbed and, came from what would now be called, dysfunctional families. Some of the children had been shown no apparent love and their interactions with their parent or parents who called could be quite heartrending. As a member of the nursing staff, I would have participated in the morning meetings with the social workers and doctors and the teachers who provided school facilities at the Unit.
- 10. The children under our care came from all over Northern Ireland.
- 11. As regards any medication these were as prescribed by the 3 doctors who were the general compliment of medical staff in my time both at Lissue and when we moved laterally for economic efficiency to the Old Foster Green Hospital at Saintfield Road, Belfast. The doctors would have prescribed the medication and its dosage. As I became more senior, I was conferred with by some doctors as to whether the dosage was adequate or too much and would certainly have reported back on what impact the medicines were having upon the children. This was in order to assist the doctors to form a clinical

- 2. While I was working with Dr McCune, he, I and other colleagues that had worked in Lissue influenced the development of the child and adolescent mental health nurse training course at Purdysburn School of Nursing. This programme commenced in 1990, which later transferred into Queen's University and has been registered by the Nursing and Midwifery Council (Nursing and Midwifery regulation body) as a recognised course. Upon completion of that course you are considered a specialist nurse. I hold that qualification since April 1992 and it is registered on my statement of entry with the NMC. I was commissioned to lead the review of Child and Adolescent Mental Health with Mr Charles Bamford, and within NI. I also had involvement in strategic planning in the scoping and preparation for the design of the current regional provision within NI.
- 3. My line manager upon commencing employment in Lissue 1984 was LS 21 I recall that LS 78 had just left the ward when I was arriving. We were divided into teams so there was one senior staff member that you would have been managed by LS 21 was my team manager.
- 4. I recall my period as a nurse in Lissue with fondness. It was a proactive experience working with Dr McAuley and Dr Nelson. They were implementing new models of practice. Dr McAuley used a behavioural model and Dr Nelson a family therapeutic model. These required different approaches with different children, and they were both of their time. Many of the techniques were new and innovative at that time in relation to the video undertaking with families, with their consent etc. From an academic model perspective I recall using the work of Michael Rutter and Dr Minuchin, and these models would also have been implemented nationally across the United Kingdom. I also recall student doctors and nurses in the Unit, as well as other disciplines working together with families in a multidisciplinary way.
- 5. There were some of the Multi Disciplinary Team (MDT) in Lissue and some came from the Royal Hospital in Belfast. There was a movement of professional staff between the two hospitals to support the children who were admitted or attending as day patients to the ward. There were weekly significant meetings of the MDT.

- 1 Q. -- there wouldn't have been a sort of compulsory
- 2 section of the RMN where you look just at the child and
- 3 adolescent bit?
- 4 A. One module where you would have looked at some of that,
- 5 yes.
- 6 O. There would have been?
- 7 A. Yes.
- 8 Q. Oh, right. Okay.
- 9 A. So in your training you may have had a placement in the
- 10 Child Psychiatric Unit.
- 11 Q. Uh-huh. Right, and the course that you spoke of being
- 12 devised --
- 13 A. Yes.
- 14 O. -- the specialist one --
- 15 A. Yes.
- 16 Q. -- how long was that and what did that cover?
- 17 A. It was over -- it was just over the twelve months. It
- 18 was fourteen months to complete, and that would have
- 19 been the child care and the law, and it would have
- looked at care and it would have looked at conditions in
- 21 relation to the ICD-10 at that time, which was the
- 22 diagnostic manual that the medical staff would have
- used. So very much looking greater at the psychological
- and indeed the medical presentation of the child.
- 25 Q. And that was full time, was it, or was it day release?

- 1 A. It would have been again day release. You would have
- 2 actually gone out on placement.
- 3 Q. Right. Last question is that we have heard about
- 4 children getting up on the roof.
- 5 A. Yes.
- 6 Q. What action was taken to stop that happening?
- 7 A. Well, what staff would have done is you would have tried
- 8 to have all of the children involved in activities so
- 9 that that wouldn't have been a choice that they would
- 10 have made. If it was known to you that a child would
- 11 have chosen that kind of behaviour from home or another
- 12 environment, then you would have been more conscious
- that you would have been trying to have that child
- engaged in activities that were away from areas. So,
- for example, the field that I was talking about, you
- might more likely take children there who were likely to
- 17 climb on to roofs, but often it was a very spontaneous,
- immediate behaviour and often happened within seconds of
- 19 you standing right beside them and they were scaling and
- up on the roof, and the roof I am talking about, because
- 21 it was the courtyard --
- 22 Q. Uh-huh.
- 23 A. -- it was one level up. So it was quite easy for
- 24 an agile child who decided he wanted to -- primarily
- 25 male -- would have got up and it literally happened

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

- 6. On a monthly basis there was also a journal club of professionals, where the Doctors, Nurses and Social Worker came together to consider training and development of practice issues through presentation of cases, research or other information.
- 7. As between the day shift and night shift nursing teams, there would be a handover. This would have been a detailed discussion of each individual patient. Occasionally if the staffing need required it, some day staff would support the night staff on the ward while others met to ensure a handover of information. On those occasions the senior Night Nurse provided a handover to the available day staff, who would then share that among all day staff.
- 8. In terms of the nursing plan, Nurses were expected to write a report on a daily basis as to the implementation of the plan, which was drawn up and reviewed through the MDT process. From a nursing perspective this report was informed by the Logan and Tierney model of daily activities of living and the nursing process assessment, plan, implement and evaluate. Each time you concluded

- 1 A. The training that I would have received during the time
- 2 I was in Lissue --
- 3 O. Yes.
- 4 A. -- I would have gone to classes on behavioural
- 5 modification. I would have gone to training around
- family therapy and particularly a model with Minuchin,
- 7 which was a structural family therapy that was very of
- 8 its time then. I would have been expected to go to
- 9 continued professional development around particular
- 10 medical conditions such as enuresis, encopresis and then
- 11 that would have given you the information about what
- that condition was and indeed then the methods of
- improving treatment.
- 14 Q. One of the things that has not been clear to the Inquiry
- to date is who was in overall charge of Lissue.
- 16 A. My memory of it was that from the nursing perspective
- that was LS21 as the Charge Nurse of the unit, who then
- 18 was responsible -- so from my perspective as a junior
- 19 Staff Nurse he was in charge, and then he would have had
- 20 to report to LS8, who was the Nursing Officer. So
- 21 I would have understood that LS8 was the in charge --
- was the most senior person from a nursing perspective.
- 23 I'm aware there was a Director of Nursing, but as
- 24 a junior Staff Nurse I wouldn't have been in
- relationship with her at that stage, and then from the

4.10. In the HSCB's submission, staff training is of the utmost importance . The nurses who gave evidence to the Inquiry recalled training on restraint 50 and LS 7 explained this by saying she was trained in the use of restraint by watching other nurses on the job. LS 80, who was the working in Lissue, also said he "was never formally trained how to do it...in those days we basically watched other people do it and modelled our behaviour on that" 51.

The evidence of LS7 and LS 80 chimes with Dr McAuley's recollection that in the 1970s "a lot of things were learnt just by observing other people". Dr McAuley also acknowledged that "training … was not in those days as sophisticated as it was, say, in the Forster Green days, when there were occasions during each year – there would have been full days or half-day sort of workshops on doing restraint." ⁵² The Board submits that Dr McAuley's evidence reflects that training programmes for health and social care staff developed over time.

4.11. In the HSCB's view, the state of affairs regarding staff training on restraint in Lissue is most likely a reflection of and in keeping with general standards and practices at the time.

SEDATION

4.12. The Inquiry has made it clear that it is not within its remit to examine the medical treatment given to patients⁵³. However, Applicants

HIA 38 and HIA 251 have complained about being injected regularly and being heavily sedated. In the HSCB's submissions, it is outwith the remit of

⁵⁰ For example, on Day 198, LS 81 said when she went to Lissue, she was taught about holding [see page 84, lines 9-4] and on Day 199, LS 21 said he had some training on restraint [see page 48, lines 11-13]

⁵¹ Day 200, pages 63, lines 9-25 and page 64, lines 1-11 for a full discussion

⁵² Day 201, page 97, lines 11-20 for full discussion

⁵³ Statement of Sir Anthony Hart, Inquiry Chairman, dated 4 November 2015

A. The reason I said that I didn't see holding as restraint
was I had worked in Purdysburn Adult Mental Health Unit
prior to coming to Lissue, and in that establishment
adults would have been restricted into a room of
isolation and that would have been named as restraint.
So -- and in other examples that individuals as adults
would have been expected to be in bed and confined to

bed and supported to stay in bed.

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So when I went to Lissue, we were taught about holding. Holding was about containing the very challenging temper tantrum behaviour that would be self-destructive and indeed potentially put other children at risk. So that would be how you would hold a child. It was meant to be a firm gentle hold with open hands and the child -- you would have expected to hold the child's hands across their chest such as this (gesturing) and then you were expected to sit behind them and quietly say to them, "Take a deep breath. Calm down", and when they began to calm, you would release their arms, and you would then take them and talk to them about what was going on, and encourage them to try and say in words -- to use words to describe what had caused them the distress that they were demonstrating in the behaviour.

25 CHAIRMAN: So we can see what it is you're demonstrating,

- 1 care plan, as it were --
- 2 A. Uh-huh.
- 3 Q. -- then you could go to the doctor and say, "Look, this
- 4 is ..."
- 5 A. "What do we do?" Yes.
- 6 Q. Another issue that we have heard about in the Inquiry is
- 7 the use of restraint for children.
- 8 A. Yes.
- 9 Q. We were discussing this earlier and I just wondered what
- 10 your recollection of the use of restraint in Lissue was.
- 11 A. Separate -- if it was, you know, children in conflict,
- separate the children, and the easiest way to describe
- it is a hug usually from behind, safer from behind,
- a hug, and, you know, things settle quickly when there
- 15 was no escalation.
- 16 Q. We have heard -- I mean, you were saying to me that it
- was -- you had some training in the use of restraint.
- 18 A. Yes, yes.
- 19 O. You said that in the altercation between the children
- 20 the staff were obliged to hold them as you describe
- 21 until they calmed down.
- 22 A. Uh-huh.
- 23 Q. But I was wondering if you ever had to use more than
- just a hug. Children have described maybe being pinned
- on the ground or being pinned on their bed. Is that --

- 1 Q. Probably they didn't have a chandelier to swing from!
- 2 A. When you have children who have a conduct disorder, you
- 3 expect there to be problems. You expect that there will
- 4 be non-compliance, there will be temper outbursts and
- 5 aggression and that kind of thing. So that wasn't
- 6 uncommon. It wasn't a daily occurrence --
- 7 Q. It wasn't a daily occurrence.
- 8 A. -- in my recollection anyway.
- 9 Q. Can I ask were you ever involved in restraint yourself?
- 10 A. Only if I was trying to help a parent learn how to do
- 11 that. So part of my role and part of the role of all of
- us there, so me along with a nurse and maybe
- a psychologist, would be doing parent training, so
- parent admissions. So you were trying to say, "Well,
- look, if a child is completely uncontrollable, this is
- how you could hold the child in a way that's safe".
- 17 Q. But that would be about modelling as opposed to your
- hands being on a child?
- 19 A. No. I would have -- I would have demonstrated how to do
- it and the nurse likewise would demonstrate how to do
- it. I was never formally trained how to do it and in
- a sense that's one of the things that would come up, you
- know, because now, of course, the training around
- restraint and care and responsibility -- in fact, I did
- 25 that as a trainer when I moved posts in 1994 --

- 1 Q. Uh-huh.
- 2 A. -- but in those days we basically watched other people
- 3 do it and modelled our behaviour on that.
- 4 O. Behaviour on that.
- 5 A. Yes.
- 6 Q. Was that -- did the consultants lead that or was that
- about nurses? I mean, when you arrived there, what you
- 8 learnt about restraint, was that --
- 9 A. Uh-huh.
- 10 Q. -- from the nurses mainly?
- 11 A. Yes, yes.
- 12 Q. The incident with the child with the black eye --
- 13 A. Yes.
- 14 Q. -- were the doctors involved in that? Were they aware
- of the complaint?
- 16 A. They would have been aware of it, yes, yes, and there
- was a process -- an untoward report went up. I am not
- quite sure where it went to. Maybe in terms of
- line management it went to -- LS 95 would have been
- 20 the line manager for the social workers at that time and
- then it became LS 96 , who were Assistant
- 22 Principal Social Workers.
- 23 Q. I was just going to ask that, about your own
- 24 supervision.
- 25 A. Uh-huh.

and hold the child till the child calms down.

That -- I mean, staff learn that from -- I don't know -- talk at ward rounds, having observed behaviour management stuff with, you know, myself working with parents and things.

With older children, that's your 10-year-old, who is in a much more difficult situation, where in order to manage them you have got to actually put them down on the floor and hold them down using a couple of members of staff.

Training on that I suppose was not in those days as sophisticated as it was, say, in the Forster Green days, when there were occasions during each year -- there would have been full days or half-day sort of workshops on doing restraint. I mean, that's just part of the changes over the time. In the '70s a lot of things were learnt just by observing other people. I think probably in the latter days, when it was more carefully managed, it maybe resulted in better -- better management of the situation, but, I mean, it's a terrible situation when restraint is so negatively viewed, because it's such an important basic thing that all health professionals should be able to do when and where necessary.

Q. I think the suggestion has been that it was over-used in circumstances where it might not have been strictly

- 1 at the main hospital and meeting with other hospital
- 2 managers, nursing managers presumably.
- 3 Just in respect of training we were talking earlier
- 4 and your recollection is that the eighteen staff, with
- one exception, had been trained and obtained the RMN --
- 6 A. Yes.
- 7 Q. -- although when we discussed that a little bit further,
- 8 that might not quite have been the case, but certainly
- anybody who came to Lissue in the '80s would have had
- that as a requirement of acceptance in the post.
- 11 A. Yes.
- 12 Q. So it is possible that maybe some of the original staff
- who had come from The Royal might not quite have had
- 14 that RMN qualification?
- 15 A. That's not my memory, but -- I'm sorry -- I can't
- 16 elaborate on that.
- 17 Q. You do remember there was in-house training, that
- Drs Nelson and McAuley trained staff in what would be
- 19 called CBT, cognitive behavioural therapy --
- 20 A. Behavioural therapy.
- 21 Q. -- or in this systems therapy, the family therapy that
- 22 you are talking about, as those innovations developed.
- 23 A. Yes.
- 24 Q. Did they ever go outside of Lissue for training? Can
- 25 you recall?

PRIVATE



THE INQUIRY INTO HISTORICAL INSTITUTIONAL ABUSE 1922 TO 1995

WITNESS STATEMENT O HIA 172

HIA 172 will say as follows:-

Personal details

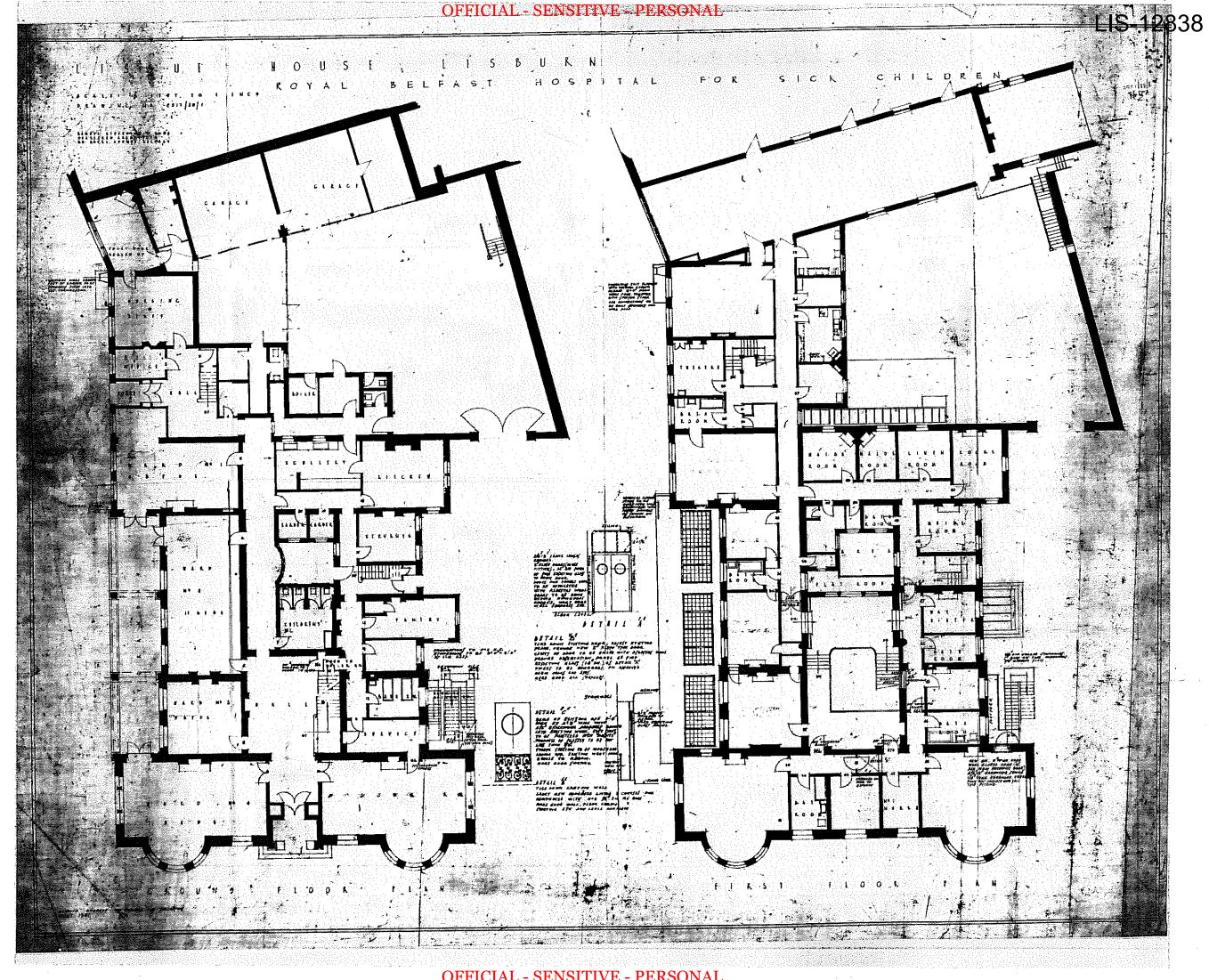
1.	I was born or	ir I have	. I have an older brother called			
	father was	and we lived it	. We returned to	Northern		
	Ireland when I was four	. We lived in	as that is where my f	ather was		
	originally from. Accordin	g to my mother, my fa	ther became very abusiv	e after he		
	and became a heavy drinker. He eventually left us and my					
	mother was not able to c	ope.				

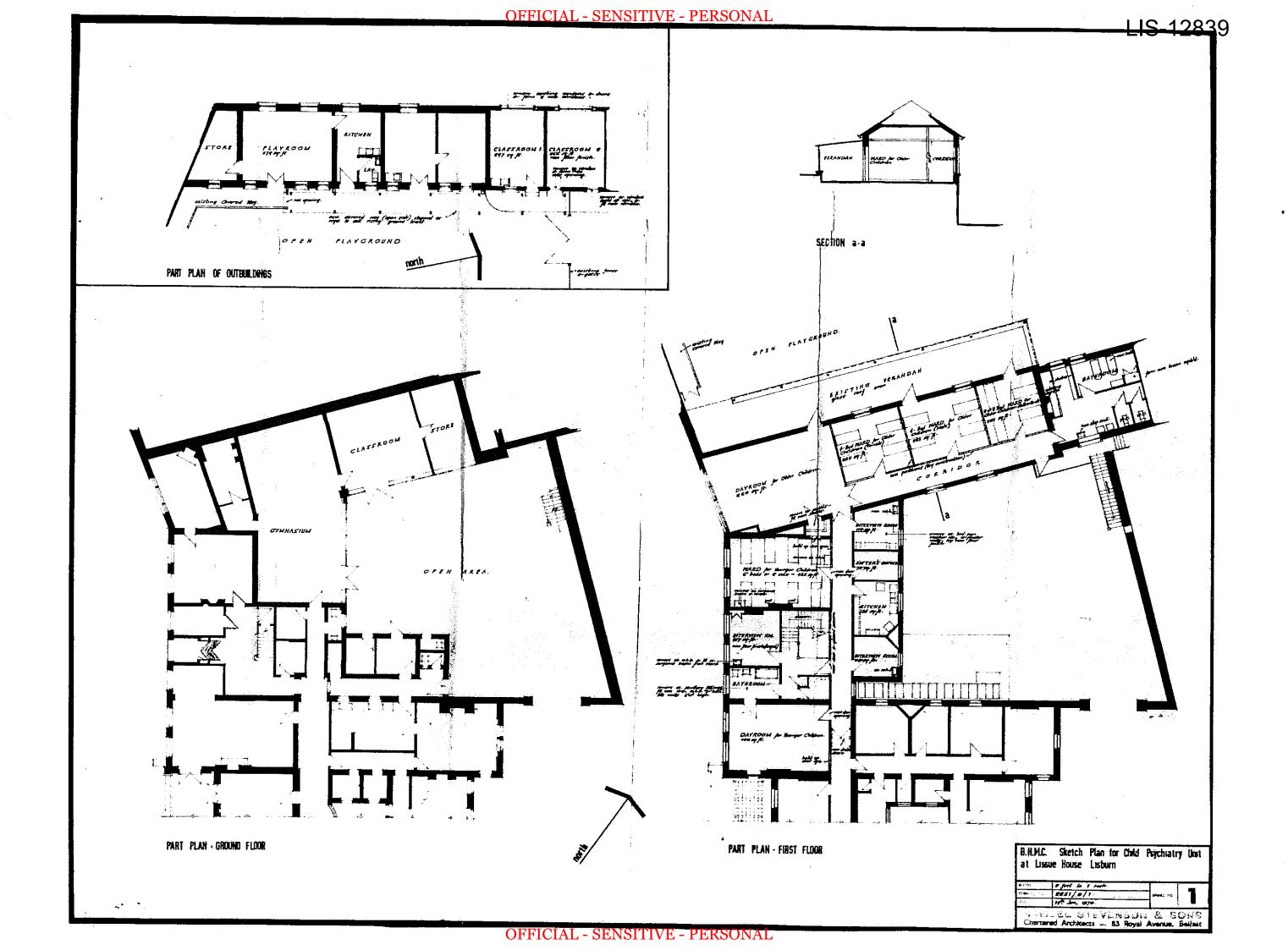
2.	1 attended	Primary School.	When	I was i	n Primary	1 my m	nother's
	sister encouraged her to seek help from social services as I was hyperactive						ractive.
	My mother told me to	nat I was hard to h	andle.	On 13 th	May 1980	l was a	dmitted
	to	1 -	was the	en trans	ferred to L	issue H	lospital,
	Lisburn						

Lissue Hospital, Lisburn (30/06/1980 to December 1985)

3. The front of the building was for physically disabled children and the nurses wore uniforms. It was the main entrance and it was a lovely part of the building. I was placed in a part of the building at the back of the building where the staff wore ordinary clothes.

HIA 172 PRIVATE 1





- it was described, was on the ground floor and the
- 2 Psychiatric Unit that you were admitted to was on the
- first floor. There was a locked door at the top of the
- 4 stairs leading into the Psychiatric Unit. Isn't that
- 5 right?
- 6 A. Yes, that's correct.
- 7 Q. You say that you were on that first floor with a mixture
- 8 of children and teenagers and you name the boys that you
- 9 shared a room with. There was also a younger boy than
- 10 you called LS89 . There would have been three to
- four children in one dormitory. You stayed in the same
- dormitory during your whole time in Lissue.
- 13 A. Yes, that's correct.
- 14 Q. You describe then in paragraph 5 the layout. You
- remember when you first arrived, you walked through two
- mahogany doors with wire mesh glass, then through
- 17 a glass partition. From there you went into the main
- 18 corridor. The kitchen and TV room was just off this
- 19 corridor to the right. The other corridor to the left
- 20 had dormitories and at the end of the corridor was the
- 21 dining room. At the opposite end of the dining room
- there was a play area and the classrooms were just
- 23 beyond that. Now we have heard classrooms were mobile
- 24 huts outside.
- 25 A. Yes. There were old buildings, ma'am, old stone -- made

- 1 Lissue. You say that:
- 2 "The unit was located in an old country mansion."
- We have seen some photographs of that.
- 4 "The rooms were spread over an area accessed by
- 5 corridors and this was never completely satisfactory in
- facilitating children's whereabouts. It on occasions
- 7 stretched nurses' resources."
- I wondered if you could maybe give us a little more
- 9 about what you meant by stretching the nursing
- 10 resources?
- 11 A. Well, because it was so spread out, it was difficult
- obviously at times to supervise children, especially if
- there were difficulties with the children. You would
- have needed a lot more staff, you know, to supervise
- children in the different areas of the unit. It might
- have been easier if the population of children in the
- 17 unit had been a more constricted -- to a more
- constricted age range, say, you know, from 5 to 10 or
- 19 something like that.
- 20 Q. Well, you go on to describe staffing here. At 3.5.2 you
- 21 say:
- "Consultants in child and adolescent psychiatry.
- 23 Between 1976 and '78 there were three consultants.
- 24 Dr Nelson attended many times each week, one of his
- visits being for a complete morning multi-disciplinary

PRIVATE

- 4. When I was in Lissue I had my own bedroom. There were dormitories but I was only placed in a dormitory when I was being put in timeout. On a typical day I would get up and get dressed. I used to wet the bed quite a lot so if I had wet the bed I was put in a bath containing dettol. The staff did not want to touch me and it made me feel like I had a disease. I felt like I was being sterilised in the bath and I found it quite upsetting. After I got dressed I would have breakfast and go to school. Sometimes I was punished by being made to wear my pyjamas all day and not sent to school. I used to sit in a room on my own all day looking at the pages of Ceefax. I was left school work to do but was unsupervised. The weekends tended to be a bit more relaxed than the weekdays depending on what members of staff were working. I believe that I broke things out of frustration or was provoked to do things by members of staff or other residents. Those things were written up as bad behaviour on my part with no reference to why I did those things. I thought that was very unjust and painted the wrong picture of me.
- 5. I remember passing a cupboard when we were away somewhere on holiday and asking what it was. I was told that is where they put the bad boys.
- 6. We were not allowed our own toys. My mother brought me an X-wing fighter once and was told to take it home. All the communal toys were kept locked in a cupboard and we were only allowed to play with them at certain times called group time.
- 7. I was punished for not eating my food. I remember a member of staff putting me in a room with a bowl of cold peas and telling me I was not allowed to leave until they were finished. I put them in my mouth and then ran to the toilet to spit them out. I think this is an example of the pettiness and inhumane treatment by the staff.
- 8. The school was in two portacabins on the grounds. Time spent at school was more productive and structured. The teachers were LS1, LS2

 LS2, LS3 and LS4 The teachers were all professionals and I do not have any complaints about the school apart from LS4 who

PRIVATE

3. My mother found it difficult to cope with me. She took me to my GP and I was referred over to the Child Guidance Clinic within the Department of Psychiatry in the Royal Victoria Hospital. I was treated by Dr Manwell and her colleague.

They recommended some intensive therapy and sent me to Lissue Hospital when I was 7 years old.

Lissue Hospital (1975-1976)

- 4. My mum brought me to Lissue Hospital in a taxi. I think my father was working at the time. When I realised I was not coming home again, I became very upset and very difficult. I had no idea why I was being left there. I kicked the doors to get out and grabbed the handles. It was the first time I had left home and I was frightened at the idea of being in a strange place by myself. I also missed my father. I was shy and quiet at the beginning and kept my own company. I remember forming a friendship with an older girl called would have been about 16 years old. She took me under her wing and I LS 11 gradually made other friends such a , and his who was only 3 or 4 years old. LS 13 had LS 13 an LS 14 I also remembe LS LS 18 LS 19 was always singing. The age range of the patients in Lissue ran from approximately 3 or 4 year olds to teenagers who were about 15 or 16 years old. The children with physical disabilities slept on the ground floor and the rest of us slept on the first floor. I was on the first floor with a mixture of children and teenagers. I shared a dormitory with LS 14 LS 16 LS 18 and a younger boy called . They would have been three to four children in one dormitory. I stayed in the same dormitory during my whole time in Lissue.
- 5. Lissue had two floors. I remember the layout quite well. I remember when I first arrived. I walked through two mahogany doors with wire mesh glass and again through a glass partition with wire mesh glass. From there I went into the main corridor. The kitchen and TV room was just off this corridor to the right and the other corridor to the left had dormitories and at the end of that corridor was the dining room. At the opposite end of the dining room there

HIA 220

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 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 19. I did not drive a I have been asked if I had a called I did not work with a called 20. I never worked with a LS 27 LS 22 **I** remember who was LS 23 very competent. I remember She was not called LS 23

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 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 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 scalled LS 20 The 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.

- 1 a slap. Very edgy."
- 2 You say you think this entry shows that staff hit
- 3 you:
- 4 "Otherwise why would I be in fear of getting a slap
- from staff if it hadn't happened before?"
- You have seen another entry from your record:
- 7 "... which again states that I was thumped by
- 8 another resident and I was frightened the doctor was
- 9 coming to give me an injection."
- 10 We looked at that last entry a short while ago.
- 11 A. Yes.
- 12 Q. That entry, just to be clear, can be seen at LIS22289.
- If we can scroll down there. Yes, that's the entry
- 14 there:
- 15 "HIA38 had enough points to gain half an hour with
- 16 a member of staff."
- I just wondered about the train set. You do
- remember a train set in Lissue. Isn't that right?
- 19 A. It was like Lissue's holy grail. It was a room the size
- of the interview room we were in just a while ago and it
- 21 had about the length of these tables a big set-up. It
- had papier mache hills and things, and that was like the
- child's, as I say again, the holy grail. It was the
- 24 train. You done everything to get to the train room.
- 25 Q. It was seen as a treat and a privilege --

- 25. I also recall patients being on the roof of the building of Lissue, and having slates thrown at staff. I have been shown a policy which related to Forster Green Hospital. That dates to after my experience, but in terms of my experience in Lissue, I do not recall many aspects of it. I do recall the escalation process, namely to alert senior staff to the events, would have applied, but I have no recollection of implementing any period of 24 hours in isolation after the event. My recollection is that one staff would have remained to speak calmly to the child, far enough away to speak, but not close enough to place yourself in any danger from potential missiles. Other children would have been encouraged away from the scene into the unit for their safety. When the child came down from the roof, the child was brought to a quiet area to discuss and explore what it was that might have initiated their behaviour. You would try to work out what started it, what kept it going and whether there was any reason for it. This would then assist with trying to help the child resolve the situation and or precipitating factors with alternative behaviours that are low risk behaviours for self and others, this was to invite and hopefully develop empathy for others. The aim was to achieve ability for the child to identify and modify self and develop alternative choices.
- 26. In terms of locking of doors within Lissue, I do not recall this as practice. I do however recall a door into the unit being locked upon the return of a patient that had absconded under the supervision of the Police, until the situation deescalated. The door was then unlocked.
- 27. In terms of bedrooms there were rooms with four beds down stairs, and then upstairs there were individual bedrooms. I do not remember bedroom doors being locked. If there were locks, I do not recall ever using them. There may however have been a door closed with a member of staff sitting at it to supervise time out. This was also the subject of debate in terms of implementing the technique with the door open, as the use of a closed door may give the child the feeling that they were closed in. This resulted in the technique being changed in consultation with Dr McAuley, so that the door would be left open.

- 1 A. Now -- well, I remember there was a door between the
- 2 kitchen and what would have been the stairway down to
- 3 the ward downstairs and that door became locked. We
- 4 had -- when I first went there, that door was always
- 5 open and the older children were allowed to go round to
- 6 the kitchen to make toast. After several fire alarms
- 7 and the Fire Brigade being with us -- because the toast
- 8 sometimes went -- well, smoked, and then the smoke
- 9 alarms went off, and then we had fire training, and we
- were advised then that that door needed to be secured.
- Now when I say "locked", the door wasn't physically
- 12 locked, but there was some mechanism that went on the
- door that, you know, you couldn't get through.
- 14 O. Can I just ask about the dormitories? Were there locks
- on the dormitories at all?
- 16 A. I have no recollection of locks on the dormitories.
- 17 Q. What about glass panels in the doors of the dormitories?
- 18 A. I can't remember that.
- 19 O. You don't --
- 20 A. I remember there were dormitories downstairs and
- I remember there were single rooms upstairs, and one of
- the single rooms upstairs had a double glass window for
- observation of sick children, and the nursing staff
- 24 would have sat in the observation room so that the child
- had some privacy, but that they could be observed, and

- 4. When I was in Lissue I had my own bedroom. There were dormitories but I was only placed in a dormitory when I was being put in timeout. On a typical day I would get up and get dressed. I used to wet the bed quite a lot so if I had wet the bed I was put in a bath containing dettol. The staff did not want to touch me and it made me feel like I had a disease. I felt like I was being sterilised in the bath and I found it quite upsetting. After I got dressed I would have breakfast and go to school. Sometimes I was punished by being made to wear my pyjamas all day and not sent to school. I used to sit in a room on my own all day looking at the pages of Ceefax. I was left school work to do but was unsupervised. The weekends tended to be a bit more relaxed than the weekdays depending on what members of staff were working. I believe that I broke things out of frustration or was provoked to do things by members of staff or other residents. Those things were written up as bad behaviour on my part with no reference to why I did those things. I thought that was very unjust and painted the wrong picture of me.
- 5. I remember passing a cupboard when we were away somewhere on holiday and asking what it was. I was told that is where they put the bad boys.
- 6. We were not allowed our own toys. My mother brought me an X-wing fighter once and was told to take it home. All the communal toys were kept locked in a cupboard and we were only allowed to play with them at certain times called group time.
- 7. I was punished for not eating my food. I remember a member of staff putting me in a room with a bowl of cold peas and telling me I was not allowed to leave until they were finished. I put them in my mouth and then ran to the toilet to spit them out. I think this is an example of the pettiness and inhumane treatment by the staff.
- 8. The school was in two portacabins on the grounds. Time spent at school was more productive and structured. The teachers were LS1, LS2

 LS2, LS3 and LS4 The teachers were all professionals and I do not have any complaints about the school apart from LS4 who

me to. They made me steal sweets from the local shops for them and made me do all manner of silly things. After more than a year of this treatment I approached LS 46 and the teachers and I finally plucked up the courage to ask them for help. Instead of dealing with the bullies they involved social services. Instead of getting to the bottom of the bullying and having regard to my best interests they elected simply to get rid of the problem. They decided to transfer me to a psychiatric hospital – Lissue. I was an innocent 9 year old child who did not deserve to be locked away in a psychiatric hospital as I was not diagnosed as having a mental illness. The only reason I believe I was placed in Lissue was because I asked for help because I was being bullied.

Lissue House, Lisburn (1979 – 1981 approximately)

- 4. I was taken to Lissue in 1979 when I was about 9 years old. There was a called LS 7 I will never forget her. She gave me an injection once a fortnight and I was made to take two Ritalin tablets every day from the age of nine and I was made to drink a brown liquid called Largactil at night. I was given a lot of medication and I don't know what it was for. I now believe it was anti-psychotic medication which I have continued to be on for life. As a 9 year old child I should never have been given such medication as my medical records show that I had no signs of a mental illness.
- 5. I was made to stand outside the doctor's room and smoke cigarettes. I think they were called Player's No 6 cigarettes. A girl called LS 47 who was one or two years older than me was also made to do this. We were given three cigarettes a day to smoke one in the morning, one around 12 or 1 o'clock and another at 4 o'clock. I believe it was just the two of us that were made to smoke. People watched us doing it and made notes. They told us it was to calm us down. I don't recall the names of these people or the roles they held within Lissue House.
- My room was a single room and I think it had a red door. I relate it to a modern day prison cell. It had bars on the window and the window only

HIA 38

opened a few inches. There were rows of single rooms spaced out along the corridor. We were locked in our rooms at night.

- 7. If you were badly behaved you were locked in your room and didn't get any supper. This was only an occasional punishment. It happened to me once or twice. Bad behaviour could have been walking too fast on the corridor, pushing the lift button, not coming in from outside or not sitting a certain way. If you were very badly behaved the staff threatened you with an injection and if you were difficult to control they held you down, usually by sitting on you and gave you the injection in your rear to sedate you. It was the scariest thing in the world to me.
- 8. On a typical day, after breakfast we were taken into a room which had a big circle in the middle with cushioned seats around it. Along the back wall of the room there was a black mirror. There was a room behind the mirror. On one occasion I got off my seat and I ran into the room when the door was left open. In the room there were two men sitting on comfy chairs and there were three video cameras pointed at the glass. Along the back wall of this long room there were hundreds of labelled video tapes. I was punished for three days by being locked in my room during association time when other residents were playing. Association time was between 6 and 7.30pm. During this time we were allowed to watch TV, play games or use the tuck shop.
- 9. LS 7 had a pick on me from day one. On occasions she grabbed me by the scruff of the neck and she was rough with me and other residents.
- 10. Next to the video room there was an interview room. We were interviewed and asked lots of questions about our medication and how we felt. There were about four or five children present each time and the interviews were video recorded. During interviews there were a number of people in the room there was a man in a suit, two larger men in white coats who could have been doctors or orderlies, LS 7 and a doctor.

- 1 Q. But on that occasion you referred it to a senior manager
- 2 --
- 3 A. Oh, I did.
- 4 Q. -- rather than talk to the person directly?
- 5 A. No. I talked to the person directly and then asked for
- 6 the two of us to speak it over -- to talk it over with
- 7 Roger and we did. Then that particular case we did talk
- 8 it over with Roger McAuley, and then we would have
- 9 looked at how we modified that in a care plan for the
- 10 child --
- 11 Q. Okay.
- 12 A. -- and then it would have changed.
- 13 Q. Can I ask you just some practical things? In the
- 14 upstairs was there a small kitchen upstairs we have
- 15 heard? There has been differing views about whether
- there was a small kitchen beside the office or the
- 17 sleeping in room upstairs.
- 18 A. No, there was no kitchen.
- 19 Q. No kitchen upstairs.
- 20 A. There was a clinical room upstairs and that would have
- 21 been where medication -- and there would have been
- a fridge in that room, but that was for the clinical
- 23 medical --
- 24 Q. So there was a fridge in that room, but no cooking
- 25 facilities?

LISBURN DISTRICT

CONFIDENTIAL

INVESTIGATORY NURSING REPORT - CHILD PSYCHIATRY UNIT, LISSUE HOSPITAL

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

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

NURSING INVESTIGATION

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

- 1. to establish the facts surrounding the allegation in as far as this could be done within the Unit and on the basis of the information available at the time,
- 2. to protect the children currently in the Unit by seeking to establish elements of risk to which they could be subject with a view to taking action on any risks found.

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

GEOGRAPHY OF THE UNIT

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

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

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

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

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

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

opened a few inches. There were rows of single rooms spaced out along the corridor. We were locked in our rooms at night.

- 7. If you were badly behaved you were locked in your room and didn't get any supper. This was only an occasional punishment. It happened to me once or twice. Bad behaviour could have been walking too fast on the corridor, pushing the lift button, not coming in from outside or not sitting a certain way. If you were very badly behaved the staff threatened you with an injection and if you were difficult to control they held you down, usually by sitting on you and gave you the injection in your rear to sedate you. It was the scariest thing in the world to me.
- 8. On a typical day, after breakfast we were taken into a room which had a big circle in the middle with cushioned seats around it. Along the back wall of the room there was a black mirror. There was a room behind the mirror. On one occasion I got off my seat and I ran into the room when the door was left open. In the room there were two men sitting on comfy chairs and there were three video cameras pointed at the glass. Along the back wall of this long room there were hundreds of labelled video tapes. I was punished for three days by being locked in my room during association time when other residents were playing. Association time was between 6 and 7.30pm. During this time we were allowed to watch TV, play games or use the tuck shop.
- 9. LS 7 had a pick on me from day one. On occasions she grabbed me by the scruff of the neck and she was rough with me and other residents.
- 10. Next to the video room there was an interview room. We were interviewed and asked lots of questions about our medication and how we felt. There were about four or five children present each time and the interviews were video recorded. During interviews there were a number of people in the room there was a man in a suit, two larger men in white coats who could have been doctors or orderlies, LS 7 and a doctor.

the extent of a 1:1 ratio. A Fortnightly Nursing Summary dated 17th May 1985 records that he has spent much of his time on a one to one basis and kept in isolation most of the time, see **Exhibit 25**.

- 18. It was also during this period that following an incident whereby the Applicant jumped of the roof "at low point and hurt his ankle", a system of Suicide Caution Card was implemented and again on the 24th May 1985, see Exhibit 26. Whilst no specific policies have been identified in relation to the CPU, the Board believes that the procedure for Caution Cards dated 8th August 1989 is one which is likely to have been in place in Lissue, see Exhibit 27. The extent of concern raised over these two incidents was highlighted in correspondence dated the 24th May 1985 from LS 8, the Assistant Director of Nursing to the LS 129, the advising that immediately prior to the medical action of placing the Applicant on Suicide Caution he had "instructed nursing staff, Child Psychiatry Unit that until further notice" nursing staff where to keep the Applicant under constant supervision, irrespective of whether medical staff recommend this or not, see Exhibit 28
- 19. The nature of this supervision is continued during the Applicant's last in patient admission to CPU on the 29th July 1985 where it is recorded on his treatment plan that the whereabouts of the Applicant was to be known at all times and that he "may require one-to-one situation at time, maybe daily or on alternate days", see **Exhibit 29**
- 20. The Applicant refers to breaking things and these being written up as bad behaviour with no reference to why he did this. The Board believes the Applicant may be referring to a reward system which was implemented during the Applicant's Educational Placement during the period 13th September 1984 until the 28th June 1985. In correspondence dated 23rd July 1985 to Mrs J Jefferson, EHSSB from N McCune, Senior Registrar in Child Psychiatry, it is stated that the Applicant's last term at school was most unsettled. As a result his behaviour, "a strict behavioural programme of earning rewards and being punished for bad behaviour had been instituted because his behaviour had

Policy to be followed if any child (in patient or day patient) goes on the roof of Ward /, 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 an 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.

(5) 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.

Dr. W. McC. Nelson Dr. R. McAuley

was a play area and the classrooms were just beyond that. The play area had a see-saw, a wooden hut, a sand-pit and swings. We were allowed to play in play area in the evenings. At the end of the laneway of Lissue there was a courtyard with green iron rod gates where the staff parked their cars. Outside the gates, there was a little cottage and a stable beside a field which kept a pony called Pepper. I remember I was allowed to sit on Pepper once.

mum lived in the little cottage. I don't recall any other parents living on site in Lissue and the staff did not reside in Lissue. There were cookery classes for the older girls in that cottage too.

- 6. My daily routine was getting up early in the mornings, getting washed and dressed, and taking my medication before breakfast. I was given Ritalin in Lissue. We had a school onsite and we started around 9.00am. I remember a called LS 20. I went to school as soon as I was admitted to Lissue and I found it hard to concentrate in school. We had a mid-morning break at 10.30am or 11.00am and then lunch was around 1.00pm. School continued to 2.30pm or 3.00pm and dinner was served about 5.00pm. The food was ok. We were allowed to play outside in the play area until supper at 9.00pm. I don't recall any physical education or sports at Lissue. I liked to run and I remember I use to race with LS 14.
- 7. The staff at Lissue were very friendly for the first three months before the abuse started. There were female and male nurses and they worked on shift LS 21 patterns was one of the LS 23 LS 24 patient's medication. I remembe LS 26 LS 25 and called . There was a and she helped the called the children from Lissue to Belfast. I only knew the were lovely people.
- 8. I remember the first time I was attacked b LS 21. I was in the dining area with some other children eating and playing with toys approached me and took me to my dormitory and locked the door. He told me I was sick and that he was my friend and wanted to make me feel better. He sat me on

HIA 220

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 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 at Lissue at the time I was working there.
- 33. I do not believe there was any 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 scalled LS 20 The 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.

- 1 A. Oh, yes, yes.
- 2 Q. -- to be able to go and play with the trains?
- 3 A. And, yes, genetically that's passed on to my son,
- 4 because he is train mad now, so he is. He loves trains.
- 5 Q. So on this particular day you and HIA172 going to play
- 6 with the trains was something that was good for you?
- 7 A. Oh, yes, yes, apart from having to watch the staff in
- 8 case they beat me round the head again.
- 9 Q. Well, paragraph 15, going back to your statement at 052,
- 10 you talk about:
- "On the grounds of Lissue there were barns and
- 12 stables with horses. There was a wooden hut with
- a giant sandpit and some of us would try to dig tunnels
- 14 to escape."
- This was obviously child's play to get out, maybe
- with a serious purpose, but you never really were going
- 17 to get a tunnel out of the sandpit. Isn't that right?
- 18 A. The 9-year-old's version of The Great Escape.
- 19 Q. And you remember on one occasion a boy had to be taken
- to hospital because a tunnel collapsed on him.
- 21 A. LS49. Yes, I remember that.
- 22 Q. Forgive me, but that sounds as though you actually
- 23 managed to dig down to a degree where something could
- collapse on him. I mean, was this just something --
- 25 a pile of sand that fell on him?

3

- 3.6 Patients up to the age of 14 years (this followed R.B.H.S.C. policy) were in the main referred from the Out Patient service at R.B.H.S.C. Other significant referrals came from Social Services. The referrals reflected a wide range of problems including; conduct/behaviour problems, emotional disorders (such as phobias, school refusal, anxiety, depression, self harming, anorexia nervosa, psychoses, Obsessional Compulsive Disorders, encopresis, and enuresis.
- 3.7 In 1976 provision was made to facilitate the admission of the parents of selected young children with difficult behaviour problems in order to provide them with intensive coaching in behavioural management techniques including differential attention, positive reinforcement, time out, use of point incentive systems etc. . Normally these admissions were time limited to approximately 2 3 weeks. This program was developed and supervised by the author of this report see Appendix 1 for 2 examples of this work also a BBC Horizon documentary made in 1981 (mentioned in requests for reports on Lissue) illustrate other examples of this work unfortunately the author does not have a copy of the documentary.
- 3.8 In 1978, Family Therapy was introduced and developed by Dr. Nelson and became an important part of the therapies in place. Largely this involved meetings with the family system (including the child) in an effort to seek out strategic solutions for the problems.

4. Day to day functioning of the Unit

- 4.0 The inpatient unit mainly functioned on a Monday to Friday basis. Children remained at the weekends only under exceptional circumstances and reasons for this may have included cases such as anorectic patients, who had not reached agreed target weights, patients who were regarded as being at a high risk of self harm, and also other who remained for reasons relating to family circumstances.
- 4.1 The average day began with the nursing handover events of the previous shift were related and discussed.
- 4.2 After breakfast children in middle age group attended a morning meeting which was in the main run by nursing staff , though often members of the M.D.T. would attend. The meeting was used to review the previous 24 hours and to attempt to resolve any untoward issues. On other occasions the meetings were used to explore the use of problem solving and social skills.
- 4.3 During the school day most children attended school during normal school hours. Breaks times were normally supervised by nursing staff.
- 4.4 Following school hours children were separated into roughly 3 age groups, and were then supervised in a range of activities such as walks, swimming, table tennis, football, various arts and crafts activities, occasional trips out in the minibus to special places obviously this was more frequent during school holidays, when it was possible to go to museums, beaches, parks etc.

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

- Q22. The Inquiry is aware that a Historical review was carried out into child safeguarding issues, (the Stinson review). How was that review received and were any steps taken by the Board on receipt of same?
- 131. Please refer to the response to Question 18 wherein the Board has detailed the process in relation to the Historic Case Review, and subsequent actions taken.
- Q23. What systems failures, if any, relating to HIA Inquiry's Terms of Reference can identify from the material?
- 132. The HIA Inquiry is examining whether there were systemic failings by institutions or the state in their duties towards those children in their care between the years of 1922-1995.
- 133. Lissue was the regional inpatient NHS Hospital for Children and Young People in Northern Ireland with the governance arrangments as described in parapraph 59 above.
- 134. Lissue Hopsital was led by Consultants in Child and Adolescent Psychiatry. These Consultants were and are highly regarded expert practitioners in their field and referrals to Lissue were made by General Practitioners, out patient Hospital Departments and Social Services in respect of children with serious behavioural, emotional, psychological and/or psychiatric problems.
- 135. As set out in the body of this statement, the Board is aware of both contemporaneous and more recent complaints of historic abuse made by previous patients in Lissue Hospital. The contemporaneous complaints known to

- and finally those adopted develop best of all (though in a portion some long term mild social difficulties in relationships are still detectable at age 17years of age.
- 8.3 Findings such as those reported above had some major influences on ongoing child care practice and policy and contributed to;
- 8.3.1 Gradual closure of many voluntary and statutory Children's Homes (and I suspect this was also driven by financial pressures).
- 8.3.2 Increased attempts to return children to their natural parents with the help of professionals from social services.
- 8.3.3 In more difficult cases moves to make more use of fostering and adoption.

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

- 8.4.1 The closure of many childrens homes often resulted in the most socially damaged children being accommodated together in the remaining homes resulting in very difficult circumstances for both children and staff!!
- 8.4.2 Attempts to return children to their own homes has no doubt in some cases been aided by the development of family centres (provided both by social and voluntary agencies). However the day to day support for families is still carried out by the youngest and least experienced social work professionals our experience in child psychiatry is that, even the most experienced professionals often find great difficulty in working with many of these families
- 8.4.3 The point mentioned immediately above also applies to many foster parents and also occasionally to adoptive parents.
- 8.5 Naturally, all of the above aspects and results of research and practice did over time have ramifications for the work carried out in the Inpatient Unit in Lissue, in the form of increased requests from social services for help with difficult (and often very abused) children in their care. In other words a sizable proportion of the children referred and admitted by us already have a history of the sorts of abuse being investigated in the I.H.A.I.
- 8.6 Dr Brian Jacobs has been critical of our decisions to attempt to help with children whose problems, and needs suggest that a long term secure and safe environment might often be preferable. It may well be, that secure and safe environments outside the juvenile justice system can be found in London in the years that Lissue existed that was not the case in N. Ireland.

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

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- 1 Q. I just wonder what your view of that is.
- 2 A. I just do not understand where that comes from, because
- 3 the way -- as I have described to some extent, the way
- 4 the whole thing worked was we did work as a team of
- 5 professionals together under the auspices of the
- 6 consultant and with their overall authority. So
- 7 virtually -- okay. Nurses did manage the children on
- 8 the ward. Teachers managed children in school and
- 9 looked after that side of things, but in terms of
- therapeutic endeavours with the families or the children
- or both, that was all done as a team. So I don't know
- where that comes from. Very much the strength of what
- we did was because we were able to work with different
- 14 professionals and have different perspectives on the
- work as well.
- 16 Q. Well, LS80, thank you. There is nothing else that I am
- 17 going to ask --
- 18 A. Uh-huh.
- 19 Q. -- but I am sure the Panel Members may have some
- 20 questions for you.
- 21 A. Okay. Thank you.
- 22 Questions from THE PANEL
- 23 CHAIRMAN: LS80, can I just ask you one question about the
- locations in England that you referred to where if
- 25 a child needed long stay --

- 1 A. Uh-huh.
- 2 Q. -- admission to somewhere, then it was open to the staff
- at Lissue to try and pursue the possibility with Social
- 4 Services --
- 5 A. Yes.
- 6 Q. -- that the child could be transferred? Do you remember
- 7 that happening at all --
- 8 A. Yes.
- 9 Q. -- or frequently, or how often did it happen?
- 10 A. Well, it was infrequent, because they are very
- 11 expensive. So you had to persuade Social Services or
- whoever was managing the budget that this would be
- an investment that's worth doing, that we no longer
- could really manage that young person.
- There's at least one comes to mind, a young man,
- 16 14/15-year-old, who went I think to somewhere in
- 17 Liverpool, which is some kind of a therapeutic
- 18 community, and that worked very well. There were
- others, but I couldn't tell you how many. It was
- infrequent, but it was always a kind of option to be
- looked at and to be seen, "Well, can we -- can we get
- this?", because within Northern Ireland or I suppose
- 23 Ireland itself there was limited options outside of
- a training school, and we didn't want children to go
- down that juvenile justice route, if we could avoid it.

3. My mother found it difficult to cope with me. She took me to my GP and I was referred over to the Child Guidance Clinic within the Department of Psychiatry in the Royal Victoria Hospital. I was treated by Dr Manwell and her colleague. They recommended some intensive therapy and sent me to Lissue Hospital when I was 7 years old.

Lissue Hospital (1975-1976)

- 4. My mum brought me to Lissue Hospital in a taxi. I think my father was working at the time. When I realised I was not coming home again, I became very upset and very difficult. I had no idea why I was being left there. I kicked the doors to get out and grabbed the handles. It was the first time I had left home and I was frightened at the idea of being in a strange place by myself. I also missed my father. I was shy and quiet at the beginning and kept my own company. I remember forming a friendship with an older girl called would have been about 16 years old. She took me under her wing and I LS 11 gradually made other friends such a , and his who was only 3 or 4 years old. LS 13 had LS 13 an LS 14 I also remembe LS LS 18 LS 19 was always singing. The age range of the patients in Lissue ran from approximately 3 or 4 year olds to teenagers who were about 15 or 16 years old. The children with physical disabilities slept on the ground floor and the rest of us slept on the first floor. I was on the first floor with a mixture of children and teenagers. I shared a dormitory with LS 14 LS 16 LS 18 and a younger boy called . They would have been three to four children in one dormitory. I stayed in the same dormitory during my whole time in Lissue.
- 5. Lissue had two floors. I remember the layout quite well. I remember when I first arrived. I walked through two mahogany doors with wire mesh glass and again through a glass partition with wire mesh glass. From there I went into the main corridor. The kitchen and TV room was just off this corridor to the right and the other corridor to the left had dormitories and at the end of that corridor was the dining room. At the opposite end of the dining room there

HIA 220

HIA REF: 251
Witness Name
HIA 251

THE INQUIRY INTO HISTORICAL INSTITUTIONAL ABUSE 1922 TO 1995
WITNESS STATEMENT O HIA 251
HIA 251 , will say as follows:-
Personal details
1. I was born o
and one older sister called . My parents separated in 1978.
My father went to prison in 1979 and my mother found it difficult to cope. My
siblings and I were all taken into care in or around 1980. We were in several
children's homes. My first placement was
was then moved to
2. My mother met her neutre
2. My mother met her partne and and legender was born in an and legender was born in an and legender was born in an analysis of the legender was born in an analy
and for a short period of time before I was sent back to in
1985. I know I started to miss school and became difficult at home. I started
drinking alcohol and experimented with solvent abuse. At the time I was
confused and I wondered why I was the only one of my siblings taken back
into care. I don't remember any bad treatment at but something
happened and I was moved to Lissue when I was 11 years old.
<u>Lissue Hospital (1985 – 1986)</u>
3. No-one told me I was being moved to Lissue. I remember I had a
called LS 32 but I don't remember any conversations with her about
HIA 251

10 MAR 2016

HIA REF: 421
Witness Name: HIA 421

THE INQUIRY INTO HISTORICAL INSTITUTIONAL ABUSE 1922 TO 1995

WITNESS STATEMENT OF HIA 421



Personal details

- 1. I was born on the HIA 421
- 2. I have an older brother called LS 17, two younger sisters called and and a younger brother called I had an older sister called who died in 1980. I never knew my father.
- 3. My mother was very violent and physically abusive. Social Services were involved with my mother before I was born. My siblings and I were treated very badly at home. I remember being burnt and beaten and I was in hospital with broken limbs. My medical records state I weighed 19lb when I was 2 years old and I was in hospital several times with dysentery. My siblings and I were in and out of care several times throughout our childhood.
- 4. My brother LS 17 and I were taken to Lissue when I was approximately 5 years old. I don't know the particular reason why I was admitted to Lissue. I assume it had something to do with my mother mistreating us at home.

HIA 421

- 1 a reference number, "HIA421". Can I just ask you to
- 2 confirm that this is the statement of evidence that you
- 3 gave to the Inquiry and that you signed that on 28th
- 4 February of 2016?
- 5 A. It is, yes.
- 6 Q. Your personal details are set out there in the first
- four paragraphs, HIA421. You are now aged 44. Isn't
- 8 that correct?
- 9 A. Yes.
- 10 Q. And you recall going to Lissue House with your brother
- and you see we have even given him a reference number to
- ensure that his details aren't in the public domain
- 13 also.
- 14 A. Yes.
- 15 Q. You recall that you were taken there when you were
- 16 approximately five years of age. You don't know the
- 17 reason why you were admitted to Lissue, but we know from
- 18 the Social Services' records that you actually went
- there on 16th January 1976. So you were right in saying
- that you went there when you were five. It was because
- 21 your siblings and yourself were out of control, if I can
- 22 put it that way, at home --
- 23 A. Yes.
- 24 Q. -- and your mother was unable to cope. So you were
- taken to Lissue, first of all, but your mother took you

- 1 Q. We appreciate that. So don't worry about that at all.
- 2 But you say you saw other children being dragged
- along the floor by their arms into their rooms and being
- 4 restrained.
- 5 A. Yes.
- 6 Q. You say you found it upsetting, because you didn't know
- 7 why you were there. You remember on one occasion
- 8 a staff member pulled you by your neck. You can't
- 9 recall whether that was a male or female member of staff
- or what they looked like. You don't know if it was
- 11 because you were young or because you were in there for
- such a short time that you don't remember, but you just
- remember feeling scared and wanting to go home.
- 14 A. Yes.
- 15 Q. Paragraph 8 you go on to talk about the fact that you
- were a bedwetter and that you had wet the bed from you
- were really young. You say staff refused to change your
- 18 bedsheets.
- 19 A. I think it got to the stage where I was wetting the bed
- so much people got fed up with me, you know. Maybe
- that's the way it was, but, I mean, I didn't have people
- coming in and, you know, changing my beds and saying,
- you know, "It's not your fault. We understand". The
- 24 bed would be left for days.
- 25 Q. You say that you would be left wearing the same wet

- that you were not going home with your mum, you became
- 2 very upset and very difficult. You had no idea why you
- 3 were being left there. You kicked the doors to get out
- 4 and grabbed the handles. It was the first time you had
- 5 left home. You were frightened at the idea of being in
- a strange place by yourself. You also missed your
- 7 father. You say that you were shy and quiet at the
- 8 beginning and kept your own company.
- 9 Now the records that the Inquiry has seen do confirm
- 10 that when you went into the unit -- and I read that to
- 11 you and it can be seen -- I don't think we need to call
- it up -- but it is at LIS1171 -- describes your
- behaviour on the ward on admission as disruptive. You
- would confirm that from your own statement, HIA220.
- 15 Isn't that right?
- 16 A. Yes, yes.
- 17 Q. You remember forming a friendship with an older girl,
- 18 whose name you give here. You thought she would have
- been about 16 years old. As I was explaining to you, we
- 20 know that children were in Lissue in the '70s up to the
- 21 age of 14.
- 22 A. Right.
- 23 Q. It is possible -- there were one or two older children
- there, but it's possible that as a 7-year-old you might
- 25 have thought she was about 16. Isn't that right? She

- 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 Philidelphia, USA, where I visited. This approach included all or

- 16. I have read undated written guidelines on time out that are available. I do not recall it being as punitive as it appears to have been written. I think it is also important to explain that time out (or time away as I called it) was not seen in the context of punishment but rather a means of de-escalation and reflection time to reconsider personal choices regarding self-regulation and support to achieve this important attribute.
- 17. My Nursing code from the regulatory body expected me to report if I saw something/poor practice as a nurse, and I did report concern to the senior nurse. I think it is also important to explain that time out (or time away as I called it) was not seen in the context of punishment but rather a means of de-escalation with an ultimate aim of habit reversal or modification of the behaviour.
- 18. One of the issues I recall arising on the Ward was the combination of children demonstrating and presenting behaviours that were described as difficult, high risk and unacceptable. It was a challenging environment to work with, children who were clashing with one another from a cultural and behavioural perspective. The ward promoted a neutral cultural environment but on occasions the history of Northern Ireland, the children and their cultural, social and family backgrounds, had to be given very careful consideration. Depending on the balance this did present the nursing team caring for the children/patients with significant challenge. Other factors that also needed to be thought about were the age ranges and the differing needs of children to ensure their needs were met.
- 19. A child's first three or four weeks on the Ward would have involved assessment and observation to learn about the presenting behaviours. Thereafter on the outcome of the assessment, the MDT would begin to design a care plan and implement to achieve positive outcomes for the patient/child.
- 20. For example for a patient admitted for anorexia, which was relatively common, a behavioural model would lead the treatment plan. This was known to me as a model being used across the United Kingdom and involved a feeding programme, which was essentially one whereby if you ate, you gained health and

- 1 how I experienced Lissue when I was there.
- 2 Q. Now, of course, we appreciate that all of this is
- 3 happening in an environment where many of the children
- 4 in the Psychiatric Unit were very difficult to deal
- 5 with. Isn't that so?
- 6 A. There were --
- 7 Q. You described it as challenging.
- 8 A. It was challenging. The challenge was you had young
- 9 people who were coming from families that were
- 10 experiencing very severe difficulties and possibly the
- 11 breakdown of family relationships and then needing to go
- into care, which is extremely distressing for the child
- and the family. You would have been working with
- children who were coming from care homes, who were
- finding the circumstances they were in very, very
- 16 difficult. You would have been working with children
- 17 who came from broken down foster care homes. You then
- 18 would have been working with children from -- some
- children from deprived areas and then some children from
- 20 highly professional parents but quite naive about some
- of the behaviours that were happening at home. So there
- was quite a mix, plus you had children from both sides
- of the community and you had children from all over
- 24 Northern Ireland.
- 25 Q. It functioned as a regional centre at that time. Isn't

HIA REF: 220
Witness Name HIA 220

THE INQUIRY INTO HISTORICAL INSTITUTIONAL ABUSE 1922 TO 1995

WITNESS STATEMENT O HIA 220
HIA 220 , will say as follows:-
Personal details
1. I was born or . I have one older brother and one older sister. had a good relationship with my parents. I had a strong bond with my father. lived with my family it and went School in .
2. When I was 5 years old, I witnessed a shooting outside some derelict house in the inear where my grandmother lived. I found out later that it was man called and I was told that he was a member of the IRA. I did not know him. I remember coming for lunch an seeing his body lying on the ground with his knee-cap blown off and other wounds to his body. I also saw a same street, being hit with the butt of a rifle by a soldier as she was administering last rites to the same street. It was very distressing and I was very unsettled by these events. Shortly afterwards I developed Attention Hyperactivity Disorder.

HIA 220

opened a few inches. There were rows of single rooms spaced out along the corridor. We were locked in our rooms at night.

- 7. If you were badly behaved you were locked in your room and didn't get any supper. This was only an occasional punishment. It happened to me once or twice. Bad behaviour could have been walking too fast on the corridor, pushing the lift button, not coming in from outside or not sitting a certain way. If you were very badly behaved the staff threatened you with an injection and if you were difficult to control they held you down, usually by sitting on you and gave you the injection in your rear to sedate you. It was the scariest thing in the world to me.
- 8. On a typical day, after breakfast we were taken into a room which had a big circle in the middle with cushioned seats around it. Along the back wall of the room there was a black mirror. There was a room behind the mirror. On one occasion I got off my seat and I ran into the room when the door was left open. In the room there were two men sitting on comfy chairs and there were three video cameras pointed at the glass. Along the back wall of this long room there were hundreds of labelled video tapes. I was punished for three days by being locked in my room during association time when other residents were playing. Association time was between 6 and 7.30pm. During this time we were allowed to watch TV, play games or use the tuck shop.
- 9. LS 7 had a pick on me from day one. On occasions she grabbed me by the scruff of the neck and she was rough with me and other residents.
- 10. Next to the video room there was an interview room. We were interviewed and asked lots of questions about our medication and how we felt. There were about four or five children present each time and the interviews were video recorded. During interviews there were a number of people in the room there was a man in a suit, two larger men in white coats who could have been doctors or orderlies, LS 7 and a doctor.

- had a row", or, you know, "Can you not tell him off for
- 2 doing any -- something?" Anything like that that you
- 3 remember?
- 4 A. I was 9 years old. I don't remember that. I just
- 5 remember the bad bits.
- 6 Q. Anyway you say along the back wall of the room there was
- 7 a black mirror. There was a room behind the mirror.
- 8 You remember on one occasion you got off your seat. You
- 9 went and you ran into the room when the door was left
- open. In the room there were two men sitting on comfy
- 11 chairs. There were three video cameras pointed at the
- glass. Along the back wall of this long room there were
- 13 hundreds of labelled video tapes.
- 14 You say that because you did this, because you ran
- into that room, you were punished for three days by
- being locked in your room during association time when
- other residents were playing. That -- you explain
- association time was between 6.00 and 7.30 pm. During
- that time you were allowed to watch TV, or play games,
- or use the tuck shop.
- 21 So on three nights instead of being allowed to do
- those things you were locked in your room because of
- 23 this incident?
- 24 A. That's correct, yes.
- 25 Q. Just the other thing that I just wanted to make clear,

- 1 was coming to get me, you know.
- 2 Q. But it wasn't a case of treatment or therapy? This was
- just a meeting where you could sort of say things like,
- 4 "Why am I here?"
- 5 A. No. It was supposed to be that kind of room, but
- I remember they were recording in the room. There was
- 7 a big like an easel kind of thing with a camera on top
- 8 of it. That was in the room every time you went into
- 9 the room. I think they were recording the way kids were
- behaving, because, like, kids wouldn't sit on the
- chairs. Kids were running round the chairs, they were
- jumping on the chairs, you know, going crazy, but when
- I was in the group room, you didn't want to tell anybody
- anything. You didn't feel safe enough to say, "Listen,
- why is my bed done like that there?" or "Why am I
- getting bathed in cold water?" or "Why did she drag me
- out by the hair?" Do you know what I mean? You were
- scared to say anything, because they weren't nice
- 19 people. They weren't -- you know when you can approach
- somebody when they're warm and friendly and, like, their
- 21 personality? You couldn't approach them. You couldn't
- do that kind of -- you know, because, I mean, you didn't
- know what way they were going to take it. You could be
- locked in your room all day for even being cheeky.
- 25 Q. I mean, I think the words you used to me were that you

1 your medication before breakfast and you talk about the

2 medication that you were given.

3 There was a school on site. You say you started

4 about 9.00 am. You remember a teacher and I am going to

5 use the name LS20, because staff who worked in Lissue

don't remember a teacher by that name, but I just want

to ask, HIA220, we have heard that there was a meeting,

8 a children's meeting, if I can put it that way, between

breakfast and going to school, where children could air

grievances. For example, if you had got into a fight or

an argument with another child, you could tell the staff

about that. Do you remember those meetings?

13 A. Yes, there was a meeting took place, but on -- yes, you

could say things, but on the abuse side of it you

couldn't, because there was a fear factor there.

16 Q. Well, what kind of things could you have talked about at

that sort of children's meeting before going to school?

18 A. I can't recall, ma'am.

19 O. You can't remember?

20 A. No.

7

9

10

14

22

24

21 Q. Okay. Anyway you went to school and as soon as you --

you found it hard to concentrate in school. You had

a mid-morning break, then lunch. School continued until

2.30 or 3.00 and dinner was served about 5.00. You say

25 the food was okay. You were allowed to play outside in

- 1 earlier that -- I will come back to it actually. I am
- going to look at it shortly. Just at 4.2 you talk about
- 3 children's meetings. The Inquiry has heard about
- 4 children's meetings. We have heard that those were
- 5 actually a device of -- an idea of LS21's,
- , in an attempt
- 7 to defuse the time period between breakfast and the
- 8 children going to school -- to occupy them during that
- 9 period to defuse potential problems for staff.
- 10 I wondered did you ever yourself ever attend those
- 11 children's meetings?
- 12 A. No, I didn't attend those meetings. I would have been
- aware of them, because the thing that's not in my report
- is that there was always a handover meeting about --
- between 9.30 and at 10.00 at which multi-disciplinary
- staff would have attended and perhaps any issues coming
- out of the children's meeting would have been discussed
- 18 at that as well --
- 19 Q. At that time?
- 20 A. -- additionally.
- 21 Q. If we can scroll down to 4.8, and this is an issue that
- I was going to come along, you say that:
- "Overall in spite of the frictions that occurred in
- 24 multi-disciplinary teams, largely caused by different
- line management responsibilities of different



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

General Comments on Interviews

(Please list separately the names of patients seen, with notes on individual interviews. In the case of a complaint, complete a separate complaint form for each).

General Comments on Ward Visits

1. The Psychiatric Unit

The unit is small, having 2 seating areas, a dining-room, some 4-bedded wards and some single rooms. Children are encouraged to bring their possessions and to put up pictures etc. Many go home alternate weekends, therefore, not as much use is made of this facility as might be.

There are 2 family flats with cooking facilities. These are used in particular for non-accidental injury cases.

A school with 4 classrooms and 5 teachers is attached to the unit and caters for children from 5-13, usually in conjunction with the child's own school.

Recreational facilities include secluded open-air play-area and room for indoor activities such as snooker, darts etc.

The children were seen at lunch and in school and were happy to talk with us.

2. Paediatric Unit

Although we were not scheduled to visit this unit we took the opportunity to visit the wards. They are used mainly as mental handicap wards and provide important respite facilities. The wards are large, bright and cheerful and there are indoor and outdoor play facilities.

Assessment and Treatment

Some of the children are admitted for assessment and stay for a short period only at Lissue. Others are there on a longer-term basis for treatment. The average stay is 2 months; some are less than 2 weeks, some over one year. The majority are boys.

PRIVATE

extremely well behaved to get into that room. You were only allowed 10 to 15 minutes to watch the train go round.

- 20. My mum and dad came up to visit a couple of times. When my parents came they were given the best china cups and were told that it was for my best that I was in there.
- 21. I only got home every few weeks for one night or two nights. When I visited home Dad said I was always lethargic and tired like a zombie and not the hyper HIA 38 that went away.
- 22. I have no good memories of Lissue House. There were no good times and no outings. There was a mobile classroom but I don't remember doing any school work. I think the was called LS 50 There was a nice called LS 51 but she might have been at I recall she taught us some which I still remember.
- 23. I didn't get an education at Lissue. Basic numeracy and literacy were taught but I did not learn much.
- 24. I believe there were many children including myself were experimented on in Lissue House. Lissue changed me. The experiences had effect on the rest of my life and I didn't have the life I was supposed to have. I know I was supposed to be something better than I became.

Fallowfield Special School, Lurgan (1981 – 1986 approximately)

25. I understand that my parents received a letter which stated that I was misdiagnosed and that Lissue House was wrong for me but that I still needed some form of educational help. I was at home for about 6 to 8 weeks before I was sent to Fallowfield in Lurgan. I was there from 11 to 16 (from 1981 to 1986). I believe I was moved to Fallowfield on the recommendation of Lissue

HIA 38

Belower Pepert for HIA 251

Academic Progress: A generally Settled attitude and south fortage retreat / effect - house her shown by HIA 251 He present his work wathy and has shown progress and interests in lake one . At times havener 556m to get started to work. I reading from Lea Hark Entraducting reading and is willing they 2 parting bank inglik skill with eighterno on spelling and is plather is partisup addita of H. T. V. Enjoys at petting / singing!

Bahawari - while last week shown a settled patter of behavior this gest week his longest to light a les settled compliant pattern. He tend of take advantage of free ntwotens. Hy late comp & class after break. (jet time out on each occasion). This mere orginestatue world challege me and i quicker to anner book the previously.

10 16th when feedup linds he completely ignered my metnetions and in company of other ran off to slide etc. At this can be freshotent to get something he wants his have been completed each time I felt it recessary to give the

Interestion: - Can be partie but he is very quick to agree / fight with peer bold his Jun: Des 5 hem a gased start in class activities but is gruch to challege me er ignere my LS 2 17.1.86 ...

- Par ---

Behaviour Report for HIA 251

Academic Progress: HIA 251

His school work He is been to improve to learn to moster new facts and slows a willipren to table assignment given. He certains to present his work restly and will ask one of his need to been and injurant experienced. He is amore of his need to been and injurant application of he soping well with heat take to the and follows "Lock and Read" with sim menue interest. He's anestury brice explicit skill and am placed with his affect the effect and a some placed with reading of interestions are but asks for any assistance and does not give in easily. In Mallo he has been practising very included and division by 10 y H. M. Stepping activities and partitions have been inverspersated.

Behaviori'- Apart from incident in greateure when a winder france was smoothed togracuitant.

HIA 251 has been compliant co-grante willing to please and to achive to class miles and limits. He is greatly chatty, relayed and can be most helpful. He willipply comied out extra court for the breakage of mider and excepted my regionand. I felt he was being besent with me and wat he had beaut a lesson from the sperious co. It shows a very carrier and is a very likeable lad.

He is very regardine to took and is eager to bear.

HIA 251

Interested - generally paintine with angulf and peer shews tolerance and can enter fully into games, ontdeer artimis arm and evergy and agrees to benefit greatly from those activities thinning the cap on timelay with for inproved effect agreed to be a great boast for his marks their are listens to stay to show that while nothing tolers in or listens to show the his marks.

While nothing tolers in or listens to show the think and third the piece of hair.

On 315t spentaneously congratulated on winning the class are

LS 2

31-1-86

Belaison Regart for THA 251

Academi Pregress' HIA 251 her been making solis factory pregress in each order of his school wake.

He has nearled teach 2 of Sea Hawk seins and is very nativaled in his reading. Vacability Less have to revised frequently but he is bying herd in basic english work plants spelling, short stay construction He present his work very nearly and conventioning division skills and is coping well.

behavior - On the whole HIA 251 has been well rettled . (1) He day however lave the region and for shorting singip out land at inapprepriate times . (6) Also an accasions he would tend to answer me back but there we not allowed to exclute and generally HIA 251 to appreciate well in class actives.

HE can be helpful and well mannered and appreciative of privillages.

No was very melinated to going out to his Club. Home an triday 7th and returned on alanday with with positive regards.

Introtion - generally pointine scort for fight with the contributes well of class archibes and participates fully, reals, very good use of free activity periods.

LS 2

13.2.86

Some deterioration!

HIA 251 Behaviow Report for Academic Progress on the whole HIA 251 has been mantaines satisfactory progress He ratheres to prevent his work very really was been to read a Forz-Byz look as well as his an reade . He marged inthant difficulty He has made progres in have planic with with which he had antial difficulty and I am pleased with the egent he has made. He comes out faint secius will pers and who an herest effort. He has been procts up multiple cotta and dission skills and latterly has been incorporating shopping. Behaiar - spent for a few incident of bulli genera, lack check HIA 251 has been fairly well rectived. He recent being regimented and can be very greek tower beach and give a smeet onever. When settled however can show great enthuriam be manned ad pleasant.

and pleasant.

On 18th he was mettled last marge in Mattery

On 18th he was remared franclars oft level for
obnoxions belowing whip Leograpy relationed about

me the returned later - cettled.

On 24th 15th - watther headless and of Loans at time.

On 27th - watther headless and of Loans at time.

Intervalue i - Maily paintive great from incident metioned! Can co-aprinte greatly in joint unter work, board games, imaginative play.

but ins and greatly ofthe break.

LS 2 28.2.86

phonormal and the same of the

Academic logues: - HIA 251

Academic logues: - HIA 251

Steady pregress and always precumplis work

4 thremely realty. He can goth himself well

4 his tenhs and is willigs to table new

areas, with some and true. It well als work

willipply alogoi to a peer. It reading behas

beginn from 260 havel 6 BK2. Some difficulty

with new cocalorlay has been experienced but

he is working a determined effect to has been

participal lance against states and in number has

been positivity lang (dur) multiplication and

has nostered this well so far

Relation: . While there have been existed of macestable behaviour ding the part to well, HIA 251 has been fail, well's etted and or quature " when work / him we given for nistemenous they have been comed out sats faterly. On 4th - he did not note it to law fee head. Non eff with ollvhors a return was given a 16th me muly, raymord out of does given time and at luck time. on 11th after beach us acting 5 bly singgens, Thortup ingregori elely . Again was maywood out then in good from he as how great interest and enthuise and contributes greatly to class discussors etc, but the refer poblem at present in his attitude and at temes lack of regrect formen the class. On 13 th plus Imoxon disaptue, walip rude soires enerthall senoved to werd at plat 2. 45 pm.

HIA 251

It tractant Agent for episode debailed interaction los been generally parties with angulf and peer the dee need from vergenent and to than who is hors. Really enjoys drawing to craft make taked he experiment on here actually periods. Does here the capacity to applicable time for his pairods of lad belo in in

LS 2

OFFICIAL-SENSITIVE-PERSONAL

REPORT SENT TO: Abbots Cross Primary School, Dough Rd., Newtownsbley, S. Andrew - 1.5.86

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LISSUE HOSPITAL SCHOOL

LS 3

Telephone No: Maze 621511

31 Ballinderry Road, LISBURN, Co. Antrim, BT28 2SL.

Name of Pupil:

HIA 251

CONFIDENTIAL

Date of births

Date of admissions

6 January 1986

The following is an outline of the work carried out by HIA 251 while a pupil at the above school.

READING

Although not a fluent reader HIA 251 has very willing to try, he was notivated and made a concentrated effort to improve his skills. New vocabulary required such revision, and, although he would stubble on words, it did not discourage him in the task and he generally comprehended story content natisfactorily.

Initially he read Sea Hawk Book One and had progressed to Sea Hawk, Book Two. He also read "Fusz-Busz", Book 4, which he brought from his own school. Currently he had been reading from Level 6, Book 2, of heading 360 reading series. He was keen to read to me delly and I was pleased with the progress he had made and the dotoroination which he showed. HIA 251 also followed "Look and Read", B.B.C.2 - "The Boy From Space" - with immense interest and participated in follow-up activities.

ORAL ENGLISH:

HIA 251 participated enthusiastically in quisaus, games, drame, postry and contributed much in these accessons. He used his creativity and imagination well.

WAITTEN ENGLISH:

HIA 251 needed much help with the basic English exills and lecked knowledge of phonic skills. Considerable exphasis was therefore put in promoting these skills. He was aware of his problems in these skills and again made a determined effort in tasks set. He presented his written work extremely neatly and his writing was always consistently neat and of a good standard. He gained practice in spellings, phonics - with emphasis on initial consonants and vowels, grapmar, punctuation, dictation, comprehension, basic story construction, basic dictionary work.

Use was made of: Sound Sense, Book One;

Sure Pire Phonics series;

First Steps to Language, Book One;

Nainline English, Book One;

I can write a story, Book One;

Word Porfect, Book One;

Stott Programmed Reading Kit.

HIA 251 also gained experience in use of the school computer and benefited greatly from it.



MATHEMATICS:

Practice was given in: multiplication of Tens and Units by one digit numbers progressing to multiplication by 10, 20, etc.

He practised division by 10, progressing to division of H.T.U. by one digit numbers. He was currently practicing multiplication of Tens and Unita by two digit numbers. He faced initial difficulty in this area but latterly had grasped the skill satisfactorily.

He made on honest effort throughout and I falt he had made satisfactory programs.

Use was made of: Modern Comprehensive Arithmetic, Book One; Follow-up Mathe, Books 3, 4; Alpha Maths, Book One.

From time to time shopping activities were incorporated to reinforce learning.

PROJECT WORK:

HIA 251 generally participated with much enthusiasm in practical activities, outdoor events and follow-up class work to compile project work based on the following topics. He had a special interest in nature and contributed greatly throughouts

ile studied - Winter Buds/Trees in Winter; the needs of birds in winter; identification of birds spotted in grounds; Grayfrikes

Bobby; How Samanas are grown; "Into Space" in connection with 'Zig-Zag' (B.B.C.2); pussy willows/catkins; snowdrops/crocuses/daffodils; the story of baked beans; the story of chocolate; the fallow deer; signs of Spring; West Building; the development of the frog.

HIA 251 was very observant in outdoor environmental activities and enjoyed assisting in creating nature scenes in class using materials he had helped to collect.

MUSICA

HIA 251 had a good sense of rhythm and skilfully played a selection of percussion instruments, especially enjoying "the druss". He participated well in accompanying singing sessions and in listening to a variety of different types of susic on the tape recorder. He liked "The Streets of London" very much.

P.E.

HIA 251 showed ability and skill in games, football, use of small and large apparatus, fitness training and entered fully into these activities.

POTTERY:

Much pleasure was derived from experimenting with and shaping the clay. Practice was also given in creating models using casting powder and HIA 251 took care in decorating bio models with pleasing results.

School Report ou HIA 251 contd.

ART/CRAPT's

HIA 251 showed special ability in sketching, design work, drawing. He had a good sense of colour and created very expert drawings/designs. He would enjoy using free activity periods on such assignments and always produced very accurate, true to life pictures. Attention was paid to very fine detail.

COOKERY:

This subject gave HIA 251 much pleasurs. He baked such items as bung, scenes, biscuits, sponge cake. He was quick to grasp methods and enthusiastic in all the work including kitchen chores.

GENERAL REMARKS:

During the time HIA 251 was in class I generally found his amenable, affable, co-operative, interested in improving his basic skills and enthusiastic in co-operative project work. He had the aspacity to concentrate on given tasks until completed. Free activity periods were generally constructively used by practising sketching, designs or lego building. There were, however, escasions when his behaviour would deteriorate. He would become argumentative, enswer back, snigger, make derogatory statements directed at me, laugh/shout inappropriately and generally become disruptive in the class. On some occasions he was removed from class to complete work in isolation on the ward. He would return, apologics and calmly settle again. Generally he was given extra work to complete for his misdemeanours and these tasks were satisfactorily carried out.

In the freer, outdoor situations HIA 251 would at times become headless and unruly, yet at other times was most responsive, co-operative and enthusiastic.

HIA 251 sattled behaviour patterns greatly out-weighed the unsettled ones and generally I found him to be a trustworthy, likeable boy who could show respect, tolerance, was appreciative of rewards and privileges and was, on the whole, popular with peers. He was responsive to teach and I enjoyed having him in my class.



Harch 1986

OFFICIAL-SENSITIVE-PERSONAL

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STATH EASTERN EDIKATION & LIERARY BOARD LISSUE HOSPITAL

SCHOOL

LS 3

Tel. No.: Maze 621511

31 Ballinderry Road, Lisburn Co. Antrim. BT28 25L

Name of Pupils

HIA 251

COMPIDENTIAL

Date of births

Date of re-admission:

12 May 1986

READING:

HIA 251 is not yet a fluent reader, needing help with new vocabulary. He does make a concentrated effort but reading tends to be rather stilted. He is motivated to improve and while in class read from Ginn 360, Level 5, Book 1. He comprehended story content satisfactorily.

ORAL ENGLISH:

HIA 251 contributed very well in discussions, creative work, quisses, drama, and appeared to derive pleasure from these sessions.

URITTEN ENGLISH:

HIA 251 needed such belp with the basic English skills. He did try hard in each area and presented his work neatly.

Use was unde of:

Word Perfect, Book 1 Sure Five Phonics, Books 2, 3 Pirst Steps to Language, Books 2, 3 Mainline English, Book 1 Stott Programmed Reading Kit

HIA 251 was conscious of his lack of basic skills and did show determination to improve on them and responded to individual attention given.

HATHEMATICS:

Practice was given in mastering multiplication skills up to 10 times, activities were incorporated to reinforce learning. Latterly Shopping well. Tables were learnt systematically.

Use was made of:

Mester Haths, Book 1 Modern Comprehensive Arithmetic. Book 1 Check It Again series Follow-up Maths, Book 3

PROJECT WORK:

HIA 251 showed much enthusiase for practical activities and contributed greatly in project work. He carried out written activities suited to his ability level for each topic which included:-

School Report contd.

Black HIA 251

The dovolopment of the from; the development of the butterfly; the invention of "cats" eyes stude"; the Great Storm; The honey bee; road safety; water safety; life on the sesshore; shape in the environment; mature in Summer; practical gardening activities - observing growth of plants etc. in school garden.

ART/CRAFT:

HIA 251 showed skill in sketching, design work, scraper foil techniques, poster design work and paid attention to fine detail. His completed works illustrated a good sense of colour and accuracy in scale.

MUSICa

HIA 251 took a great interest in listening to a wide selection of music and on occasions would ask if he could play some music on tape recorder while he was carrying out some written work. Practice was also given in use of selected percussion instruments.

COOKERY

This subject gave HIA 251 much pleasure. He approached it with interest and quickly picked up the various procedures to bake acoust, buns, biscuits, pies. He willingly shared what he had baked with others. Kitchen chores were carried out speedily and carefully.

GENERAL REMARKS

After an initial period of very unacceptable, unsettled, disruptive behaviour HIA 251 managed to settle well to class routine. He latterly showed a good interest in ongoing class activities, was appreciative of privileges, interected positively with peers (who were younger than himself), was keen to please and showed a willingness to comply and co-operate within the structured school environment. He could be most helpful, considerate and amenable when in this settled state.

LS 2 Class Teacher

Dates June 1986

NAME: HIA 3

WEEK BEGINNING: 3 NOV 1987

DATE

BEHAVIOUR

self-pitying.

INTERACTION

TUESDAY 3RD Very distressed during morning period Crying bitterly and complained of headache.
He fears he has brain damage although
logic tells him no. Did not appear back
in class break/lunchtime period. Returned
after lunch. Fine with me but repeat performance of morning with
2.15 pm. Very depressed.

Little interaction though some with When settled, worked with great concentration and no interaction.

WEDNESDAY 4TH First period of morning he was excellent.

2nd period saw a re-occurance of crying and complaining (eye, this time). He settled amazingly quickly and talked through it sensibly. Worked well. Afternoon period showed very poor concentration and little work done. No crying although on the verge a couple of times. A basically lazy boy, I think.

Didn't bother much with anyone. Any interaction was normally carried out.

THURSDAY 5TH Much brighter today. Still work-shy regarding anything but Geography
Needs pushed often to work. Pleasant though Excellent.

FRIDAY 6TH Upset at not going to get home. Worked well when urged. Still lazy - everything is "too hard". Settled well though and completed tasks.

Not tolerant of who was having bouts of crying. He came round when I pointed out that he also cried. Settled well.

LS 1 6.11.1987

DATE	BEHAVIOUR	INTERACTION
NONDAY 9TH	Eyes dry all day today. Still moaning about difficulty of work but is able to complete it all with help. No behaviour difficulties. Finds other people who cry amusing - double standards. No behaviour difficulties.	Excellent especially with
TUESĎÄY 10TH	As lazy as water in a puddle. Can work well when pushed. Tries to get off with writing "I can't do" on his book. A definite chancer who kno s he's chancing it. I told him I was really looking forward to talking to his - 2 pages of work followed in approximately 5 mins! - enough said?	Excellent.
WEDNESDAY 11TH	Continuing the laziness pattern. Really needs to be watched constantly. Work = headache - in that order. Presents no behaviour problems except for his self-pitying which can be backed up by tears in the eyes. Has many work problems and difficulties.	Gets on well with me and with his peers.
THURSDAY 12TH	Much improved. One threatened headache on presentation of day's lst piece of work. Didn't happen though. Worked quicker and well.	Excellent. Talked to about his utterances Understanding.
FRIDAY 13TH	An excellent day.	Excellent.

LS 1 13,11,1987

NAME:	HIA 3 WEEK BEG	WEEK BEGINNING: 16 NOV 1987			
DATE	BEHAVIOUR	INTERACTION			
MONDAY 16TH	Brought in work from his own school - copying out notes and maths. Had complain of headaches again when I urged him to work quicker. A good day all in all. Worked reasonably well.	Excellent. No problems ts with anyone.			
TUESDAY 17TH	A poor attitude and a poor day's work. Kept from pottery to complete tasks - repeated one task 3 times. Headaches, throat, requests to go to ward etc. Complied at end of session ie 2.30 - 3.00. Was difficult and feigning help- lessness re work.	Muttering about me under his breath - said he was cursing me. He denied it. Kept interrupting work. Secretly smiling to himself. Unsatisfactor interaction a lot of times			
WEDNEŞDAY 18TH	Attitude is greatly improved. Worked hard and well all day. It's surprising how hard HIA3 can work when he sets his mind to it. Excellent day.	Excellent all round.			
THURSDAY 19TH	Another excellent day. I'm seeing how capable he now is at working. Good attitude, good work, good cheer! - is it a miracle?	Excellent.			
FRIDAY 20TH	Dying to win the cup. Well motivated again today. Is working well. Happy also. Won cup together with (2.45 pm)	As 19th.			

LS 1 20.11.1987

NAME;	HIA 3	EK BEGINNING: 23 NOV 1987
DATE	BEHAVIOUR	INTERACTION
MONDAY 23RD	Another excellent day. Concentration improving greatly. No complaints by him (re head) nor by me (re attitude)	
TUESDAY 24TH	Well done. As above. Very much imprall round.	coved Excellent.
WEDNESDAY 25TH	Gained tokens for continuous work. Very conscientious. An excellent day	Excellent.
THURSDAY 26TH	Very keen to please re behaviour and Another excellent day.	work. Excellent except for a short period of niggling re his crying on ward at night.
FRIDAY 27TH	As above. Cup Winner!!	Very helpful to Excellent.



DATE	BEHAVIOUR	INTERACTION
MOND'AY 30TH	An excellent day. Worked well and in a conscientious manner. No problems displa In an exceptionally good mood.	Excellent with everyon
TUESDAY 1ST DEC	1st period was fine. Complaints of head- ache after break. Settled to work then began to weep. Settled quickly. Good remainder of day.	Excellent,
WEDNESDAY 2ND	Once again, an excellent day.	Excellent.
THURSDAY 3RD	More unsettled today especially from 11 - 12.15. Started giving me smart answers re: his work.	Attempting to get into trouble re: his untidiness.
FRIDAY 4TH	An excellent day. No problems at all. Worked very well. Shared class cup with	Excellent.

LS 1

4.12.1987

DATE	BEHAVIOUR	INTERACTION
MONDAY 7TH	Worked well. Complained of stomach disorder 9 - 12 am. Better after lunch. This boy has really come round and out of himself. An asset to class.	Very sensible attitude towards everyone.
TUESDAY 8TH	Again, an excellent day. Worked very hard all day.	Excellent.
WEDNESDAY 9TH	A difficult (fist period (9-11). Trying to get out of work by feigning ignorance (i.e. choosing easier S.R.A. card) a most annoying habit when you know it's all "staged".	Excellent in general, only tried to wind me up!
THURSDAY 10TH	A bit huffy after mentioned 'brain haemorrhage'. Refused to play the game. Again signs of blatant attempts to ignore me and do his own thing. Talked about his 'stupid' Primary School teacher who was easily manipulated	Not great today. He seemed intolerant and annoyed at everyone at times. Fair/Good
FRIDAY 11TH	Not in Class - home on extended weekend.	

LS 1

11,12,1987

NAME	OF	PUPI	L :	Α,	3
				 	

WEEK BEGINNING: 14 DECEMBER 1987

DATE	BEHAVIOUR	INTERACTION	
MONDAY 14TH	An excellent day. Arrived back with some work from his own school and worked solidly from this all day. He's in very good form!	Excellent.	
TUESDAY 15TH	An excellent day. Complained of headaches after break, but settled down. Asked me not to mention his headache as he wanted to get out of here.	Excellent.	
WEDNESDAY 16TH	An excellent day - no complaints of headaches etc.	Excellent.	Skut ^{ek} nickt til die gegegigen van de vertiet te gewe.

16.12.1987

Name of Pupil:

HIA 3

WEEK Beginning: 4.1.88

·	
BEHAVIOUR,	INTERACTION
the An excellent day leally out of uniself now. Still talks about discharge	Excellent with
Making mushroom compost was his big	
heme today - this is what he was	
long when "hit by the stone on the	
read". Worked very well undeed.	
a: Concentration less today although he	Incheases interaction
completed all required work. No	& comment passing.
rehaviour difficulties and was pleasant in cheerful all the time. Easily	
listractable	A compared to the contract of
Generally an excellent day. No	
problems, worked well and in a very	Excellent.
food wood.	
No change. Working well.	4 ,
h. Excellent.	Excallent.
Non classeup bjetter until	
He is by a home for sweek theat	
Hoom school.	
,	

- documents to show the Inquiry the kind of documents that
- were being kept on children in Lissue.
- 3 At paragraph 3 of your statement then at 002 you
- 4 describe how you were in a dormitory when you first went
- in and then you were moved to your own room when you
- 6 were there for a while. You think there were about four
- or five beds in the dorm. You recall about eighteen to
- 8 twenty children of all age groups.
- 9 "During the day we were put into two groups, a red
- group and a green group."
- 11 You were in the green group. We have heard that the
- children were grouped according to their age. Red would
- have been the younger children and you were in the older
- 14 children's group.
- 15 A. Yes.
- 16 Q. "We stayed in our groups during meal times and
- 17 recreation. There were three members of staff who
- looked after the green group and three looked after the
- 19 red group."
- 20 Then you go on to talk about -- paragraph 4 here --
- 21 during your time at Lissue:
- "... I was subjected to physical and mental abuse on
- a daily basis by three members of staff."
- Now, HIA119, you will see that we have given them
- designations to protect their identity.

- 3. I was in a dormitory first and then I was moved to my own room when I was there for a while. There were about four or five beds in the dorms. I think there were about eighteen to twenty children in Lissue of all different ages. During the day we were put into two groups, a red group and a green group. I was in the green group. We stayed in our groups during meal times and recreation. There were three members of staff who looked after the green group and three looked after the red group.
- 4. During my time in Lissue I was subjected to physical and mental abuse on a daily basis by three members of staff LS 34 LS 7 and a man called LS 35. The abuse started a couple of weeks after I arrived. There were staff who were nice and they were called LS 6 and LS 36. They witnessed the abuse such as the slaps and the pulling of ears but they did not intervene or tell the other staff to stop. All they did was stand beside me and say 'you'll be okay' and they comforted me.
- 5. I was slapped, kicked and nipped by LS 34 , LS 7 and LS 35.

 S 7 was the worst. I suffered constant verbal abuse. They were always shouting and saying things like 'don't you be a smart ass'. At night when I couldn't sleep because of nightmares of when my father died I wet the bed.
- 6. I was slapped around the legs by the three staff which was very painful. During meal times if you were caught talking or laughing you were slapped around the head and pulled from your chair by the ears and sent to your room without anything to eat. Sometimes we were locked in our rooms.
- 7. While I was playing football in the recreation area which was in the basement I fell and LS 35 came over and stamped on my hand. He stamped on my hand several times. Later that day I was in so much pain and I complained to the staff. Eventually LS 35 brought me to Lagan Valley Hospital. On the way to the hospital I was told that I had to say it was an accident. He told the doctors that I had an accident. I had a hairline fracture in my finger on my left hand.

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PRIVATE

was a play area and the classrooms were just beyond that. The play area had a see-saw, a wooden hut, a sand-pit and swings. We were allowed to play in play area in the evenings. At the end of the laneway of Lissue there was a courtyard with green iron rod gates where the staff parked their cars. Outside the gates, there was a little cottage and a stable beside a field which kept a pony called Pepper. I remember I was allowed to sit on Pepper once.

mum lived in the little cottage. I don't recall any other parents living on site in Lissue and the staff did not reside in Lissue. There were cookery classes for the older girls in that cottage too.

- 6. My daily routine was getting up early in the mornings, getting washed and dressed, and taking my medication before breakfast. I was given Ritalin in Lissue. We had a school onsite and we started around 9.00am. I remember a called LS 20. I went to school as soon as I was admitted to Lissue and I found it hard to concentrate in school. We had a mid-morning break at 10.30am or 11.00am and then lunch was around 1.00pm. School continued to 2.30pm or 3.00pm and dinner was served about 5.00pm. The food was ok. We were allowed to play outside in the play area until supper at 9.00pm. I don't recall any physical education or sports at Lissue. I liked to run and I remember I use to race with LS 14.
- 7. The staff at Lissue were very friendly for the first three months before the abuse started. There were female and male nurses and they worked on shift LS 21 patterns was one of the LS 23 LS 24 patient's medication. I remembe LS 26 LS 25 and a called . There was a and she helped the called transfer the children from Lissue to Belfast. I only knew the were lovely people.
- 8. I remember the first time I was attacked b LS 21. I was in the dining area with some other children eating and playing with toys approached me and took me to my dormitory and locked the door. He told me I was sick and that he was my friend and wanted to make me feel better. He sat me on

HIA 220

PRIVATE

opened a few inches. There were rows of single rooms spaced out along the corridor. We were locked in our rooms at night.

- 7. If you were badly behaved you were locked in your room and didn't get any supper. This was only an occasional punishment. It happened to me once or twice. Bad behaviour could have been walking too fast on the corridor, pushing the lift button, not coming in from outside or not sitting a certain way. If you were very badly behaved the staff threatened you with an injection and if you were difficult to control they held you down, usually by sitting on you and gave you the injection in your rear to sedate you. It was the scariest thing in the world to me.
- 8. On a typical day, after breakfast we were taken into a room which had a big circle in the middle with cushioned seats around it. Along the back wall of the room there was a black mirror. There was a room behind the mirror. On one occasion I got off my seat and I ran into the room when the door was left open. In the room there were two men sitting on comfy chairs and there were three video cameras pointed at the glass. Along the back wall of this long room there were hundreds of labelled video tapes. I was punished for three days by being locked in my room during association time when other residents were playing. Association time was between 6 and 7.30pm. During this time we were allowed to watch TV, play games or use the tuck shop.
- 9. LS 7 had a pick on me from day one. On occasions she grabbed me by the scruff of the neck and she was rough with me and other residents.
- 10. Next to the video room there was an interview room. We were interviewed and asked lots of questions about our medication and how we felt. There were about four or five children present each time and the interviews were video recorded. During interviews there were a number of people in the room there was a man in a suit, two larger men in white coats who could have been doctors or orderlies, LS 7 and a doctor.

3

- 3.6 Patients up to the age of 14 years (this followed R.B.H.S.C. policy) were in the main referred from the Out Patient service at R.B.H.S.C. Other significant referrals came from Social Services. The referrals reflected a wide range of problems including; conduct/behaviour problems, emotional disorders (such as phobias, school refusal, anxiety, depression, self harming, anorexia nervosa, psychoses, Obsessional Compulsive Disorders, encopresis, and enuresis.
- 3.7 In 1976 provision was made to facilitate the admission of the parents of selected young children with difficult behaviour problems in order to provide them with intensive coaching in behavioural management techniques including differential attention, positive reinforcement, time out, use of point incentive systems etc. . Normally these admissions were time limited to approximately 2-3 weeks. This program was developed and supervised by the author of this report see Appendix 1 for 2 examples of this work also a BBC Horizon documentary made in 1981 (mentioned in requests for reports on Lissue) illustrate other examples of this work unfortunately the author does not have a copy of the documentary.
- 3.8 In 1978, Family Therapy was introduced and developed by Dr. Nelson and became an important part of the therapies in place. Largely this involved meetings with the family system (including the child) in an effort to seek out strategic solutions for the problems.

4. Day to day functioning of the Unit

- 4.0 The inpatient unit mainly functioned on a Monday to Friday basis. Children remained at the weekends only under exceptional circumstances and reasons for this may have included cases such as anorectic patients, who had not reached agreed target weights, patients who were regarded as being at a high risk of self harm, and also other who remained for reasons relating to family circumstances.
- 4.1 The average day began with the nursing handover events of the previous shift were related and discussed.
- 4.2 After breakfast children in middle age group attended a morning meeting which was in the main run by nursing staff, though often members of the M.D.T. would attend. The meeting was used to review the previous 24 hours and to attempt to resolve any untoward issues. On other occasions the meetings were used to explore the use of problem solving and social skills.
- 4.3 During the school day most children attended school during normal school hours. Breaks times were normally supervised by nursing staff.
- 4.4 Following school hours children were separated into roughly 3 age groups, and were then supervised in a range of activities such as walks, swimming, table tennis, football, various arts and crafts activities, occasional trips out in the minibus to special places obviously this was more frequent during school holidays, when it was possible to go to museums, beaches, parks etc.

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- 4. When I was in Lissue I had my own bedroom. There were dormitories but I was only placed in a dormitory when I was being put in timeout. On a typical day I would get up and get dressed. I used to wet the bed quite a lot so if I had wet the bed I was put in a bath containing dettol. The staff did not want to touch me and it made me feel like I had a disease. I felt like I was being sterilised in the bath and I found it quite upsetting. After I got dressed I would have breakfast and go to school. Sometimes I was punished by being made to wear my pyjamas all day and not sent to school. I used to sit in a room on my own all day looking at the pages of Ceefax. I was left school work to do but was unsupervised. The weekends tended to be a bit more relaxed than the weekdays depending on what members of staff were working. I believe that I broke things out of frustration or was provoked to do things by members of staff or other residents. Those things were written up as bad behaviour on my part with no reference to why I did those things. I thought that was very unjust and painted the wrong picture of me.
- 5. I remember passing a cupboard when we were away somewhere on holiday and asking what it was. I was told that is where they put the bad boys.
- 6. We were not allowed our own toys. My mother brought me an X-wing fighter once and was told to take it home. All the communal toys were kept locked in a cupboard and we were only allowed to play with them at certain times called group time.
- 7. I was punished for not eating my food. I remember a member of staff putting me in a room with a bowl of cold peas and telling me I was not allowed to leave until they were finished. I put them in my mouth and then ran to the toilet to spit them out. I think this is an example of the pettiness and inhumane treatment by the staff.
- 8. The school was in two portacabins on the grounds. Time spent at school was more productive and structured. The teachers were LS1, LS2

 LS2 LS3 and LS4 The teachers were all professionals and I do not have any complaints about the school apart from LS4 who

- 1 A. Uh-huh.
- 2 Q. -- there was a member of staff sitting in a chair.
- 3 A. Yes.
- 4 O. So --
- 5 A. That was like that one-to-one thing that we were talking
- 6 about earlier.
- 7 Q. You made the point to the police that someone suggested
- 8 to you at some subsequent time that perhaps the Lego toy
- 9 that was waiting for you to play with was to buy your
- 10 silence.
- 11 A. There was a box of Lego by the bed whenever I woke up
- and there was biscuits and snacks and stuff sitting
- there. I don't understand why, because I wouldn't
- 14 normally be treated that way. So it kind of had me
- thinking, "Why are they being this nice?"
- Most of the toys, as I was talking about earlier,
- not to yourself, but the toys were -- most of the time
- the toys were locked away in cupboards. There was --
- whenever I first went to Lissue, there was three groups,
- the red group, the yellow group and then the blue group.
- 21 Additionally when more and more patients arrived, they
- opened up a green group. There was these corrugated
- 23 metal stationery cupboards that had all the toys kept
- in. They were locked away. They were only brought out
- for different group activities. Whatever group you were

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

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

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

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

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

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

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

e) How were children supervised at night?

- 1 A. Uh-huh.
- 2 Q. We have heard that they were divided into groups.
- 3 A. We would divide them into groups after school, and they
- 4 went to school from 5 years of age, and the other -- the
- 5 small children would remain in the unit --
- 6 Q. Yes.
- 7 A. -- and then when they came out, we'd put them into
- groups, with the older groups together, you know,
- 9 according to age.
- 10 Q. It's been --
- 11 A. We took them all swimming except the small toddlers.
- 12 They went swimming every week.
- 13 Q. Every day they went swimming or every week?
- 14 A. Every week.
- 15 Q. Every week. I know you are going to tell us a little
- bit more about some of the other places they went to,
- but if I can just deal with a couple of other matters
- 18 first, it's been described as a challenging environment
- in which to work.
- 20 A. Yes.
- 21 Q. Medication, I was just going to ask you a little bit
- about that. In the body of your statement, in fact, at
- paragraph 11 here, you say that any medication were
- 24 prescribed by the doctors.
- 25 A. Yes.

- who have come to speak to the Inquiry who make
- 2 allegations about you. As I explained to you, I am not
- 3 going to go through all of those allegations. Those
- 4 people have spoken to the Inquiry and the Panel have
- 5 heard recently what they had to say. In summary they
- 6 allege that you slapped, hit, nipped or kicked children,
- 7 that you humiliated them and that you made an example of
- 8 them.
- 9 A. No, no way. None of the nurses would. Nor I didn't do
- 10 it either.
- 11 Q. I mean, I think you described to me that the children
- that you looked after were spoilt?
- 13 A. They were all spoilt.
- 14 O. You said that --
- 15 A. Even the untrained staff, the assistants, were terrific
- 16 with them.
- 17 Q. When we were talking earlier, you said that they got
- 18 more attention at home --
- 19 A. Yes, definitely.
- 20 Q. -- from you than they got at home?
- 21 A. No, from everybody.
- 22 Q. When I say "you", I mean you as a unit rather than you
- personally, but they were taken on outings and went --
- you were explaining that there were various places that
- 25 they were taken to.

- 1 A. Yes.
- 2 Q. Marble Arch caves was one of the places.
- 3 A. Yes.
- 4 O. The North Antrim coast.
- 5 A. Yes.
- 6 Q. Taken to parks. Lady Dixon Park and Lurgan Park I think
- 7 were a couple of the places.
- 8 A. Yes, and Carnfunnock Park.
- 9 Q. Carnfunnock. You even said that you took them to see
- 10 the Orange parades --
- 11 A. Yes. Uh-huh.
- 12 Q. -- in July. You said the police actually kept a place
- for the minibus for you.
- 14 A. Yes.
- 15 O. You also took them to church. Those small numbers who
- were kept in over the weekend were taken to church or to
- 17 chapel.
- 18 A. Yes.
- 19 Q. You address the allegations that are made about you,
- LS7, both in your interviews and statement to the police
- and also in your Inquiry statement, which is at the next
- page here, paragraph 12. Now you essentially deny that
- 23 you treated children as alleged and in some instances
- 24 you offer an alternative account for something that
- a child might have misremembered, if I can put it that

- 1 Q. I am going to use names in here, LS7, because it is
- easier for you to know who we are talking about, but
- I just want to remind people that we don't use the names
- 4 outside of this chamber. I was asking, "Was that a girl
- 5 called LS47?" and you said that it wasn't her.
- 6 A. No, it wasn't.
- 7 Q. You did mention about another boy who you named as
- 8 bringing cigarettes in --
- 9 A. Yes.
- 10 Q. -- to the unit.
- 11 A. Yes.
- 12 Q. And if I have understood what you were saying is that
- 13 staff could smell that somebody, some child in the unit
- was smoking.
- 15 A. Night nurses said they could smell smoke, but they
- 16 couldn't trace where -- who had them.
- 17 Q. But you suspected this particular boy, and I will just
- use his first name,LS97 .
- 19 A. Yes.
- 20 Q. And you actually were telling me that you searched him
- 21 for the cigarettes.
- 22 A. Sunday night when he came back from the weekend and like
- 23 he took his -- took the jumper -- he took the jumper off
- 24 and I made him -- I checked pockets and asked him to
- take the trousers off, and I gave him a towel to put

- 1 round himself, but he still had the trunks on. The
- shoes, I tried it. When I went to hand the shoes back,
- one fell, and the matches -- loose matches, red-headed,
- 4 were between the heel and the sole, and I noticed that
- 5 he was standing awkwardly. I asked him to spread the
- 6 legs out a wee bit and just cigarettes fell on the
- 7 floor.
- 8 Q. So he was, in fact, smuggling cigarettes into the unit?
- 9 A. Yes, and he was giving them to other children, younger
- 10 children as well. They were afraid of him.
- 11 Q. He is, in fact, the boy who you describe as the vicious,
- 12 deceitful bully --
- 13 A. Yes.
- 14 O. -- whenever you were talking later on. He was the only
- child that you didn't actually like.
- 16 A. No. He kept -- he was at secondary school in Lisburn
- 17 and he would have -- he came out of class and he brought
- some boys out or else through the break he hadn't
- returned to school, but one of the teachers found him in
- 20 parts of the ground with other children and they were
- all smoking and he reprimanded them. I don't know
- whether LS97 attacked him in the grounds or in the
- school, but he attacked a teacher. He was sent out of
- school. That's why we got him.
- 25 Q. He ended up in Lissue as a result of that, of having

- 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 Philidelphia, USA, where I visited. This approach included all or

to the Devlin and Jacobs reports would be, I am very saddened that I was not made aware of the issues therein at the time they were alleged to be occurring. As I have previously indicated in this statement. I was in Lissue very nearly every day at some time. It is unfortunate that staff did not feel able to approach myself, as I talked often to various staff in the unit particularly nursing staff. I was not aware of Dr McAuley or Dr Barcroft having been made aware of any of these issues or events.

22. It would have been so much easier to have dealt with the difficulties as they were occurring, rather than having to consider these issues on the basis of complaints made up to 15 years after the alleged events. I was under the impression that I had a good enough relationship with the staff at Lissue and that they could have approached me about these difficulties. It is disappointing that this does not appear have been the case.

Response to the allegations:

- 6. When I was contacted by the police I attended Banbridge Police Station on a voluntary basis with my Solicitor. I was interviewed on 25 February 2015 between 2.00pm and 4.23pm.
- 7. In each of the three tape recorded interviews I answered every question that was put to me by the police. I supplied the police with as full and complete answers as I possibly could, considering that the allegations apparently related to the periods between 1975 and 1976 almost 40 years.

I state that all the answers I provided to the police were true and complete to the very best of my memory and recall.

I wish to rely upon the contents of my interviews with the police as being my version of the events.

- 8. I received a letter from the Public Prosecution Service which unfortunately I have not kept, advising me that there was to be no further action taken against me. I believe this was probably in August or September 2015. I did not keep the letter because I wanted nothing about me relating to these foul allegations. I was trying to move on having had the recurrence of the depression because of the necessity of being interviewed by the police to repudiate the allegations.
- 9. It came as a complete surprise to me that I was therefore required to provide any evidence to the Inquiry. I have already outlined the effect that this has had upon myself and my elderly wife.

10. I worked at Lissue from in or arou	und 1971. I was a	until	Then I was
promoted and was a	I moved from Lissue to		in or
about			

11. There would have been two staff members for every child and I worked in the Child and Adolescent Psychiatry Department. Our primary function was records. We had to develop relationships with the children. We had to record their views, their feelings, how they were and how they were interacting. We had to act as liaison with the teachers and the other team members. Much of our work was in meetings and then with the children from perhaps 3.00pm to 7.00pm or perhaps 7.30pm. We had to be in a position to implement the therapies that were assigned and determined for each individual child on a daily basis. Everything we did was designed to have detailed records prepared for meetings. These meeting involved the multi disciplinary team which included psychiatrists, social workers, nurses, head teacher and psychologists. This work was done every morning from 9.30am until 11.30am. Determinations about the progress of each child was then assessed and we

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 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 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 scalled LS 20 The 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.

- patients were part -- they were seeing nursing staff,
- doctors, social workers. There was a very good social
- 3 work team attached to Lissue. They were also in
- frequent contact with parents. They were only in
- 5 Lissue, some of them, for very short periods. So one
- 6 would expect those -- those channels of communication to
- 7 be used, and certainly concerned parents would have had
- 8 access to the complaints procedure. It's highly
- 9 unlikely that inspections -- unless -- unless practice
- 10 had been observed or information had been communicated
- 11 to inspectors to that effect, it's highly unlikely that
- inspection would pick up problems such as those
- described.
- 14 Q. Just in respect of this, you were spoken to by someone
- who had built up a relationship of trust with you as
- someone who had worked with her formerly. I am talking
- about the girl LS66.
- 18 A. Yes.
- 19 Q. And obviously it was many years before she mentioned
- that to you?
- 21 A. Absolutely, yes.
- 22 Q. Certainly in some documentation, and I don't have the
- page reference, but it was the view that these
- complaints were seen as having a degree of credibility,
- even though they didn't result in any prosecution and

- 1 He said that you had gone on a home visit to his
- 2 mother's. First of all, can I just ask: did you pay
- 3 home visits to people's house?
- 4 A. I -- there were occasions when I did home visits to
- 5 the -- as I said before, to the anorexic child's
- 6 parents, who needed support. Not often, but certainly
- 7 not in in the '70s.
- 8 Q. Yes. I think you made the point in mid-1970s this was
- 9 not an area that you personally would have gone to.
- 10 A. No.
- 11 Q. You think that if any home visit was carried out, it may
- have been a social worker who did that?
- 13 A. It would have been a social worker, who would have had
- contact with the family in any event.
- 15 Q. He remembered the teacher LS20, but you have still no
- 16 recollection of any teacher of that name.
- 17 A. I am sure I can find out.
- 18 Q. Thank you. Well, I was asking you then -- moving on
- from what HIA220 had said, I was asking you about some
- other matters that the Inquiry has learned of in respect
- of Lissue. One was an incident of peer abuse, as it is
- now known, where one child abuses another child, from
- 23 1983. That was a boy LS71 -- I will use his first name,
- LS71 -- who was put into Lissue, then went back to the
- children's home perhaps for weekend leave and then was

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

- 9. My memory is that I was expected to record the implementation of a model of care that had been prescribed by the consultant in charge. At the MDT that is where the plan would have been modified. That was the expected practice. Any changes to the plan should have been recorded in the notes. If I was working with someone with encopresis the plan should have been evident, so that as key nurse if I was not on the Ward other Nurses could be aware of the plan and what was expected, intended, in the management of that child. For a child with encopresis, this would have psychological, nutritional, fluid intake and toileting elements or factors.
- 10.I recall that I would have been specifically assigned to four children as key Nurse at a time. A second Nurse would also have been assigned, with a health care support person making up a core team of three for each four patients. I do not recall difficulties with staffing while I was there; in fact this was a considered a good staff, patient ratio. We of course had occasions when staff members were sick when alternative plans had to be made to cover care for their patients care needs, but short staffing is not a prevailing memory I have during my time in Lissue between 1984 to 1986.
- 11. As regards records in Lissue, I recall that each section of the MDT kept their notes separately, in different cabinets in the one room, during the admission.

 There were other diary type books that information was recorded in. I cannot recall exactly what types, but I do remember other logs. I also recall people were advised not to write into the book. If it was relevant to a specific child it needed to be recorded in their notes.
- 12. There was a manual on the ward, with printed out copies of guidance that you would be expected to read and be up to date on. I recall that when I started, I spent the first few days having the time to read that folder; this was part of an induction period. If you later had any doubt you would be directed back to the office to refresh your knowledge and practice. Other training involved a planned

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

- 6. On a monthly basis there was also a journal club of professionals, where the Doctors, Nurses and Social Worker came together to consider training and development of practice issues through presentation of cases, research or other information.
- 7. As between the day shift and night shift nursing teams, there would be a handover. This would have been a detailed discussion of each individual patient. Occasionally if the staffing need required it, some day staff would support the night staff on the ward while others met to ensure a handover of information. On those occasions the senior Night Nurse provided a handover to the available day staff, who would then share that among all day staff.
- 8. In terms of the nursing plan, Nurses were expected to write a report on a daily basis as to the implementation of the plan, which was drawn up and reviewed through the MDT process. From a nursing perspective this report was informed by the Logan and Tierney model of daily activities of living and the nursing process assessment, plan, implement and evaluate. Each time you concluded

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

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

Q12. Was there any vetting of staff?

- 64. The recruitment of staff would have been consistent with Health Service arrangements as they developed over the years.
- 65. For any appointment of a Doctor or Nurse at Lissue Hospital references would have been taken up during the recruitment process and checks would have been undertaken with their registering body.

Q13 What records were kept in Lissue?

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

Nursing Notes

Medical Notes

Psychology Notes