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
Social Work Notes
Family Therapy Notes

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

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

Q14 Was any form of physical chastisement permitted in Lissue?

a) What form did physical chastisement take?

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

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

b) Under what circumstances was it administered?

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

71. Having noted that physical restraint was used, the Board refers the Inquiry to the analysis of same in the Historic Case Review at paragraph 6.1.1 on pages 14 – 15 and Appendix 5 commencing at internal page 35, which identified the use of
treated surgically, continued long after the surgery to resist ordinary feeding - many attempts by different professionals using different strategies were tried unsuccessfully - after 9 months we took this case over, and after careful consideration we engaged in a force feeding regime with parents agreement, and which began to work well after about 10 days – thereafter progress being slow but always forward. Other occasions of importance may arise as a result of special problems, for example when children started to climb onto the roof of the main building. A response to this situation involved sitting down with the M.D.T. and drafting a management policy for the problem.


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

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

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

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

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

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

7.1 The case mix in general became more difficult to manage as the years went on – there were more serious child care problems referred by social services, and this from time to time as already mentioned caused difficulties.
treatting 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 Lissieu 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 Lissieu. He only worked in Belfast for a limited number of years.

15. Some years after the opening of Lissieu, I started using a Family Therapy model of assessment and treatment based largely on the teaching of Salvador Minuchin from Philadelphia, USA, where I visited. This approach included all or
2. While I was working with Dr McCune, he, I and other colleagues that had worked in Lissie 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 [redacted] 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 Lissie [redacted] was [redacted]. I recall that [redacted] 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, [redacted] was my team manager.

4. I recall my period as a nurse in Lissie 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 Lissie 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.
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 [redacted] 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
A. Normally the individual who was working with the family, but on occasion where you would go as an observer that would have been a second person, and the key worker would have asked the family, "Is it okay for that learner to come?"

Q. Just in terms of key working -- I was going to deal with this later -- but from your statement it is clear that each child was assigned a member of staff as a key worker.

A. Now there's two key workers. Sorry for the confusion. As a nurse you were a key worker within the ward for 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 The Royal Hospital, and you would have been going out with them, because there were two units.

Q. Can I just check? The reason I ask this is because of something we have heard from one of the witnesses. I am going to ask you later about some of the staff you worked with. Just I am going to use names, but remind 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 have been your experience?
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.
11. On our bedroom doors we each had a chart with stars or ticks for good behaviour. I think they were blue or red marks and points. At the end of the week they would give you a plastic toy if you were well behaved. I did not get a toy very often.

12. I have seen my records from my time in Lissue. One of the documents states 'method: 1 member of staff to set tasks and give red points from 8.00am – 5pm, another from 5 to bedtime. All staff to give blue points. Points: Compliance / Co-op interaction / attention seeking / non compliance / 3 blue points – to in bed in pyjamas. Exchange: 20 red points in a day – 'special attention' for ½ hour. 100 red points at the end of the week. To receive gift.' Another record describes what feeding times were like. 'To be treated the same as the others during meals. If necessary be told once to eat up otherwise the plate is taken away.' This demonstrates the harshness of Lissue – 'eat now or be starved'.

13. A record shows that I as a nine year old child was not allowed to have the staff’s attention – 'Usual demanding HIA 38. Appears to bring out the worst in peers. Receives the odd kick and thump from the older peers. This does not discourage HIA 38 he still goes back for more. Had his arm twisted by LS 48 for no reason at all.' This shows that the staff knew I was being beaten by other children and they did nothing about it. If anything the tone of this record would suggest that the staff thought I deserved the beatings. I was beaten by other children almost daily. There is another similar record in my notes ‘1/6/81 on the verge of trouble several times during the evening sometimes heedless of warnings which earned a few thumps from peers. Needed constant supervision.’ I think this also demonstrates that the staff did not intervene to prevent other children from thumping me.'

14. An entry from my records interestingly shows my fear of staff ‘4.3.81 HIA 38 had enough points to gain ½ hour with member of staff. Took to trains with HIA 172, they both played very well together. HIA 38 seems to watch staff through play as if he was afraid of doing something wrong or turn his back in case he would get a slap, very edgy. I think
call home was 750 points or a trip to the swimming pool required 1050 points. I remember getting to swimming pool once. It would have been very difficult for a child to get 750 points because a lot of them were more rebellious than me. I also remember Miss World visited the children in Lissue one time and the Army use to visit on a weeknight and brought movies to watch in the TV room. I think they were from Thiepval Barracks in Lisburn.

17. If you were caught misbehaving the nurses made you stand in the corner facing the wall. One time I was thrown into the cupboard and locked in the dark. I do not know how long I was in there for. I hated the dark. Whenever I was at home my mum kept my bedroom door open and landing light on because I hated the dark.

18. I ran away once with [ ] who was a few years older than me [ ] suggested the plan to me and it was shortly after the sexual abuse I suffered from [ ] and [ ]. I was delighted with the plan and wanted to get away from Lissue. It was around Spring time and we waited until everyone was in the dining area eating supper. We then left through the play area at the back of the classrooms. We crossed a stream and came to a railway track that ran in front of Lissue Hospital. We were heading along the railway track when the [ ] and [ ] caught up with us. They grabbed us and put us in the back of a car and took us back to the hospital. They separated us and I do not know what torture they did to [ ] that night. They put me in a bath of ice cubes and then threw me into bed while I was still soaking wet and freezing. The next day my bed was totally soaking. I do not know if it was because I wet myself that night or because I was soaking wet when I went to bed. When I look back on my experiences in Lissue Hospital, I often think Lissue should have been a place of safekeeping for children but I was not safe there. I do not think the other children were safe within Lissue either. I remember [ ] tried to escape Lissue one time. He kicked the wooden panel of an emergency exit door to try to get out but failed.

19. I did have some talking therapy with Dr Manwell at Lissue. He came to visit me in Lissue but I honestly do not remember any other type of therapy in
this entry shows that staff hit me otherwise why would I be in fear of getting a slap from staff if it hadn’t happened before. I have seen an entry from my records which again states that I was thumped by another resident and that I was frightened the doctor was coming to give me an injection.

15. On the grounds of Lissue House there were barns and stables with horses. There was a wooden hut with a giant sand pit and some of us would try to dig tunnels to escape. On one occasion a boy called [LS 49] had to be taken to hospital because a tunnel collapsed on him.

16. About two or three of us always tried to escape. [LS 47] was one of them. I think one might have been [HIA 172]. I have had no contact with [LS 47] since I left Lissue. We realised that we could walk out through the stables which brought us out onto the main road which was in the country surrounded by fields. The police always brought us back. This happened about three or four times. I think the police were from Lisburn Station but I don’t remember any of their names.

17. On one occasion [LS 7] tried to take blood from me. She tried both arms and was unsuccessful but kept tugging at me. The needle came away from the syringe and stuck in my arm. She called me a ‘stupid bastard’ and gave me a slap across the head. The blood went all over her white coat. I have been petrified of needles ever since.

18. [LS 7] was evil. She would grab you by the scruff of the neck and shove you into your room if you annoyed her. She could be quite nice to you if you did everything she told you to do and acted like the robot she wanted you to be. If you didn’t draw her attention she left you alone. I have memories of hearing other residents squealing but I never witnessed abuse directly.

19. The only toys I can remember in Lissue House were in a room next to the interview room. In that room there was a big train set and you had 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. **LS 7** and the head doctor usually were present.

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**LS 50** was called **LS 7** There was a nice **LS 51** called **LS 51** but she might have been at **LS 51** I recall she taught us some**HIA 38** 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.

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**HIA 38** I was there from 11 to 16 (from 1981 to 1986). I believe I was moved to**HIA 38** on the recommendation of Lissue
A. I don't remember that, but that -- you know, I actually went out on home visits. So it may have happened.

Q. So nurses did actually go on home visits?

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

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

A. That would have happened, yes.

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

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

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

A. Certainly from 1984, yes.

Q. So it may be prior to that a general nursing qualification might have been sufficient. We will hear
inappropriate or even abusive involved a serious case in which a 2-year-old, who had congenital oesophageal problems and had been treated surgically, continued long after the surgery to resist ordinary feeding. Many attempts by different professionals using different strategies were tried unsuccessfully. After nine months you took over the case and after careful consideration engaged in a force feeding regime with the parents' agreement, and that began to work well after about ten days."

I think the point you are making is that while force feeding a child might be seen in some circumstances to be abusive, this was part and parcel of the treatment to try to deal with the medical problem that this child had.

A. It simply dictates that, you know, what has happened before in terms of trying to manage this problem had not worked. Various things had been done by other people outside the unit and we are left with this. So if we hadn't done that, I suspect that this child would have continued to have fed himself by tube for the next n years.

Q. I think just in talking about tube feeding you were saying -- and I know you were here when LS7 gave evidence this morning --
that the child's father suggested that allowing the
child a cigarette helped to calm her down and improved
her behaviour. Therefore cigarettes were given to her
as part of the care plan. Do you ever remember that
happening?

A. No.

Q. You go on to talk in terms of bedwetting. You say:

"There was a bell and buzzer system. If the child
wet the bed, he or she would be encouraged to help the
nurse take the bedsheets off and then the nurse would
remake the bed for the child to get back into."

You say you understand the policy of children
helping to take the sheets off the bed is still
a practice recommended today.

"Charts were used to see whether there were patterns
and some children had enuresis in relation to
psychological issue and some had a physical issue in
respect of it."

They were also used, as we have seen, to build up a
pattern -- a sleep pattern of the child.

You go on to describe how children -- patients were
not expected to engage in chores. Chores would not have
been given as a punishment. They might have been
expected to keep their room reasonably tidy.

Bullying was not condoned. That is something I want
No he just turned round and said there's a name for people like this, for people like me.

Eh eh. Anything else happen in Lissue then?

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

Who was that by?

The doctor that was there at the time.

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

Yeah.

You said for up to a week?

Yeah.

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

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

A pyjama top just?

Yeah.

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

Back into the room.
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 de-escalated. 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.
Policy: to be followed if any child (in patient or day patient) goes on the roof of Ward 7, Peter Green Hospital.

Aim: to ensure that all disciplines are aware of the course of action to be taken to ensure full co-operation of all staff.

A. The following persons must be informed immediately by Nurse in Charge:

(1) Consultant Psychiatrist of the child/children.
(2) Parent/guardian of the child/children.
(3) Assistant Director of Nursing Services, WARD 7, who should inform Director of Nursing Services.
(4) The Unit Social Worker (Child Psychiatry, F.G.H. if present, and in cases where child is the subject of a Court Order the Senior Social Worker in the Social Services Department which has taken out the Order. Outside of office hours the Social Worker on standby for that department should be contacted through Contactors Bureau.
(5) The Administrator for Hospital Services should be contacted via switchboard in main hospital - (Dial 0)
(6) An entry should be made in the Nursing Notes giving the times that above persons have been contacted.

B. Action to be taken when child/children come down from the roof:

(1) Child is isolated in his/her room immediately for a 24 hour period, during which all comics, books, radios and drawing materials should be removed. Posters may be removed from the walls for this period and all personal clothing except night clothes, dressing gown and slippers. No interaction to be allowed with other children. School work may be asked for from teaching staff. Members of nursing staff will be allocated to stay with child/children during this 24 hour period.

Medication will be prescribed and administered intramuscularly if the child refuses to accept it orally.

(2) On completion of this 24 hour period all clothes, posters, personal belongings shall be returned to the room.

(3) The child/children will for the next 24 hour period be supervised on the ward. For this period they may not be given or share in any of the pleasurable activities available to other children. They should be closely accompanied to and from classroom by nursing staff in this period.

(4) If at the end of this 24 hour period there is sufficient demonstration of compliant behaviour the privileges available to all the other children may be gradually restored to the child/children at the discretion of the nurse in charge in consultation with other disciplines.

(5) If the above measures are not effective this policy should be reviewed and as a last option if this course of action fails discharge of the child will be undertaken.

(6) During the first 24 hour period (isolation period) recreational activities to all other children may be restricted as a consequence of any child having climbed on to the roof.

Dr. W. McG. Nelson  Dr. R. McCauley

LS 8
Q. As I was explaining to you, the Health & Social Care Board might well point to quite a number of the more serious incidents that might get well beyond the category of what you are describing of normal behaviour from children, breaking windows, climbing on to roofs and throwing slates down and so on. Those are perhaps beyond the type of thing you are talking about.

A. Yes, but I think you're talking about one incident where I broke a window and claimed on to a roof and then threw slates down. I broke a window to get out. I climbed on to the roof to get somewhere safe and I threw slates down out of idleness and boredom.

Q. There are a number of incidents on the roof.

A. I think I climbed up on to the roof quite a few times, yes.

Q. LS7, when she is being spoken to --

A. But I wasn't the only person that claimed up on to the roof. There was plenty of kids that did that, you know.

Q. It seems for some reason to have stuck in staff's mind, as I was explaining to you earlier, that it was you who climbed on to the roof, but your recollection is there were other people who did this as well.

A. Oh, yes, yes.

Q. She -- LS7, if we look at 31537, please, in her interview she explained that she would have -- if
MR LANE: Was the roof easy to get on to?
A. I can't remember, sir.
Q. You can't remember?
A. I can't remember.
Q. There is talk about there being a bungalow. Was that round the back of the place or what? Do you remember?
A. Yes, that was out the back.
Q. Right.
A. That was out the back, and then if you were out the back, on your left-hand side would have been a big barn with hay in it.
Q. Uh-huh.
A. There was never no mention of that, me setting that on fire, is there, because that just dawned on me there, like. I lit that on fire, so I did.
Q. Uh-huh.
A. That was the day that we had gained entry into the wee bungalow. They couldn't find us, because we had climbed in through the window and were hiding in the bungalow.
Q. Right. Do you remember at all who it was who gave you the injections?
A. No.
Q. It was just a member of staff as far as you are
5. FINDINGS

5.1 This section sets out the findings under the following heading:
5.1.1 allegations of sexual abuse by peers
5.1.2 allegations of sexual abuse against peers
5.1.3 allegations of sexual abuse by staff
5.1.4 allegations of physical abuse by peers
5.1.5 allegations of physical abuse against peers
5.1.6 allegations of physical abuse by staff
5.1.7 grooming.

Details in relation to children are provided using the reference letter from the Glossary. Peer sexual activities are considered under 2 headings: *allegations of sexual abuse by peers* and *allegations of sexual abuse against peers*, the former are allegations made by children while the latter are third party allegations of observations recorded by staff.

5.1.1 Allegations of Sexual Abuse by Peers (Category 1)

Total number of children abuse 8

Of the 8 cases, 7 related to girls whose ages ranged from 8 to 14 years of age (average age 11 years), the only boy was 10 years of age. The nature of the allegations ranged from:

- fondling other children e.g. breasts/testicles (6)
- alleged sexual intercourse (one)
- kissing private parts (one)
- exposing body parts (one)

Appendix 1 provides details relating to the nature of the incidents detailed in children’s case records.

5.1.2 Allegations of Sexual Abuse Against Peers (Category 2)

Total number of abusing children: 6

Of the six cases falling within this category, four were boys whose ages ranged from 9 to 14 years (average age 12 years). Both girls were aged 11 years of age. Three children were recorded as touching other children on various parts of their bodies, two boys were alleged to have sexual intercourse, one with a 11 year old girl while in Lissue; the other with a resident of a children’s home prior to admission. In one child’s case, there were concerns about his sexualized language and knowledge. It was also noted that this 9 year old was vulnerable to older peers, although the nature of this vulnerability is not specified. He was, however, a frequent absconder with peers.
Appendix 2 provides details relating to the nature of the incidents detailed in children’s case records.

Overall, these incidents demonstrated issues relating to the risks which children presented to one another. The records generally provided little detail regarding how risks were identified, or reported to social services and/or police. The result was that at times it appeared that completing the record was a sufficient action. There was nothing to indicate that records were reviewed by managers who could take an overview across children’s files to identify if the mix of children at any given time was of particular concern. There were periods where there was a higher level of absconding but no information on how the potential to use these absences for untoward behaviours was assessed or addressed. The lay-out, size and grounds associated with both hospitals and the previous experience of abuse of a number of children presented challenges for supervising vulnerable children. There is no indication how staffing levels took account of either locations or in-patient context; there was at times reference to staff shortage. Such shortage would have had implications for child supervision.

5.1.3 Allegation of Sexual Abuse by Staff (Category 3)

Total number of incidents: 3

The 3 allegations within this category related to girls whose ages ranged from 8 to 13 years (average age 10 years). Two of the allegations relate to unnamed staff, while one named a staff member. One of the former and the latter were referred to the Police Service for investigation. In one case, as the 8 year old could not name the staff member, no outcome is recorded. There is also no evidence of a review of the case files when the allegation was first made in 1990 to seek to identify any potential untoward event. In the latter case, relating to a 13 year old girl, the absence of corroborating evidence when a disclosure was made some 15 years following her discharge from Lissance meant there was no police action. The absence of a criminal charge does not, however, obviate the need for consideration at employer level using the balance of probability associated with safeguarding of children.

The remaining allegation related to an 8 year old girl whose mother alleged that a doll's arm had been put up her daughter’s bottom by staff in July 1993. This matter appears to have been resolved to the satisfaction of the parent, however, the records do not specify how.

Appendix 3 provides details on these 3 incidents.

5.1.4 Allegations of Physical Abuse by Peers (Category 4)

The file extracts made available contain many references to named children being
to ask about. You say you remember arguments on the
ward, but that would have been managed by staff with the
patients or children.

"The nurse would have engaged with the children
involved in the argument to resolve the issue and
re-engage them in cooperative play. Any serious
concerns were discussed through the multi-disciplinary
team meetings."

We have heard that children were involved in
altercations and staff just sat down -- sat by, rather,
taking notes and didn't intervene. Is that your
experience?

A. No, that's not my experience.

Q. If a child was being physical towards another child,
what would staff have done?

A. Well, certainly I can speak for myself, and what I would
have done is I would have said in a firm, loud voice,
"Please stop this" and then I would have moved towards
them and encouraged them to stop the fighting. I have
to say in my experience and memory the children then
would have still been saying things to each other, but
they had stopped the physical, and then we would have
went to a quieter room where we could sit down and talk
about what had happened.

Q. You go on to talk about you had no awareness of peer
Q. LS7, just a couple of other things that the Inquiry has heard about and I just wondered if you had any recollection. We have heard there was a train set like a model railway in Lissue. You have no recollection of that?

A. No, no. The only place it can be is --

Q. I think we were talking about there was an occupational therapist at one stage --

A. At one stage.

Q. -- and you thought it might be in the room that they used?

A. Yes. She had a room of her own beside the school and she took them up.

Q. You don't remember an arts and crafts room either?

A. No. It could -- must have been in the same room.

Q. I was asking you what would you do if children were fighting? I mean, if one child was hitting another, it's been alleged that staff basically just observed, made notes and didn't intervene in any way.

A. We always intervened in case it got out of control or some child got hurt.

Q. In what way did you intervene? What exactly was done?

A. You talked to them, and if they lost their tempers and were out of control and keeping on and the other child
was older, you would have took -- brought him or her and
done -- grabbed -- get a nurse -- usually there were
other nurses about -- and take them to the bedroom.

Q. When they were in the bedroom, they were restrained
until they calmed down.

A. Yes.

Q. Then they were kept there for a period of time before
they were allowed out. Is that right?

A. No. Well, we would have sat and talked to them,
explained to them that if we had allowed it to happen
and the other person got the better of them, they would
have come out the worse, and there was no shame to walk
away from things like that. We would let them stay
there for a short time to settle down and then come up
-- come out.

Q. The Inquiry has heard that restraint was used
inconsistently, that staff dealt with restraint in
different ways. Is that your memory?

A. No.

Q. You say that all of the staff --

A. All the staff --

Q. -- did the same thing?

A. Yes.

Q. Then at paragraph -- on the same page here you say --
you talk about not having any particular animosity
whose surname you give, who were nurses on night duty. You say they were both nice. You can't remember the names of any other members of staff in Lissue.

You go on then -- sorry. I should just say that the records -- and we looked at these earlier -- show that it wasn't just the night staff who were trying to help you, but there were other staff during the day time who were trying to help you with your anxieties, such as helping you with relaxation techniques.

We looked at a couple of those at 20119 to 20120. That's 20119. If we just look down at the bottom, this first entry here was about at night-time whenever you were upset and they managed to get you up, telling you not to worry about not getting to sleep and giving you a comic or letting you read your comic and you eventually fell asleep.

But then this is on 3rd November and this is just after you went in. This is straight after you went. You went to school that morning after attending the group meeting.

"A telephone call was received from LS1", who was the teacher, "stating that HIA3 was complaining of a headache and had become tearful. At break-time he was observed to be having an anxiety or panic attack. Relaxation was carried out, deep breathing and talking
through his worries, fears and innermost thoughts.
Stated he felt he was going mad. Reassured++. Given
drink of milk. Said throat felt very dry. Out of
school for remainder of morning. Chatting more freely
after school. Participated in group debate, which he
enjoyed" -- sorry -- "group relaxation, which he
enjoyed. Later group had a debate. Was able to address
the chairperson, although under some stress, able to
control his voice and coped well. Praised and looking
a little more cheerful at teatime."

You will see that's signed by the Staff Nurse LS34.

A. Yes.

Q. There's another incident where you were brought from the
school. I think it might be this next one. You felt
homesick and wanted to go home. So the staff -- the
reason I am just showing you those documents, HIA3, is
to say it wasn't the only the night staff who were
trying to help, that there were other staff during the
day time who were trying to be of help to you. Would
you accept that?

A. Well, I got better. I stopped thinking I was taking
a brain haemorrhage, but these incidents happened during
the day with day staff and with this guy LS44 and
belittling me and punching me repeatedly, numerous
times, and making fun of my problem when I was there,
Social Work Notes
Family Therapy Notes

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

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

Q14 Was any form of physical chastisement permitted in Lissue?

a) What form did physical chastisement take?

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

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

b) Under what circumstances was it administered?

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

71. Having noted that physical restraint was used, the Board refers the Inquiry to the analysis of same in the Historic Case Review at paragraph 6.1.1 on pages 14 – 15 and Appendix 5 commencing at internal page 35, which identified the use of
28. I have also been asked about Tourette's syndrome. There was also a
behavioural model for treatment at that time, which by today's standards would
be considered harsh, but it was a model of the time. Habit reversal was a
technique that would be used. The theory was that if, in relation to vocalisations,
could the patient gained the ability to manage the vocalisations, this would in turn
be less disruptive and open up opportunity's for greater socialisation in school
and other leisure/public environments as well as at home or care placement.
These techniques would have been used in a one-to-one setting, not within a
group, and timetabled at particular times of the day.

29. I have been asked about searches. If children returned from home leave and the
family shared their concerns that they may have been able to access medication
and/or sharp implements, the child themselves would not physically be searched
but their property would have been, for their safety and the safety of other
children that were vulnerable on the Ward.

30. I understand that further questions have been posed. My recollection in respect
of the various issues are:

   a. I do not recall children being provided with cigarettes or being allowed to
      smoke. Some children would have been smokers on admission and we
      would have asked them to give up their cigarettes. I do not recall nursing
      staff ever holding cigarettes for a patient.

   b. I have no recollection of physical chastisement in Lissue.

   c. In terms of wetting the bed, there was the bell and buzzer system. If the child
      wet the bed, he or she would be encouraged to help the nurse take bed
      sheets off and then the nurse would remake the bed for the child to get back
      into. I understand the policy of children helping to take the sheets off the
      bed is still a practice recommended today. Charts were used to see whether
      there were any patterns, as some children had enuresis in relation to a
      psychological issue, some for a physical issue. Charts were also used to
      build a picture of the sleep pattern of the child.
discharge a patient prematurely and you were saying that
unfortunately that was really up to Social Services
then, because they were their responsibility.

A. It was unfortunately bumped back into Social Services'
lap. It may well have meant that the juvenile justice
system was used to house that young person.

Q. You also have made the point just about these children
that Lissue you thought had a fairly high tolerance
whereas children's homes couldn't have necessarily coped
with these children.

A. Uh-huh.

Q. I wondered was that because there was a greater staffing
ratio in Lissue than there would have been in
a children's home?

A. Well, I think that's one factor in it, and I think also
the fact that we are used to dealing with, you know,
a difficult and sort of quite diverse population.

Q. And would have had greater training to do so than
perhaps they had in a children's homes?

A. Greater experience I would say, because I think the
training has already been talked about.

Q. Paragraph 5 you go on to discuss your own role within
the Psychiatric In-Patient Unit. You talk -- you give
an example here of problems with working with treatment
regimes. One example you gave that might be regarded as
75. The examples documented indicate involvement of nursing staff in physically restraining the children.

d) How was it recorded?

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

e) To whom was it reported?

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

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

78. A primary aim of the Child Psychiatry Unit at Lissue Hospital was to help children who had significant emotional and/or behavioural problems. This included children with conduct disorders. In this respect, what may be perceived as “discipline” within the unit formed part of a Consultant led treatment plan for a child by way of behaviour management or behaviour modification. These treatment plans were discussed at a weekly ward round attended by the Consultant Psychiatrist. The parents of the children were also closely involved in implementing the plan, through attending at the hospital for direct engagement with the therapists, and in some cases living on site, to learn the techniques.

This was a clinical approach which should be seen in the context of practices of the time, the medical and nursing oversight available in the Unit and the available Nursing Policy on behaviour modification dated 1989 (see Exhibit 6)

79. The Board offers the following examples:
   a. Keeping a child diagnosed with anorexia confined to bed;
   b. Time out for children where it was felt that they need to be removed to reduce aggression or hostility;
c. The use of medication to respond to particular behaviours (for example HIA 251);
d. Being placed on special observation;
e. Being placed in pyjamas;
f. Confining a child to his room with loss of privileges and on constant observation by a member of nursing staff until he earned his way back out of his room by means of a star chart (an example of which is seen in the nursing notes of HIA 251);
g. A card system or points system to achieve privileges, or have privileges removed (an example of which was loss of outdoor clothes in respect of HIA 172).

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

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

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

82. The Board is aware that in March 1983, [LS 71] alleged buggery by another patient in the Child Psychiatry Unit. The following chronology summarises the steps taken:
   a. [LS 71] was an inpatient in Lissue from 19 August 1982 to [REDACTED];
   b. [LS 71] was subsequently placed in [REDACTED] Home. In February 1983 consideration was being given to a further admission to Lissue, which upset [LS 71]. Over the course of discussion with his [REDACTED], [LS 114], on 25 and 28 February 1983, he disclosed sexual abuse by a peer (whose name he did not know) within the unit during his previous admission;
   c. This matter was immediately reported to police. The [REDACTED] accompanied [LS 71] to the police station on 1 March 1983. On that date he
EASTERN HEALTH AND SOCIAL SERVICES BOARD.

AREA NURSING TEAM Policy No. ANT/4/88

POLICY - USE OF RESTRAINT *

Objective: To detail the nurse's role where restraint is deemed necessary.

Attention is drawn to the Eastern Health and Social Services Board letter dated 23rd December, 1982, regarding use of restraining equipment which states:

"while it is accepted that there are occasions when such forms of restraint are required and they cannot be entirely discontinued, the Board wishes their use to be confined to extreme and exceptional circumstances on the understanding that joint consultation between medical, nursing and, where appropriate, social services staff is undertaken prior to devices being brought into use".

Policy:

1. Restraint is only to be used where all other methods of management have failed.

2. In deciding to use restraint, the nurse must assess and record in the nursing notes:

   (a) problem behaviour
   (b) why this behaviour is a problem (i.e. is it a danger to the patient or to others)
   (c) the proposed solutions (which will include restraint)
   (d) the reason why restraint is the method of choice.

3. Restraint should be a time-limited intervention with built-in review.

4. Guidelines should be agreed by Unit of Management Groups on a multi-disciplinary basis to reduce the use of restraint - this to include the involvement of relatives.

5. The Royal College of Nursing document "Focus on Restraint" should be used as a basis for local nursing policy.

* 'Restraint' is defined as restricting someone's liberty, preventing him from doing something he wants. Commonly used methods include -

- cot sides
- harness
- sedative drugs
- baffle locks
- arranging furniture to impede movement
- inappropriate use of night clothes during waking hours
- chairs whose construction immobilises patients.

4.1.89

Evelyn J. Sandor
Chief Administrative Nursing Officer.
MANAGEMENT OF VIOLENT OR POTENTIALLY VIOLENT PATIENTS
WARD 7, FORSTER GREEN HOSPITAL

(Ref: Report of the Advisory Group on the Management of violent or potentially violent patients - September 1980)

AIM
To give guidance to nursing staff in Child Psychiatry Unit on prevention and the management of violence in children in our care.

To ensure that all staff have instruction and training in dealing with violent or potentially violent patients.

(A) PREVENTION:
Many contributory factors to violent outbursts can be lessened considerably by appropriate attention to key elements.

1) An awareness of the propensity for violent outbursts in some children.

2) The importance of building relationships and providing stability for children and of controlling their own emotions.

3) The development of and the display of objectivity in all reports and interventions.

4) The avoidance of repressive regulations and unnecessary restrictions.

5) The pursuit of simple and clear forms of communication between children, nursing staff and parents.

(B) MANAGEMENT OF THE VIOLENT INCIDENT:

1) Avoid confrontation and try to avoid physical intervention even if there is a display of temper which you think may cause damage; unless you feel that someone is likely to be hurt you should try to divert the child's attention by talking and listening.

2) If force is necessary then the minimum needed to achieve control should be used and the aim must be to safely reduce the outburst to a degree where the child can talk and be listened to.

3) If it is necessary to remove a child for the purpose of getting rid of an 'audience' or to ensure that he/she remains in his/her room for a short while to settle or as a punishment (if appropriate), then the door must not be locked, the nurse must close the child's own room and when the episode has passed there should be no change in the prescribed attitude to the child.

4) Whilst bearing in mind that confrontation and excessive force must be avoided, extra help should be called when it is judged necessary. This can be achieved in Child Psychiatry Unit by the use of a buzzer in Day and Night Station which can alert other nurses in the vicinity.

(C) RECORDING OF INCIDENTS: (Page 8, section 4.9)

(a) A detailed summary of the incident must be entered in the child's daily nursing notes.

(b) Names of all nursing and other staff directly involved must be shown.

(c) An entry should be detailed in nursing notes.

(d) Medical staff must be informed immediately.
"Restraint was used in circumstances necessary to
safeguard the child or others from risk of harm."

A. Uh-huh.

Q. I am wondering whether that is a fair conclusion to
reach, because we have heard that there was
an inconsistent approach to restraint. I am just
wondering what more you wanted to tell us about
restraint.

A. I believe the nurses involved -- the nurses would have
been the people who would have done restraint, because
they are the ones that would have been closest to the
patient 24 hours a day, and they are the people who
would have enacted behaviour modification programmes and
others. The evidence we have in terms of Stinson and
the extracts from the patients' notes indicate that
restraint was noted and recorded in the nursing notes,
which gives you reassurance that it was an open and
transparent process. The problem we have is we haven't
got the context of the total, so we haven't. Many of
these children were very disturbed and many of them
required -- and you have heard from staff in Lissue --
required particular management and therefore
intervention, and I think mental health services always
have this challenge between care and control, and it's
a very skilled practitioner that can do it with
compassion and kindness. I think we have heard
evidence -- the Inquiry has heard evidence that some
staff took a perhaps more gentle approach, but it would
have been on a spectrum, so it would, and I believe that
the restraint used was to safeguard the children.

Q. You did say to me when we were talking earlier that
really it would all depend -- you know, you could have
all the training in the world in a technique, but it
would really come down to the individual applying that
technique and the individual patient.

A. You are absolutely right. You can have all the policies
in the world and all the protocols in the world. It is
the practical application of that in the work place that
is key, which goes to, you know, the ethos, the value
base that is nursing and indeed social care.

Q. I just wondered in the context of different approaches
taken --

A. Uh-huh.

Q. -- by staff was there any suitability at the time Lissue
was operating of staff suitability for the roles that
they were being asked to undertake? I know there was
the qualification, the Mental -- sorry -- the Registered
Mental Health -- Mental --

A. RMN, Registered Mental Health nursing, yes.

Q. Yes -- that they would have had if they wished to apply
care plan, as it were --
A. Uh-huh.

Q. -- then you could go to the doctor and say, "Look, this is ..."
A. "What do we do?" Yes.

Q. Another issue that we have heard about in the Inquiry is the use of restraint for children.
A. Yes.

Q. We were discussing this earlier and I just wondered what your recollection of the use of restraint in Lissue was.
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 was no escalation.

Q. We have heard -- I mean, you were saying to me that it was -- you had some training in the use of restraint.
A. Yes, yes.

Q. You said that in the altercation between the children the staff were obliged to hold them as you describe until they calmed down.
A. Uh-huh.

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 --
LS81, but to turn it into words what you have shown is
the hands being folded across the chest of the person
concerned.

A. Yes.

Q. Is that right?
A. Yes.

Q. And does it mean that a member of staff had their arms
round that -- the child in that position to hold the
arms in place?
A. Yes, yes. You would have held your hand here and you
would have held your hand here in an open position
(gesturing).

Q. On the elbows?
A. Yes -- sorry -- just, you know, when your hands are
crossed here (gesturing).

Q. Yes.
A. It is very difficult for me to do it. I would then have
my hand here (gesturing).

Q. If one suggested the staff member is behind the child --
A. You would have been behind the child.

Q. -- behind the child --
A. Yes.

Q. -- putting their arms --
A. Yes.

Q. -- right round them in a bear hug type position, if
one can visualise it in that way (gesturing).

A. One could describe it as that, yes.

Q. And then that pins the crossed arms of a child in the crossed position. Is that right?

A. Well, we wouldn't have used the word "pinned". We would have just held.

Q. Well, restricted, kept it in that position. Is that right?

A. Yes.

MS SMITH: LS81, the Inquiry has seen documentation where a former member of staff said that there was an inconsistent approach taken to what he termed restraint and others who say that it was used. We have heard complaint from former residents about its use.

You have also -- I was asking you when we were speaking earlier did you ever see anyone use this holding technique or a different type of technique or use more -- be more physical I suppose with children in trying to restrain them?

A. Not holding, but certainly I did see staff move quickly to time out, and that would have then been a professional discussion with the person and within the professional team with the Charge Nurse and then also with the medical team.

Now what I mean by that is that each child needed
a personal understanding of our care plan. So, for example, time out, often you would actually do a diversionary technique first for a child. So that would give them the message that the behaviour they are engaging in is not an acceptable behaviour and could that be stopped. You possibly would ask -- direct them into another activity or another place so that could de-escalate, or your next option was then to remove the child, you know, to support the child to be in a different place so that they could be calm. That would have been the time out.

What would have happened is occasionally some members of staff would have gone straight to time out, asking the child to leave rather than try the diversionary technique first, and then what you would have done is brought it to that member of staff's attention, brought them back to the care plan, had a discussion with the Charge Nurse, and if any changes were required, then that would be -- that would be made, and certainly I know that that did happen. The changes happened.

Q. Was it your view that maybe some members of staff were too quick to go to time out, as it were, too quick to go there without considering the diversionary option?

A. On occasions there were staff who made -- there were
considered restraint. The theory was that the child was being held to contain self
(self-regulation) and the situation, and helping them learn to self-regulate. All of
the approaches were modified for the individual needs of the particular patient,
how they presented and what their particular challenges were. Holding would
have been to contain for example severe temper tantrums. In physical terms this
would have been a firm but gentle response encouraging calmness and de-
escalation of the situation. This approach would have had particular application
for children that were younger, perhaps up to the age of around 10 years. This
would often translate into the child wanting comfort when calm and or to cuddle in
to the member of staff, and this is where professionalism was extremely
important not to facilitate this behaviour, although support the patient/child to self-
comfort in an appropriate way. As a professional you needed to be mindful to be
providing care within the context of maintaining a professional environment for
the patient/child, preventing confusion or blurring of roles for the
patient/parent/professional. One little boy I had worked with asked me if he could
home with me and I could be his Mummy. This required great professional
sensitivity while providing professional care for this young person.

23. I do not recall ever witnessing restraint been used. I do recollect holding. If there
was a child that was particularly aggressive you might have persuaded them to
remain in another part of the unit that was less dangerous to them. If the child
absconded, for example, they might have been returned by policeman with quite
an outburst by the patient/child on their return. In those occasions you would
often try to use a part of the unit which gave them space in a safe way to de-
escalate their behaviour, while not placing either themselves or others at risk.
The aim was to achieve the point where the child could regulate their own
behaviour.

24. I have also been asked about my memory of sedation being used on patients in
Lissue. Medication was prescribed for patients/children in line with their
presenting condition and was only used as prescribed by the consultant
responsible for the patient/child’s care plan. I am aware that on occasion,
medication that may have had a response of sedation on a patient would have
been prescribed as part of the patient/child care plan.
the older child that would have been taken to another room.

Q. How -- you were describing to me when we were talking earlier how they were taken to the room for time out.

A. Well, again what would you try to do is you would ask the child to come, and if the child wasn't coming, then what would happen is you and the nurse that were working together would have supported the child by holding the arm here and at the back of the upper arm.

Q. So at the top of the arm and lower arm?

A. Yes, but again in an open movement that you were supporting them physically to come with you. What you would find 99% of the time is when you moved to do that, then the child moved without you having to physically touch them.

Q. But on occasions they did have to be physically taken out?

A. Yes.

Q. And we have heard complaints from people that that could be quite physical, that there was a degree of grabbing and pushing and so forth. Did you witness that at all?

A. No, I didn't. If I did, I would have reported it immediately.

Q. Paragraphs 26 and 27, you don't remember the doors ever being locked.
child would be put on the floor and held on the floor?

A. Yes.

Q. And how were they held, LS7?

A. One nurse would hold the two arms out and the other one would hold them by the ankles to prevent them from kicking.

Q. If there were a number of children about, that holding down took place in the dormitory, in the bedroom. Is that right?

A. Yes.

Q. And they were placed on the bed and held on the bed until they calmed down?

A. Yes.

Q. And again having their arms held down and their feet held down?

A. Yes, because they would be struggling.

Q. Yes. I think you were actually explaining to me that on one occasion one -- I think it was a girl, was it, who was kicking so much that her foot was going to come down and hit the end of the bed. Is that --

A. Yes. She was a new child came in. The father brought her in, and he didn't tell her she had come to see the doctor or anything, and after Dr Nelson had spoke to them he left. As soon as he left she went berserk. They had to take her up to the bedroom, and Dr Nelson
was there and he was the one -- one of the ones that
held her down, but she was well-built and she was
struggling, and every time she struggled the legs came
up and she'd put the heel in and she was moving further
down the bed.

The two of them had a busy job holding and bringing
her up again, but she would slide down again, and she
was screaming at the top of her voice, and when they
came up, they came down heavy. I noticed she had come
down to the bottom of the bed. So I went round to the
bottom and when the leg came down, I put my hand out and
her heel came down, and she had the shoes still on, and
the heel came down and hit my hand and jammed it against
the top of the bed.

Dr Nelson asked for LS21 to take over, and he asked
me to go down with him, and he went down and he got
Paraldehyde. I got the syringe and the kidney receiver
and the pieces of gauze and that, and he looked up
a book to see the dosage and he went up and gave her the
injection, and she settled very quickly and was out
sleeping.

Q. You were telling me, LS7, you still have problems with
that hand that was hit after that incident.

A. Yes. Dr Nelson examined it and said there was no bones
broken, but the muscle is affected here and I can't grip
Q. One other thing just in terms of holding children on the beds. We have heard -- I think it might have been in one of the documents -- that someone had said that there were gloves that could be used to restrain children and keep them not actually tied to the bed but some sort of gloves to keep them in the bed. Anything like that you remember?

A. No way. No, there wasn't.

Q. The first person who complained about you, and that's HIA172 and his first name is HIA172, you do remember him.

A. Yes.

Q. At 70078 -- I am just going to go through the various -- not his entire transcript, but just so we can follow this. He speaks about you, and you were telling -- he made an allegation that he had made himself a pair of white shorts from a bed sheet and that you had taken those off and humiliated him. You are saying well, no. There was an episode involving him and sports, but they were black shorts -- a pair of black trousers that he had taken out of the store and cut up and cut too short. He was going to humiliate himself because they were so short was really what you were saying. You spoke to the
Q. So there was quite a lot of mixing between the age groups?
A. Yes.
Q. Presumably that meant that children could observe other children playing up or different --
A. They never played up at the meal tables.
Q. But at other times like during the TV watching or whatever?
A. Oh, yes. The children would walk in front of them and they've had one of the youngsters crying or something like that there.
Q. So you needed always to be on your attention?
A. Uh-huh.
Q. We have heard about and read about clothing used as a restraint.
A. No, no way.
Q. You've no memory of ...?
A. There was no restraints.
Q. Okay. HIA251, who is one of the people we are going to hear from, who was one of the children who went on the roof, when he came back down again, and he did receive sedation, there was then a bit about keeping him in bed and that he would earn his way out of bed again. Do you remember that?
A. No, I don't. LS21 was there at the time. I had just
You went into Lissue wearing your normal clothes and you remember wearing odd pyjamas whilst you were there. You don't know where those clothes came from.

You go on to describe in paragraph 6 how you shared a room with your brother at the start. You were frightened of him. He had behavioural problems and was really violent. He was always trying to break and smash things and trying to escape. You remember that the staff tied his arms in a child's jacket to restrain him.

We were talking earlier, HIA421, and I was asking you if you could describe this jacket to me. So do you feel able to do that or do you want --

A. No. They just -- the jacket itself, to me it was like a mummy's outfit. It looked like a big bandage twisted round. That's the way I seen it then. So now I know it was a straitjacket, but then to me it was just them ones tying him up to keep him from -- his arms -- he couldn't use his arms, and they were able to lift him, like, from the back like cattle, you know, and hold him like above, you know, the floor and remove him from the situations, you know.

Q. Yes. He wasn't that much difference in age to you.

Isn't that right?

A. I think he's about two or three years older than me.

Q. I will just double check that. He, in fact, would have
Lissue House (1976)

5. I remember my first day in Lissue. I was brought into a big building with massive doors and a long corridor. At the time I didn’t know what Lissue was but it felt like a hospital. I remember the staff ushered LS 17 and me away while my mother went down the corridor and left us. I cannot remember how long I stayed in Lissue but I do remember it was a horrible place. It was very strict and there was no care or affection from the staff. I remember lots of children crying and screaming all the time. It seemed like nobody cared that the children were unhappy. It was a cold and frightening place. I went into Lissue wearing my normal clothes and I remember wearing odd pyjamas whilst I was in there. I don’t know where the clothes came from.

6. I shared a room with LS 17 at the start. I was frightened by [REDACTED]. He had behavioural problems and was really violent. He was always trying to break and smash things, and trying to escape. I remember the staff tied LS 17 arms in a child’s jacket to restrain him. He would kick out and scream hysterically. He would also thump me and take his anger out on me. I don’t understand why I wasn’t protected from him. I cannot recall how long I shared a room with LS 17 before I was moved to single room.

7. The staff were very physical and rough. They pulled me by my arms and my hair and trailed me down the stairs. I was shoved, dragged, and thrown into my room and locked in on several occasions. It was an awful place to be in. I saw children being dragged along the floor by their arms into their rooms and being restrained. I found it upsetting because I did not know why I was there. I remember on one occasion a staff member pulled me by my neck. I cannot recall if they were female or male. I cannot recall what the staff looked like. I don’t know if it was because I was young or if it’s because I was in Lissue for a short time. I just remember the feeling of being scared and wanting to go home.

8. I wet my bed from when I was really young and I constantly wet my bed in Lissue. The staff refused to change my bed sheets. I would be left wearing the same wet underwear for days. It was sore and when I complained about it the
why I was in Lissue. It felt like I was in one minute and the next minute I remember being in a room at Lissue which had big green plastic chairs in it. I think I was admitted twice to Lissue Hospital, for a period of a few months each, between 1985 and 1986.

4. I don’t remember much of my time in Lissue because I spent the majority of my time strapped to a bed. I remember the medical officers strapping me to a bed on several occasions and going out cold. They gave me injections. I could have been under for days and in that time I don’t know what they were doing to me. There was a large mirror in my room and I must have been observed by the medical officers. I was given injections regularly and I do not know how long I was sedated for. That’s how I remember my time in Lissue. I would like to know what injections they gave me to put me out. I feel the injections had a negative impact on my life.

5. I also remember there was another room with lots of cameras in it and they took videos of us playing. There were toys and a sand pit in the room. My step-father[redacted] told me once he remembers that room. He thought it was abnormal. My mother and[redacted] went up to Lissue for an interview once. I think it was an interview about me being allowed home for weekend visits and they recorded that interview.

6. I was kept in a room by myself and was very rarely allowed out to mix with the other children. I can visualise the corridors but I cannot remember where the rooms where as I was kept in my room most of the time. I know the staff office was right beside me so they could observe me. The door was always kept open and I could see out. I remember a boy and girl who were brother and sister. They used to live up the[redacted] in[redacted]. On one occasion I remember looking out of my room and seeing the girl being followed into a room one day by a member of staff. This particular man was small with dark hair and he was horrible. He walked up the corridor after her and he followed her into one of the dormitories. I always wondered what happened to that girl.
7. The other thing I remember about the boy and the girl is that they had a big meccano set and they used to build cars and motorbikes out of them. They loved it. I remember on one day this same member of staff was walking down the corridor and he kicked the motorbike to smithereens when we were playing with it. I was very upset and they took me back to my room and strapped me to my bed again. After about twenty minutes, my next memory was waking up in bed the next morning.

8. That same member of staff hit me on several occasions also. He would ask me if I wanted a cigarette and when he gave me one he would say “Do you want a light”, and when I said yes, he would hit me on the face or head. It was like he was playing mind games with me.

9. I also recall a man who came to the window in my room in the evenings. I think there was a fire escape outside my room. The window hatch was opened slightly and he use to knock and slip cigarettes under the hatch. I don’t know who the man was. He was [REDACTED] The staff at Lissue thought I made this man up. I know I didn’t because I remember looking forward to getting a cigarette in the evening and a bit of conversation.

10. I don’t recall any particular routine at Lissue. I have no memory of attending school during my time there or being taught school lessons. There was a cookery class and we used to make buns during it. I also remember a teacher taking our photographs with instant cameras.

11. I remember that as a punishment the staff would put me in a room with children who were severely disabled. I know I had behavioural issues but I was not disabled. The staff would make me sit with these children for hours and I could not understand why. I thought that they were playing mind-games with me and were punishing me in some way. These children had special red chairs with sheepskin padding and I remember these chairs very clearly. My mother came to see me regularly when I was at Lissue and when she saw I was sitting with these children she couldn’t understand why. I think it upset
A. No.

Q. Certainly they believe that you would not have been restrained in the way that they (sic) are describing, but you do remember being strapped down?

A. Aye, but sure nobody is going to turn round and tell you they were hitting kids who were there.

Q. Sorry, HIA251. I didn't ...

A. No one is going to turn round and say they hit kids, do they?

Q. Treatment plans after you were readmitted show you were restricted because of absconding. We will look at some of those also.

If we can go back to your own statement, HIA251, at paragraph 5 you also say that you remember:

"There was a room with lots of cameras in it and they took videos of us playing. There were toys and a sandpit in the room."

You remember your stepfather once told you that he remembered that room. He thought it was abnormal. Your mother and he went to Lissue for an interview once and you think it was an interview about you being allowed home for weekend visits and that that interview was recorded.

Now we certainly know, and as I was explaining to you, that family therapy sessions were often
"The Board -- the records regarding ..."

Sorry.

"There are no mentions in the records of straps being utilised to achieve this but rather constant supervision."

That's about restraining you in bed:

"The Board does not believe that this method of restraint was likely to have been employed in this case. The Board -- it is known, however, that restraints, including gloves, which could be attached to beds and bedding, were used in very particular circumstances with very disturbed children. This would have been in cases where children may have tried to harm themselves or remove clothing and this method was employed to try and prevent them from doing further damage to themselves."

Now I am highlighting that not so much in response to what happened to you, HIA251. Do you remember gloves being used to restrain you on the bed or anything like that?

A. No. I was strapped to the bed, like.

Q. You were strapped to the bed?

A. Aye, strapped to the bed. So I don't know what they're talking about saying that.

Q. But it wasn't with gloves? But it wasn't with gloves or anything like that?
A. No.

Q. Certainly they believe that you would not have been restrained in the way that they (sic) are describing, but you do remember being strapped down?

A. Aye, but sure nobody is going to turn round and tell you they were hitting kids who were there.

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Now we certainly know, and as I was explaining to you, that family therapy sessions were often
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
speaking necessary. That comes back to the different approaches of staff.

A. Well, the different approaches of staff -- I mean, if you have got -- I think you have had LS21 talking. He would have been somebody who would have been much more able to talk to children when they would look as if they are getting into an out of control situation and maybe through that would have avoided it. There are other members of staff who are not as good as that and the situation blows and they get involved in a full restraint.

Now you could say that's inappropriate in the fact that some staff members need to improve their skills in being able to talk children down, I mean, and that's the -- I suppose that was the realistic mix of staff over time.

Q. I think just to be -- to descend into personalities, you would say that LS7 went straight to a management situation.

A. Would be more inclined -- I would have viewed more inclined to go straight to a management situation than take a long time -- not a long time -- you don't want to take too long -- just attempting to give the child the options to cool down, as it were.

Q. The use of time out. We have had -- I mean, again the
restraint in the files of 6 patients, 2 of which related to admissions to the Child Psychiatry Unit at Lissue Hospital. In respect of the patients analysed:

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

72. As regards the examples of restraint in Lissue, it is documented as having occurred in the following circumstances:

a. “her behaviour was unreasonable yesterday”;
b. “verbally abusive and non-compliant and restrained by staff as she was losing control”;
c. “would not settle despite being given several chances to do so and eventually had to be physically restrained”;
d. “had to be restrained by clothing due to aggressive self abuse and injury to others”;
e. “restrained for his own safety and that of staff and peers”;
f. “got aggressive to staff and became a danger to himself and others”;
g. “became physically aggressive to [..] eventually had to be restrained and put to bed”.

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

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

c) By whom?
75. The examples documented indicate involvement of nursing staff in physically restraining the children.

d) How was it recorded?

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

e) To whom was it reported?

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

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

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

79. The Board offers the following examples:
   a. Keeping a child diagnosed with anorexia confined to bed;
   b. Time out for children where it was felt that they need to be removed to reduce aggression or hostility;
that it may be the roof incident that the Applicant is referring to. On 30 May 1986 it is recorded that the Applicant went onto the roof once more, see Exhibit 21. On receiving this information, it is recorded that staff immediately put into place the guidelines recommended by Dr McAuley in Exhibit 18 above. After three hours, the Applicant was brought down from the roof after which he ran away across the fields. Staff members gave chase and were able to apprehend him and he was brought back to the Unit. On return to the Unit, Exhibit 18 records that the Applicant was put to bed and given 20mgs of Diazepam intramuscularly. The Applicant was subsequently constantly supervised and the behaviour programme noted above was reinstated in order to allow the Applicant to earn his way out of his bed. The records regarding reprimand for the roof incident often concern the Applicant being put to bed and earning his way out of bed, see Exhibits 19 and 21 above. There are no mentions in the records of straps being utilised to achieve this but rather constant supervision. The Board does not believe that this method of restraint was likely to have been employed in this case. The Board does not believe that this method of restraint was likely to have been employed in this case. It is known however that restraints, including gloves which could be attached to beds and bedding, were used in very particular circumstances with very disturbed children. This would have been in cases where children may have tried to harm themselves, or remove clothing and this method was employed to try and prevent them doing further damage to themselves.

14. In a separate record of 30 May 1986, Dr McAuley is recorded as stating that the child was being given a tranquiliser to relieve nursing pressures and not as a punishment for being on the roof, see Exhibit 22. He also requested that nursing staff were not to be negative towards the Applicant. The Board notes that Lissue staff are then recorded as saying that they were not negative towards the Applicant but that other disciplines had done nothing regarding arranging contact between the Applicant and his parents as they had promised and that the child had little to look forward to. The Applicant was subsequently given two more injections of valium, see Exhibit 23.

15. In paragraph 10 of his statement, the Applicant says that he has no memory of attending school in Lissue although he does recall cookery classes. Exhibit 24,
NURSING POLICY ON BEHAVIOUR MODIFICATION

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

Objective

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

Policy

1. Before commencing behaviour modification the Directors of Nursing Services together with the local Nurse Managers Group should establish the parameters within which all programmes should operate.

2. The Assistant Director of Nursing Services or Nursing Officer responsible for the Unit should be the principal nursing input into the Multidisciplinary Clinical Team, thus ensuring good communication and liaison.

3. In no circumstances should a patient be deprived of his/her basic needs nor should his/her dignity be diminished. Positive and negative reinforcers should in no way impinge on the patient's human rights or dignity.

4. The consent of the patient and/or relative must be sought and a full explanation of the care programme and its implications given.

5. The care programme must be clearly defined for each individual and the nursing staff in the ward be fully conversant with the programme.

6. 'Time Out' is an important part of the therapy and is a break from the treatment programme. It does not mean "seclusion" in a secure room.

7. It is essential that detailed nursing records of behaviour modification programmes are kept for all patients involved.

December 1986
0181D

[Signature]
NURSING POLICY ON SECLUSION

Objective: To differentiate between 'time out' and 'seclusion', to ensure that Nurses are fully aware of the action to be taken when seclusion is used, and to ensure that the patients' rights are protected at all times.

Definitions: For the purposes of this policy 'seclusion' is defined as the social isolation of a patient in a locked room, on his/her own which he/she is unable to leave of their own volition.

'Time out' is defined as a break from the treatment programme.

Policy

1. Seclusion must only be used in instances of prolonged uncontrollable agressive or violent behaviour where the patient is a danger to himself or others.

2. There are a small number of patients with established disturbed behaviour patterns where such outbursts can be anticipated. When these indicators are present it is necessary that alternative nursing action is taken before seclusion is considered.

3. A full description of the behaviour preceding seclusion must be recorded by the Nurse in charge of the Ward or Department. This record also requires the observations of the Assistant Director of Nursing Services/or Nursing Officer and the format agreed locally.

4. A patient may not be secluded unless this has been agreed by the relevant Doctor and this recorded in the patients case notes.

5. On each subsequent occasion when seclusion becomes necessary the Assistant Director of Nursing Services/Nursing Officer on duty and the relevant Doctor must be notified without delay and a procedure for this developed locally.

6. Nursing records must give full details of the seclusion period/periods and the Nurses' observations.

7. Accommodation used for seclusion must ensure adequate observation of the patient at all times.

8. The patient must be removed from the seclusion for a minimum of five minutes in each one hour period.

9. All incidents requiring seclusion should be regularly reviewed by the Directors of Nursing Services with senior nursing staff and detailed guides developed locally.

December 1986
0181

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

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

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

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

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

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

There are a number of simple guidelines for the use of time-out. The first involves the actual place selected. This should be a place which is reasonably non-reinforcing and which is not associated with any positive form of reinforcement - for example time-out in a corridor may be ineffective because other passing persons may provide the child with a source of amusement or attention. Bedrooms will only be ideal if they are devoid of enjoyable activities. Also in the selection of a place one wants to give some consideration to potential destructive behaviours, that some children might exhibit. If the child is likely to kick or throw things around then the place selected for time-out should be one where such behaviours, are not only less likely (because there isn't much to destroy or throw) but also are of least concern to parents (perhaps because they are not as concerned about the paintwork in the area). Next is the duration of time out. In most young children short durations of approximately five minutes are quite appropriate. However in general the duration should not begin until the child is reasonably quiet. Once time-out has been completed then the child should be released. There is no excuse for extending the time or forgetting that the child is in time-out. Finally the implementation and handling of behaviours during time-out needs attention. When a rule has been violated or a behaviour which warrants time-out has been exhibited, then the time-out should be applied efficiently and with a minimum of fuss. A statement of the infringement should be made to the child, and then he should be asked to go to time-out. If he refuses he should be taken. If he refuses to remain in time-out then he should be restrained there physically (not only providing that this is feasible). The overall effort should be aimed at the child sitting (or standing) quietly on his own without restriction and also with the adult applying the time-out remaining at distance from the time-out. As mentioned above the time-out does not begin until the state of affairs has been reached. If it is reached and disrupted further then the time resumes once again. Time-out only ends when the supervising adult decides that the requirements have been met. Right throughout the period of implementation to end, all other behaviours should be ignored. There should be no arguing or debating with the child. It is particularly important to avoid all manipulative efforts by the child to frustrate the application. Children quite naturally will pull every “ploy under the sun” in order to disrupt the process. On some occasions they will show automatic obedience and on others they will simply refuse to leave time-out at its end - these all should be ignored. Perhaps the only circumstance which might be handled differently relates to requests to go to the toilet. In this case the child can be taken but is immediately returned to time-out after toileting.
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.
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
29. The Applicant also states at paragraph 9 that one of ways of being punished was by being put in “time out”. As highlighted in the Board’s overview statement an accepted form of discipline within the context of behaviour modification was to implement at time out for children where it was felt it was needed to remove or reduce aggression. Guidance identified regarding “time out” and which is referenced by the Board in its overview statement at paragraph 25 states with regard to the recommended duration of “time out” that in most young children durations of approximately 5 minutes would be appropriate; that in general the time should not start until the child is reasonably quiet and that there is no excuse for extending the time or forgetting the child in in time out.

30. The Applicant goes on to state that during periods of time out you could be left for quite a long time … “for the rest of the day or until the next meal time”. From a review of the Applicant’s records during his period of admission to Lissue, the Board believe that in addition to “time out” the Applicant may have on occasion been subject some form of seclusion or isolation. A Fortnightly nursing summary dated 17th May 1985 and exhibited at exhibit 25, states that the Applicant “has spent much of his time on one to one basis and has been kept in isolation most of the time”.

31. A school behavioural report for the period ending 7th June 1985 states the Applicant has only been in class very briefly over past two weeks, see Exhibit 34. Whilst the period of the Applicants admission pre-dates a policy identified by the Board in relation to the use of Seclusion as referred to at paragraph 25 of its overview statement, the Board accepts such practices may have been used in Lissue.

32. The Applicant references going up to the medication room and being given medication at various time. The records confirm that at various times throughout his admissions, the Applicant had been on different oral medications. During his period of admission in 1981, it is recorded that the Applicant was placed on a trial of “Ritalin”, see Exhibit 35. A prescription of Mellioran is recorded during his admission in 1982 see Exhibit 36.
suggestion was that it should be a minute for every year of the age of the child, but other people have said it was not quite that prescriptive.

A. Yes. No. I mean, the basic thing about time out is with, say -- and this is just a rule of thumb -- would be in children of 5 or 6 the time out begins when the child is standing or sitting quietly and then it's just two/three minutes. In fact, you keep it as short as you can, because you don't want to create problems for yourself.

Q. Uh-huh.

A. With older children, 10 and 11, maybe five, ten minutes.

Q. But never as long as forty-five minutes or --

A. That's ridiculous, because that's a waste of time. It is an utter waste of time.

Q. It would be counter-productive essentially?

A. The only difference, that sometimes children were very smart and would say, "Well, I am staying here". You just let them get on with it and go and say, "You can come out when you want".

Q. One other thing I hadn't discussed with you and ought to have done before you came in is the issue of medication and the prescription of medication --

A. Uh-huh.

Q. -- and how much discretion nursing staff might have had
environment and what might happen is the child might begin to behave challengingly again. You might have asked them to be calm and it might be that you take them to the room for a few minutes for calm, but it wouldn't have been that you were establishing time out, but I would understand that a child might think that you are taking them back into time out.

Now that may have taken five, maybe ten, more minutes just to say an explanation and then to see if they could put in words what was it about the social environment that you took them back to that started the process off again of being angry, but it wouldn't have been another time out.

Q. You used the expression "prescribed period". Was there a prescribed period of fifteen minutes as the maximum or ...

A. No, no, no. The prescription was one minute per age or year. So if I was 2, it would be two minutes. If I was 5, it was five minutes. If I was 10, it was ten minutes. If I was 13, it was thirteen minutes.

Q. I see.

A. And the idea was that you had a little bit of time but not too much time just to calm down. "De-escalate" is the term that would have been used in the training.

Q. And then there may have been in the eyes of the child
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.
1 having a child stuck in the corner when he's settled.
2 It's only while the screaming, shouting, cursing passes
3 and back.
4 Q. Well, from recollection, LS21, can you say what kind of
5 period of time we might be talking about on average that
6 it might have taken for a child to calm?
7 A. Yes. The rule of thumb was five to ten minute.
8 Anything excess of that was regarded as unnecessary.
9 Our advice would have been a couple of minutes until
10 things settle, the message being, "We can't tolerate
11 that uncontrolled behaviour anymore. So when you
12 settle, it's over" and that -- those words, "When you've
13 settled, it's all over".
14 Q. Generally it was an effective means of --
15 A. Oh, yes.
16 Q. -- defusing the situation?
17 A. Oh, yes. It was all we had and we used it effectively.
18 Q. You also talk in your statement about the reward system
19 that operated --
20 A. Yes.
21 Q. -- the point system. Now it wasn't a general reward
22 system that operated for every child.
23 A. No, no.
24 Q. It was only for certain children.
25 A. Those children who found it not to their advantage to be
assessment and adjust the medication, if they thought in their judgement it was correct to do so.

12. I have had an opportunity to consider the statements and interviews given by 3 complainants, who allege wrong behaviour on my part. I refute all and every such allegation from the most minor, to the most serious.

Pertaining to any allegations of misconduct on my part, I respond as follows:

(a) The medication [being Ritalin and Largactil] was prescribed by the medical staff in line with their experience as to the selection or dosage. These were matters for the doctors though I saw nothing that would have indicated to me in my experience that their choices were anything other than proper. Some major drugs in fact had to be signed as received by two nurses when delivered by the porters from the pharmacy at Lagan Valley Hospital. Nurses had no ambit of discretion in the administration of medication. This was a matter of clinical judgment by the doctors.

(b) As regards the smoking of cigarettes, this was actively discouraged and all cigarettes were put in the bin if any were smuggled into the unit. I recall one occasion, a father suggesting that his daughter's behaviour was improved by smoking cigarettes and the unit agreed that she would be allowed to smoke but this was never compulsory, quite the contrary. We would have preferred if she did not smoke. I strongly disagreed with the view that any minor should be given cigarettes. I never allowed my children or my grandchildren to smoke.

(c) Our method of trying to create an orderly atmosphere was that if a child was beginning to lose his or her temper, or behave in a manner that was disruptive then they would be invited in reasonably firm terms to stand facing a corner. That is entirely correct and true and it worked in the most instances as standing facing a corner for 3 minutes does have a calming, and
salutary effect upon a child. The second stage of that strategy, if the first failed to produce calm, then the child, would be taken by 2 members of staff in an established planned method to his/her room and placed upon their bed. They would not be stripped of their clothing and would be told that they would return upon amendment of their behaviour. I was trained in restraint techniques at that time and these would have been used if the situation required it for the safety of the child in question, the other children and the staff members, but a child would not have been struck by me or nor was a child struck in my presence. Equally children’s hair was not pulled, nor were they nipped. I disagree entirely with any suggestion by any witness that this behaviour took place either through me, or by any of my colleagues; (d) I did not have any specific animosity towards [HIA 38]. I found all the children that we worked with to be engaging to varying extents and almost all save one were capable of engendering affection and warmth from me and from my colleagues. That boy [who I will name to the Inquiry if asked] was a vicious deceitful bully who wound other children up to misbehave and stood back then to witness the after effects; (e) I did not take blood in a manner set out at paragraph 17, nor use the language suggested. I dislike the use of swear words and would not use them myself; (f) Equally I did not grab a child by the scruff of the neck and shove any child into its room, rather that a child would be restrained in the proscribed manner to remove that child from causing further disruption, upset and spreading his or her behaviour among the other children which was unsettling for the entire unit. No children were abused and any squealing was out-with my experience. I do not believe it happened; (g) Parents were treated respectfully. We tried were we could to explain our various strategies to both parents of the in-patients and the day patients. Some parents took some time to understand the ideas that were co-ordinated by the medical/ nursing staff to the benefit of their children. For example, I do recall a mother objecting to our strategy where her child would lie immobile on a bed. In order to get that child to mobilise and toilet herself, we
15. I went back to [redacted] during holiday periods and I would stay at my Auntie's house in [redacted] at weekends. I had stayed with my Aunt shortly before one of my visits to [redacted] and she gave me cigarettes to take to my parents. A [redacted] called [redacted] took me to his house in Lisburn and put me under enormous pressure to give him the cigarettes. They were not my cigarettes to give and my Dad would have been very angry if I had no cigarettes to give him. I thought it was very inappropriate to ask me for them and to put me under pressure to hand them over.

16. I remember my mum coming over from [redacted] to visit me. I knew she was coming and the thought of having her back again made me quite rebellious to the staff. I climbed out the bedroom window one night and was running around the grounds in my bare feet. I climbed in the kitchen window as I was hungry. I was about to climb back out the window with a tin of biscuits when one of the [redacted] found me. She said to me to come on and go back to bed. Just as I was climbing down to go with her [redacted] burst in to the room, grabbed me by the hair and dragged me down the long corridors and up a flight of stairs back to my room. He flung me in to my room and my head bounced off the window sill. I was left with a large bump on my head. My mother visited me the following day and I told her what had happened. [redacted] denied hurting me and told her that I did it to myself. My mother did not have the strength to stand up to them and people in authority do not admit when they are wrong.

17. Eventually my mum left my dad and moved back to Northern Ireland. Lissue became normal to me and going home to my family felt weird. It should have been the other way around. When I was at home I had a room to myself and was not told what to do. It was impossible for me to relate to normal everyday life because I was not used to it. The emotional effects of Lissue have had a deep affect on me. I live in constant fear of the consequences of making a mistake and expect to be beaten and punished when I do.

18. Lissue was a horrible place but there was a [redacted] called [redacted] who made the place much easier. Even when [redacted] was being strict and punishing you by
putting you in timeout she was fair and did what she said. If she told me I was going to my room for five minutes then I was put there for five minutes. I respected her and she was kind. Although some of the staff were kind I find it difficult to understand how they were able to stand back and allow horrible things to happen to me. I thought that any act of kindness was so wonderful but I realise that that is just normal.

19. Feeling alone and being separated from my family was punishment enough without being in a harsh, unfair environment.

20. I was not properly discharged from Lissie as I ran away a few days before I was due to leave and was not sent back. I spent a few months at home with my mum. I attended the Jaffa Centre where the staff were good people who had a lot of time for the children. My mother could not cope so I was moved to Rathgael.

**Rathgael Training School, Bangor (22/05/1986 to 30/01/1990)**

21. I was admitted to Rathgael in the summer of 1986 on a place of safety order. I was placed in house 5 which is the reception unit on the young offenders’ side as there was no room on the care side. The **were RG 50**

**RG 51** On arrival in house 5 I was told to have a shower and when I was dried there was a uniform waiting for me. I have no idea what happened to my old clothes. I was handed a mop and bucket and told to clean the bathroom. That was my introduction to child labour. All the unskilled labour was delegated to the children who were then assaulted if they did not do it. Everyone in house 5 wore outdated, humiliating clothes. The clothes were all similar and felt like a prison uniform. I already felt like I was an oddball and did not like being made to wear clothes which marked me out. When we were in Bangor we were easily identifiable as being from Rathgael as we were in our “uniform”.

22. Within four days of being admitted to Rathgael I had been beaten and left with a black eye. At breakfast I complained that someone had spat in my cereal **told me to shut up and eat it. I said no**.
call home was 750 points or a trip to the swimming pool required 1050 points. I remember getting to swimming pool once. It would have been very difficult for a child to get 750 points because a lot of them were more rebellious than me. I also remember Miss World visited the children in Lissie one time and the Army use to visit on a weeknight and brought movies to watch in the TV room. I think they were from Thiepval Barracks in Lisburn.

17. If you were caught misbehaving the nurses made you stand in the corner facing the wall. One time I was thrown into the cupboard and locked in the dark. I do not know how long I was in there for. I hated the dark. Whenever I was at home my mum kept my bedroom door open and landing light on because I hated the dark.

18. I ran away once with [LS 29] who was a few years older than me, [LS 29] suggested the plan to me and it was shortly after the sexual abuse I suffered from [LS 27], [LS 26] and [LS 27]. I was delighted with the plan and wanted to get away from Lissie. It was around Spring time and we waited until everyone was in the dining area eating supper. We then left through the play area at the back of the classrooms. We crossed a stream and came to a railway track that ran in front of Lissie Hospital. We were heading along the railway track when the [LS 21] and [LS 27] caught up with us. They grabbed us and put us in the back of a car and took us back to the hospital. They separated us and I do not know what torture they did to [LS 29] that night. They put me in a bath of ice cubes and then threw me into bed while I was still soaking wet and freezing. The next day my bed was totally soaking. I do not know if it was because I wet myself that night or because I was soaking wet when I went to bed. When I look back on my experiences in Lissie Hospital, I often think Lissie should have been a place of safekeeping for children but I was not safe there. I do not think the other children were safe within Lissie either. I remember [LS 30] tried to escape Lissie one time. He kicked the wooden panel of an emergency exit door to try to get out but failed.

19. I did have some talking therapy with Dr Manwell at Lissie. He came to visit me in Lissie but I honestly do not remember any other type of therapy in
Q. But it wasn't a case of treatment or therapy? This was just a meeting where you could sort of say things like, "Why am I here?"

A. No. It was supposed to be that kind of room, but I remember they were recording in the room. There was a big like an easel kind of thing with a camera on top of it. That was in the room every time you went into 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 people. They weren't -- you know when you can approach somebody when they're warm and friendly and, like, their 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.

Q. I mean, I think the words you used to me were that you...
staff would drag me into the bathroom and throw me into the bath. I was bathed in cold water with disinfectant. It smelt like something a cleaner would mop the floors with. I remember my skin was roaring red when they washed and scrubbed me down. It was very sore. After my bath I would be left standing freezing with no towel. This happened frequently because I was a constant bed wetter. I had to sleep on the floor quite a lot when my bed was wet. The sheets were never changed and it smelt appalling. I could not sleep properly and I found it hard to cope during the day because I was so tired.

9. I also found it difficult to eat in Lissue. If I refused to eat my meals the staff would leave the food sitting until it was eaten the next day. It could have been sitting for a day or more. Sometimes when I was so hungry I would eat it. Some of the food did not taste good. I remember getting cereal or toast in the mornings and potatoes for dinner. Morning times were mayhem. I remember children screaming and banging at the table.

10. I remember sitting in a group room where I used to stare out the window. I never interacted or bonded with anyone. The children were not allowed to talk and communication was not encouraged. I cannot recall any specific staff members. I just remember them all as unkind and uncaring. I had no one to talk to about my bed wetting. I had blisters from wetting the bed and I was never given any cream to soothe my sores. I felt I was being locked up in a dungeon because I was strange or because I had upset people or because nobody cared. It was like a nightmare. My mother did not visit me and I don’t know how long I was in Lissue for. After Lissue, I just remember living back home with my mother, my brothers and my sisters again.

11. My life went from one extreme to another after I left Lissue. When I was back in my mother’s care, we lived in LS 17 on the LS 17, where I suffered horrific physical and sexual abuse. My brother LS 17 was in and out of care and he was sexually abused by Father Brendan Smyth. When he was at home, he and his friends sexually abused me and my sisters. I was approximately 6 or 7 years old when the sexual abuse started. LS 17 was approximately 8 or 9 years old. My mother also allowed her boyfriends, and married men, to come in
taught My hair had grown quite long because no one had cut it and she made me wear a girl's hairclip which I found humiliating.

9. Certain members of staff were great and others were quite fearsome. There were three types of people working in Lissance: the gentle and kind people, the neutral people and then the vicious people. The latter were bullies who seemed determined to humiliate and punish at every opportunity as they were disinterested in the children. [LS 5] was a member of staff who would grab me by the ear. There was no humanity in the care they provided and I was deprived of any motherly love. One of the ways we were punished was by being put in timeout and you could be left for quite a long time. I think some of the staff over used timeout so they did not have to deal with us. Sometimes they would strip you and put you into bed. You could be left for the rest of the day or until the next meal time. If you resisted you were manhandled. If you fell asleep because you had been left for so long and then couldn’t sleep that night you were punished again for not going to sleep. The boredom and frustration that resulted from being stuck in a room made me hallucinate. I remember looking at the curtains and the images on the curtains melted and changed in to faces. I used to wonder whether the hallucinations were caused by boredom or just the medication that they gave me. I remember going up to the medicine room and being given medication at various times. I remember being fed ice-cream by a member of staff. I was on my own and it was not at a meal time. I believe that the ice-cream was laced with something as it was gritty and tasted of ash. I was told that the ice-cream was pistachio but I do not believe that such an exotic flavour would have been offered to me. I was always paranoid that the staff were doing things to me and then laughing about it.

10. On one occasion I locked myself in to the observation room. The staff eventually talked me round and I let them in. When I was opening the door they threw water over me, pinned me to the floor and knocked me out. They pulled my pants down and gave me an injection.

11. On one occasion my mother saw one of the nurses lashing out at me. I think I had kicked the nurse and she pinned me down saying “you little bastard”. I
Q. -- is obviously an issue as well, but what is in the material is that when we get to this point in May-June 1985 --

A. Uh-huh.

Q. -- steps are taken through a card system of reward and privilege and then subsequently a suicide card system that would see you receiving effectively one-to-one supervision and -- whatever the right term for it is -- being separated from the rest of the group for prolonged periods of time. So there would be some group time and it would work well according to the records for a short time before deteriorating, but you would spend a lot of time isolated, as it were, one-to-one with a staff member.

Now you were saying to me you don't remember that process essentially at this remove.

A. I think I can remember on occasions being put in my room and a member of staff sitting outside or in the doorway itself in a chair communicating with other nurses that were passing or would sit with them, but whenever -- the way you quote it in the document it sounds like I am getting some sort of one-to-one personal treatment -- "Let's go to the park and play, HIA172" -- when that wasn't the case.

I was essentially being punished, but I was being
punished where I was on observations -- "obs" I suppose
would be the term used -- where I am in bed and you are
staying there. I am on time out, full time out. It
wasn't one-to-one. That sounds like, you know, they are
giving me special support, you know, where I can freely
move, but I will have a member of staff there with me
supporting me along the way to make sure I don't get
into any mischief when it was no, no, no. So you are
left in your room and a member of staff sitting by the
door to make sure you do nothing.

Q. You know I was discussing with you earlier that may well
be exactly what they say they were doing and your
perception of it is different from theirs.

A. Well, I'm thinking about other people's perception of it
and I just want to clarify that.

Q. This is -- obviously the Panel will be able to ask
Dr McAuley, but it seems that as part of the way of
managing the escalation of behaviour one-to-one tasking
was engaged in --

A. Yes.

Q. -- and separation from the rest of the group.

A. Isolation, time out. It's the same thing.

Q. The two other matters that you talk about in the same
section of the statement, you mention -- and I am going
to deal with this very briefly -- sitting on the toilet
and being made sit on the toilet for hours even if you didn't need to.

A. Yes.

Q. I was discussing with you that, having gone through the material, there clearly was a medical issue --

A. Yes.

Q. -- when you first --

A. I had regularly soiled myself whenever I was -- this was maybe during my early period in Lissue.

Q. Yes.

A. And I remember being left to sit on the toilet and there was no staff about. It was just, "You stay there" and they came back later, and if I had moved from the toilet, I would have been punished.

Q. Well, what I am saying to you, HIA172, is the records show that a behavioural treatment plan to assist with toileting --

A. Uh-huh.

Q. -- that seemed to be a problem before you came into Lissue --

A. Uh-huh.

Q. -- was engaged in, and in fairness to the staff in Lissue you would agree it ultimately was effective.

A. Yes. I wouldn't -- I wouldn't contradict the effectiveness of it. What I am saying is that the
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 [blurred] doctor.

HIA 38
A. No. It looked unusual. You know, that didn't happen, you know. Like if there was anybody being on their own, that would have been me on my own with a member of staff, but it never happened to anybody else as far as I was aware.

Q. You didn't --

A. That's why it stuck in my head.

Q. Because this was something that was out of the ordinary?

A. Aye. What was he doing with her on his own, because you never seen that.

Q. Well, the records that we've looked at -- and I'm just going to look at -- I looked at some of these with you -- I will just give the page references -- show that you had a strong friendship with another boy. I will give his full name, but I'll just remind people that names are not allowed to be used outside of this chamber. That was a boy called LS65. You have no memory of him?

A. No.

Q. It shows that you took part in group time, that you played games and watched television and that you went swimming on one occasion. The reference to that is at LIS613. I don't think we need to call it up, because I looked at it with you, HIA251. You have no recollection of ever going swimming?

A. No.
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.
119. The Board believes that there was nursing supervision at night in Lissue as was the case in any other hospital.

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

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

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

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

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

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

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

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

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

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

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

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

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

Q21. The Inquiry is aware that a television documentary was made in relation to Lissue, please provide a copy of same.
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 de-escalated. 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.
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 staff were LS 1, LS 2, LS 3, and LS 4. The staff were all professionals and I do not have any complaints about the school apart from LS 4 who...
NURSING CARE PLAN

FORTNIGHTLY SUMMARY

Name: HIA 172      Date: 17th May, 1985

Consultant: 

PEER INTERACTION

Appropriate Interactions

During this period has been almost non-existent

Inappropriate Interactions

Other than to banter, HIA 172 niggles and is rough physically and verbally to other peers. He seemingly cannot interact at all.

INTERACTION WITH STAFF

Appropriate Interactions

Unless staff are being very tolerant and ignoring all HIA 172 unacceptable behaviours, he is being allowed to have his own way in all aspects, this is nil.

Inappropriate Interactions

Physically abusive at times, constantly abusive verbally to most members of staff. Cheeky and defiant, regardless of his mood.

Conversational Content

During this assessment period, conversation consisted of speaking about parents in blank and expressing derogatory remarks about staff and fellow peers.

GENERAL BEHAVIOUR

Attention and Concentration

Due to his over-activity this fortnight, HIA 172 has been very easily distracted, attention and concentration level is very very poor.

Participation - Group Activities

Has spent much time on a one to one basis and has been kept in isolation most of the time. But when he was on group activity, HIA 172 participates very well, for a short time only.
why I was in Lissue. It felt like I was in one minute and the next minute I remember being in a room at Lissue which had big green plastic chairs in it. I think I was admitted twice to Lissue Hospital, for a period of a few months each, between 1985 and 1986.

4. I don’t remember much of my time in Lissue because I spent the majority of my time strapped to a bed. I remember the medical officers strapping me to a bed on several occasions and going out cold. They gave me injections. I could have been under for days and in that time I don’t know what they were doing to me. There was a large mirror in my room and I must have been observed by the medical officers. I was given injections regularly and I do not know how long I was sedated for. That’s how I remember my time in Lissue. I would like to know what injections they gave me to put me out. I feel the injections had a negative impact on my life.

5. I also remember there was another room with lots of cameras in it and they took videos of us playing. There were toys and a sand pit in the room. My step-father told me once he remembers that room. He thought it was abnormal. My mother and went up to Lissue for an interview once. I think it was an interview about me being allowed home for weekend visits and they recorded that interview.

6. I was kept in a room by myself and was very rarely allowed out to mix with the other children. I can visualise the corridors but I cannot remember where the rooms were as I was kept in my room most of the time. I know the staff office was right beside me so they could observe me. The door was always kept open and I could see out. I remember a boy and girl who were brother and sister. They used to live up by the in Lissue. On one occasion I remember looking out of my room and seeing the girl being followed into a room one day by a member of staff. This particular man was small with dark hair and he was horrible. He walked up the corridor after her and he followed her into one of the dormitories. I always wondered what happened to that girl.
Room by pushing bed against the door. Hand to be restrained in order to allow to settle and other children to settle. Very little restraint needed. All clothes removed from room — to be in play jacket until he earns his clothes back.

6-2-86

Discussed @ team handover, home to Cairnview of his role

unless staff have any objections

He remains all day and in room doing school work. Which he did very well and more reliably and accepted all advice well. Said he wished to be helped and wanted his problems solved.

S/N

I participated in 'Social Skills' group this evening.
IN-PATIENT NURSING NOTES

Name: HIA 251  
Date: 3-3-86  

A bit unsettled during group time, although settled after a period and joined in; watched TV. This evening

Placed Pool for a time this evening

Explained 9.20 that he could not go to school tomorrow. He was quite upset about it.

HIA 251 related how he had spent the weekend helping his father build a hedge. He boasted of watching hedgehops rolling down the ground on fire!

Ran off from school although back at the unit by lunchtime. Put on pyjamas and read, but could not settle to a simple pain programme

where

1) even back his clothes
2) even sit his privileges
3) even his weird pan

To remain in floating group until behavioural improves.

Behaviour at teatime was unsettled and a bit "high"
4/5-3/86: Settled quite well for 8pm and allowed to watch recording of 'W'. Settled well at bed-time. Still in pyjamas.

5/3/86

HIA 251

was permitted to go down to dance this morning and his school reports were good.

Got his clothes back at 3.30pm, was not allowed to go swimming. Watched T.V. appeared a bit irritable at times.

Evening Report:

Trying hard to keep his "room clean." Watched football before going to bed.

HIA 251

5/7/86. Horse playing w/wayne. Apologised and

HIA 251

settled to watch T.V. until bed time.

HIA 251

Mum keen to have another F.T. Session & Social Workshops. Inform Counselling Staff re: Spires. Please check with

HIA 251

staff when is scheduled on Sunday. Unsettled at school over the week.
IN-PATIENT NURSING NOTES

Name: HIA 251

Doctor: 

Date: 

14.5.86 Morning Report

Remained in pyjamas this morning expressing a "can't care less" attitude. Trying to
imitate other children to encourage them to
misbehave. Peers attempted to put pressure
on during morning break, but he
turned a deaf ear to them. Went to
class as usual but left class at 9.30 am
I spoke to him in venture area & he agreed to go back a class peacefully. There
was no foul language or aggressive
behaviour, he gave the impression
he had been told he would be going to
Rattsgaard & just couldn't wait to be there.
I said he would play in clean & put up
with it until the end of the week.

At 10.00 am, I

reported to me that

were on the burglar's roof. I designated
staff to maintain a continuous surveillance
of the area, and ensure the children were
within sight. They alternately took

and acted accordingly. However,

proceeded to vandalise the roof using

in boxes. T.J. was also present at roof.

S/N

LS 34

LS 34

HIA 251

HIA 251

HIA 251

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HIA 251
IN-PATIENT NURSING NOTES

Name: HIA 251

Dr. Nelson contacted by phone and later visited the unit to assess the amount of damage and to discuss what should be done with HIA 251.

Following discussion with HIA 251 and myself, Dr. Nelson felt that:

1. HIA 251 should remain in his pyjamas, confined to his room, with loss of privileges.
2. To be under constant observation by a member of the nursing staff.
3. LS 80 is to contact HIA 251 parents and arrange a meeting with them in an effort to determine:
   a) Should HIA 251 remain here for treatment with the possibility of an input from his parents
   b) Should an alternative placement be found for him.

To be further discussed with Dr. Nelson and a decision to be made on Friday.

Seen by Dr. Nelson later, who reported this.
Q. The records also show that when you misbehaved, you were put to bed early and on other occasions you were put into your pyjamas. That's LIS617 through to 618.

There is also a record of a time when you were put into isolation. That happened in March '86, 4th and 5th March '86, when there was an incident. You had been home or back to Carnview for the weekend. Other children who were in that children's home told staff in Lissue that you had burnt hedgehogs and had been boasting about burning hedgehogs. Staff immediately isolated you and took you away from the other children.

First of all, HIA251, you have no recollection of that happening at all?

A. No. I have never met a hedgehog, to be honest.

Q. Well, in fact, it turned out --

A. That's what's queer to me, like. I've never done -- I've never held a hedgehog.

Q. Well, it turns out, in fact, when staff actually checked with Carnview, Carnview put staff in Lissue right and said, "There was never any such incident. HIA251 didn't do anything like that". Then staff in Lissue had to apologise to you for the way they treated you at that time.

A. I can't remember.

Q. Well, paragraph 7 of your statement the same member of
IN-PATIENT NURSING NOTES

Name: HIA 251

Doctor: 14-5-86 Morning Report

Remained in pyjamas this morning expressing a "couldnt care less" attitude. Trying to irritate other children to encourage them to misbehave. Peers attempted to put pressure on during morning activity but he turned a deaf ear to them. Went to class as usual but left class at 9.30 A.M.

I spoke to HIA 251 in venture area & he agreed to go back to class peacefully. There was no foul language or aggressive behaviour. He gave the impression he had been told he would be going to Rattendale first & just couldn't wait to be there. Said he would play & clean up with it until the end of it's week.

At 10:00 a.m. HIA 251 and staff do maintain a continuous surveillance of the area, and ensure the children were within sight. They alternately look instruction and act accordingly. However, proceeded to vandalise the roof again 20th November. AP 940
It's true, and I heard many self-satisfied people say, "Look, I'm doing my part."
I can't afford to lose our building. It's a teaching tool that's been around for some years. I'm a child of the same era. I hope all children have access to a quality education in today's society, (LIS 129)

I am a teacher and a parent. I know what's at stake for our children. I'm glad to be a part of this fight. (HIA 251)

If you're not happy and sanding around, imagine: why not help build a building for our children? (LIS 128)
IN-PATIENT NURSING NOTES

Name: HIA 251
Date: 14-7-88

Doctor: of a "Fiesta Car" belonging to one of the domestics here. As this continued police gradually redirected children from higher roof to area with less danger both children jumped down and ran off. Police gave chase and across fields. Returned them do unit at 11:45 a.m.

LS 129

unfair of same.

LS 128

do not avail

2. Mr. Weir following discussion attempted to contact Do inquire re

No places aware that Mrs. Weir is also Mr. Buchanan) admissions

No later than this coming Friday 16-5-88.

3. Central Services Agency do contact

AP 940

NSITIVE-PERSON
NSITIVE-PERSON

LIS-631

HIA 251

LS 34

NSITIVE-PERSON


IN-PATIENT NURSING NOTES

Name: HIA 251
Doctor: Nelson
Date: 30-5-86

On coming on duty this morning I was informed by staff nurse (redacted) that the above patient, HIA 251, had once again managed to abscond on to the roof - he had been to the toilet, accompanied by staff nurse who waited outside the door, and managed to squeeze through the small window in the toilet, from where he managed to gain access to onto the roof before being apprehended by a member of staff.

On receiving this news I immediately put into operation the recommendations outlined in Dr. R. McAllister's letter to LS 8, dated 20th May 86, which referred to the previous incident when a similar episode occurred.

The following steps were carried out:

1. Assigned initially a member of the nursing staff - Staff Nurse LS 7 - to keep HIA 251 under observation from a safe distance and to report the situation without attempting to interact.
with him in any way.

2) I then instructed staff to ensure the safety of the children remaining in the unit by moving them to a safe area (in this case the dining area initially, and following breakfast, the smaller of the two day rooms), making sure to keep all personnel away from any windows, and closing all the curtains on the windows.

2) I informed the remaining personnel in the unit of the situation and to ensure their safety and safety of the children in the Paediatric Unit, I advised the nursing staff in the Paediatric Unit to:

a) Remove the children from any areas of danger, especially from below the skylight in the main hall.

b) To place a notice on the stairway below the same skylight instructing all personnel not to use this stairway exhibit HIA 251 was on the roof.

4) I also instructed all personnel to move their
4) Continued—

Cars away from the main building area, down the drive to a safer location.

(Unfortunately there had been some cars left overnight in the main car-park at the front of the building by other disciplines attending a two-day conference and they could not be contacted to move these and some value subsequently damaged before they could eventually be moved).

5) I instructed LS 40 and LS 99 members of the staff, to:

a) Block off access up the drive and instruct any incoming personnel of the danger, and re-route them to the unit by a safer route.

b) To block-off the stairway leading from the reception area to the Child Psychiatry unit and to erect a notice instructing personnel not to use it (this stairway also had been a
sky-light which would prove a potential source of danger.

I instructed the following personnel re phone of the incident:

1) LS 8 , to his home, giving him the details at that time.

2) LS 142 ; who asked if we were carrying out the instructions recommended by Dr. McInerney and I assured him that we (were) had; he also assured me that she would instruct Dr. McInerney of this incident (Dr. McInerney would be attending the clinic later so he was also attending the "work shop").

3) I attempted to contact LS 129 , at the Health Centre; and informed LS 141 ; she was deputising for LS 129 of what had occurred, giving her details of the incident as I knew them at that time.

4) I also contacted Ruth Wark, Deputy Director-in-Charge of Glen View Children's Home, from whom the infant was admitted, from; and she agreed to contact the relevant Social Services department as HIA 251 is presently under a
IN-PATIENT NURSING NOTES

Name: HIA 251  
Date: 5-8-86  
Doctor: Nelson

"Hit Persian Order."

These steps taken I then arranged for the children remaining, to have their schooling on the road, as I did not want to expose them to any unnecessary danger by moving outside the building. With the help and co-operation of the teaching staff this was duly completed.

I assigned further members of staff to help to monitor movements on the roof without drawing attention to themselves or exposing themselves to danger.

Whilst they embarked on an orgy of destruction, the members of nursing staff attempted to continue on the routine of the unit as best they could.

Dr. McNeely and LS 142 were late on hand personally to see what had occurred, and both were persistent that HIA 251 was to
receive no attention which might further aggravate the root situation, and were happy to leave the situation in the hands of the nursing staff, they then continued with their work shop.

After approximately three hours, moved off the main roof area onto the roof above the video viewing room, and with myself (front) blocking his access back to the main roof;

managed to trap him between no books.

At this stage, jumped into an adjoining field and ran off across the towards the railway line.

immediately gave chase and managed to catch up with him on the railway line before he was placed in any further danger, and with the help of nursing staff returned him back to the unit.

On return to the unit was immediately put to bed and received no care of Diagopan intravenously by

instructions giving no time to bring the unit back into its full routine.

A nurse was assigned to maintain constant
IN-PATIENT NURSING NOTES

Name: HIA 251
Date: 30-5-86

Doctor: NA

Supervision on HIA 251 and a behavioural programme is to be re-instigated allowing HIA 251 to earn his way back out of bed to pull peer interactions.

The relevant disciplines were then brought up to date on the situation, and all information duly documented, and relevant forms completed.

LS 138

30/5/86
IN-PATIENT NURSING NOTES

Name: HIA 251
Doctor: Nelson

Date: 30 May, 1986

8:15 A.M.

LS 138 asked me to observe from a distance as instructed by Dr. W. A. Lynch. During my observations from 8:15 A.M. to 10:10 A.M., child would run on top of roof of main building and covered way. If no one could be observed by him, no damage or throwing of missiles, but as soon as he noticed anyone around, he would commence to lift up slates and break windows or throw slates down on ground. When at the front of the building, still on roof, he threw slates and large pieces of glass at cars parked in front. I observed a grey coloured car getting a direct hit on the bonnet, head of other cars being hit, I saw side window from both, phoned S.P. from Night Nurses Station, S.P. answered, I asked her to inform LS 138 of cars being damaged and it was impossible for nurse to observe him at all times as he could quickly go from side to side and back to front of building and by the time I would rush to one area he could be in another, child was not aware majority of the...
time he was under observation, as I kept behind trees and bushes. He pulled up lead flashing and pulled off curved like pipes on roof, swung on a wire which broke and he fell on flat roof; he appeared to disappear at times? into roof space and would return with clothing, throwing them around, appeared with long sticks and a doll, put the doll on top of the pole and ran around the roof, shouting to anyone to came towards building, I heard him shouting to and then throwing slates, van from L.V.H. appeared, stopped by on approach road to main building, drivers got out and were talking, he shouted at them and commenced breaking nine glass windows on top of roof and pulling slates and threw these, when they went away, he continued to break windows, lift large pieces of glass and slates and stock pile same in area of flag pole at front of roof, he also pulled at T.V. mast. When he heard noise of motor of machinery at back play area he would run towards the back and talk to the man working there for a time, then return to main building. He would shout down at anyone he observed within threatening them or telling them it was alright and myself directed personal into building by tasty door prior by moving well away on grass, sheltered by bushes and out of sight of child after my phone call to S/W she was
sent to help me to continue observations. I was relieved at 10.10 a.m. by S/P LS 44. Whilst on duty in unit on my return, phoned unit several times and asked me to check with staff and phone back to Paediatric unit and tell them when child was at the back of the building to enable car be removed from front car park.

When HIA 251 was returned to unit, I was asked to relieve S/P LS 130 from her close observations of child. Child had been given IM Valium, he was in bed in an elated state; pressure of talk, talked to his glue sniffing, sniffing Talc Bond Cigarette lighter flame gas flame, stated he had brought some back with him on pass from Cairnie, sniffed outside and in Farmer's barn at Cairnie in "glen" different groups met skin heads, Punkie mods etc. He was in the Home's children from the home and the pass word got them into "glen", said he often got "high" from sniffing, said he once took 3 blue tablets from his mum and slept for 2 whole day.

A second injection of Valium 10 mg was given by S/P LS 128 at 11.50 a.m., remained elated, pressure of talk asking if I would observe him when he went asleep in case drug damaged his brain as he had glue sniffed.
said he had nothing to live for, nothing to look forward to, would like to go home to his mother but she would not have him because of after sniffing said he would promise to stop it if she would take him. Eventually fell asleep at 12.35, I went to lunch relieved by S/W.

During 3–4.30pm I asked him to get back into bed, he had to be guided into bed by myself, however, he began a struggle in my attempts to prevent him damaging himself I held his wrists firmly. He tried to bite me on the back of my arm, slightly breaking the skin, said this was my fault and he would never come. However he calmed down and I then released his wrists and of this incident.
The Royal Belfast Hospital for Sick Children
DEPARTMENT OF CHILD PSYCHIATRY
Belfast BT12 6BE Northern Ireland. telephone 240503 EXT 3550/2100

20 May 1986

LS 8
Lissue Hospital

Dear LS 8

RE: HIA 251

I understand that following an incident last week, when this child and another child were on the roof of Lissue Hospital at which time they did considerable damage that the problem was discussed with Dr Nelson and it was agreed that HIA 251 should in the meantime stay in Lissue Hospital. I understand it perhaps most importantly he should not be allowed to gain his objective of admission to Rathgael by extreme behaviours such as those mentioned above. At the moment he is being closely supervised but my own worry is that this can hardly be particularly productive in the long term and therefore I record below a proposed plan of action which has been discussed with you and which I am now recommenting should be put into action.

1. Careful attention should be given to easy access points to the roof and if it is feasible, access to these points should be made more difficult. A further point which I think is worthy of attention is that cars should where possible be parked in the main carparking area and perhaps not be parked in areas where they may be easily damaged from the roof - here I am thinking especially of car parking perhaps in the bothy region. Obviously you may only be able to go so far on these points but I think each is worthy of consideration.

2. If the child returns to the roof then it is my opinion that his behaviour should be ignored. It would seem that it is far more dangerous to attempt to get the child down and infact such efforts may meet with increasing levels of destructiveness and direct aggression. Further any chase on the roof could result in either the child or staff members falling and seriously injuring themselves. During the period that the child is being ignored then it is my opinion that he should be observed from a distance by one member of staff who does not in anyway attempt to interact with the child and whose sole purpose is to really monitor the situation. In general large scale observation should be avoided and persons including adults and children should be cleared away from any potentially dangerous areas. Of course this suggested course of action may have to be reviewed in the light of further experiences but it would seem to me that the most important thing is to try a definite course of action.
3. Following any episode in which the child goes out on to the roof and later comes down my opinion is that he should be given a tranquillizer in the immediate phase and this should hopefully also allow the situation created in the general ward to settle down. Following this then a programme in which the child earns his way out of his own room should be instigated. This has already been discussed with staff at Lissie and I hope that they would take this as their responsibility to design.

4. Very importantly I think that various people need to be informed about this course of action mainly in view of its potentially serious nature. Firstly both the district nursing and administrative people should be contacted and the plan of action revealed to them. Secondly social services should be informed since the child is I understand on a Fit Person Order. If there are problems with our plan which are raised by any of these bodies or if you perhaps yourself envisage any difficulties I would hope that you would immediately consult back with me.

I would appreciate your passing this information on to both nursing staff and other disciplines in Lissie and also to the district authorities as mentioned above. Perhaps you could ask one of the social workers on the unit to ensure that social services have also been informed as is mentioned above.

I hope that this course of action will help defuse the situation and deal with the problem if it reoccurs.

Yours sincerely

R McAuley MD MRCPsych
Consultant Psychiatrist

RMCA/SMCK
Q. You didn't see that happening?
A. No.

Q. Some of the other things we have heard about children being sent to their rooms and being put into pyjamas as a form of punishment or having all their clothes taken off them and being put into their room.
A. A child who absconded from the unit might be asked to take their clothes off and put pyjamas on, but more to act as a deterrent to running away again, but again that wouldn't have been -- that was very rare, very rare, and again it might have been with a child who was engaging in behaviours that would have been described as very risky to themselves.

Q. Okay, and children's clothes being taken off them completely?
A. No.

Q. Okay.
A. That would not be an acceptable way of behaving with children.

Q. Okay. Thanks very much.

MR LANE: You mentioned that any medication would have been prescribed by one of the psychiatrists --
A. Yes.

Q. -- rather than nurses.
wear pyjamas all day and not sent to school. In it overview statement as detailed above the Board have highlighted that as part of the behavioural management or behavioural modification treatment plan which operated within the CPU, an accepted form of discipline within the context of behaviour modification was for a child to be placed in pyjamas.

13. A recorded dated 9th December 1982 records that on the 9th December the Applicant “was put to bed for extremely bad behaviour”. The Board believes it is likely this would have been one such occasion when the Applicant was made to wear his pyjamas. There is no indication of how long this was for, see Exhibit 21.

14. A further notable incident when it is recorded the Applicant was put in his pyjamas was the 24th May 1985 when following an aggressive outburst and a failed attempt by staff to calm his down through talking and ignoring, the Applicant climbed on to the roof of the building and began to throw tiles. As a punishment for this, he was taken to “observation room and put in pyjamas” see Exhibit 22.

15. Following this behaviour the Applicant was placed on a Reward Card whereby he had to earn privileges which included having his own birthday party. The Board notes however that when withdrawing privileges, this did not extend to ether receiving phone calls from Mother or having weekends with Aunt, see Exhibit 23.

16. With regard to the supervision of the Applicant during his various times in Lissue, records suggest that the Applicant was continually supervised. A Fortnightly Nursing Assessment for the period 23rd September -1st October 1982 states that the Applicant “needs constant supervision”. A further nursing summary dated 27th September 1984, references the need for the Applicant to be strictly supervised, see Exhibit 24.

17. Towards the latter part of his time in the CPU when his behaviour became increasingly difficult, the records indicate that the Applicant was supervised to
POLICY – USE OF RESTRAINT *

Objective: To detail the nurse's role where restraint is deemed necessary.

Attention is drawn to the Eastern Health and Social Services Board letter dated 23rd December, 1982, regarding use of restraining equipment which states: -

"While it is accepted that there are occasions when such forms of restraint are required and they cannot be entirely discontinued, the Board wishes their use to be confined to extreme and exceptional circumstances on the understanding that joint consultation between medical, nursing and, where appropriate, social services staff is undertaken prior to devices being brought into use".

Policy:

1. Restraint is only to be used where all other methods of management have failed.

2. In deciding to use restraint, the nurse must assess and record in the nursing notes:

   (a) problem behaviour
   (b) why this behaviour is a problem (i.e. is it a danger to the patient or to others)
   (c) the proposed solutions (which will include restraint)
   (d) the reason why restraint is the method of choice.

3. Restraint should be a time-limited intervention with built-in review.

4. Guidelines should be agreed by Unit of Management Groups on a multi-disciplinary basis to reduce the use of restraint - this to include the involvement of relatives.

5. The Royal College of Nursing document "Focus on Restraint" should be used as a basis for local nursing policy.

* 'Restraint' is defined as restricting someone's liberty, preventing him from doing something he wants. Commonly used methods include -

- Cotsides
- Harness
- Sedative drugs
- Baffle locks
- Arranging furniture to impede movement
- Inappropriate use of night clothes during waking hours
- Chairs whose construction immobilises patients.

4.1.89

Evelyn J. Slack
Chief Administrative Nursing Officer.
STATEMENT CONTINUATION PAGE

STATEMENT OF:  LS 66  CONTINUATION PAGE NO: 2

him dry his hair in one of the girl's room. The girl wasn't in the room at
the time. I remember one day LS 78 give me an awful kick up the behind.

I know I had done wrong by scribbling on the table but it was an awful kick.
LS 21 and another nurse LS 78 were always violent with the
children. Especially children over six years of age. If they done anything
wrong LS 21 or LS 78 would grab them by the hair and pull them down the
corridor. There were times when other staff were present when LS 78 or
LS 21 would grab the children by the hair. The staff never ever done
anything about it. During this stay at Lissie I got injections. Usually
LS 21 give me them but sometimes LS 78 give me the injection. I always got
the injection in the hip. One day when LS 21 was taking me to school I said
to him about how violent he was to the younger children. I will always
remember his answer, "I'm sure I'll be forgiven for that." There was no
need for the violence LS 21 and LS 78 used, especially on children as young
as six. I remember one day all the staff were at a conference. I was in
the Day Room. Although I was heavily sedated I can remember lying on the
floor in front of the settee. LS 21 was lying beside me. He opened the
zip on his trousers and took out his penis. He made me touch it. Because
of the medication I was on I was unable to control my hands to masturbate
him. I just fondled him. I had never seen a penis before that day. He
had an erection. At first when I thought back I thought LS 21 may have been
wearing a Durex because of a knob at the end of his penis, but now that I
know the difference I think LS 21 may be circumcised. I remember that there
was semen, so I take it he must have come. I then went to the toilet which
was beside the day room. Again because of the medication I couldn't do up
my trousers when I had been at the toilet. I remember standing at the door
and LS 21 fixing my trousers. I was discharged when I was 14 years of age.
Due to pressure at home with my father shouting about me for taking my tablets
and the fact that I had fell behind at my schoolwork I fell under stress.
There was the odd tablet that I forget to take. I also had lost some very
close friends during my stay at Lissie. Due to all this I went back to Lissie

SIGNATURE OF STATEMENT GIVEN... LS 66
July 1981, which is about eight months roughly. Okay?

I am just going to tell the page reference numbers so that the Panel can look at them if they want to check that later. They can see at page 22172 the referral by the GP. There is an educational psychologist's report at 22170. There is another report at 22173. There is reports at 22229 and 22220. I have got those page references right hopefully.

If we can go back to your statement here, HIA38, at paragraph 4 -- if we could just scroll down, please -- you talk about being taken to Lissue when you were about 9 in 1979. You remember a nurse. I am just going to use the first name. As I have explained, we don't use names. You will see that she has been given the designation "LS7". She was called LS7. You say you will never forget her.

You say she gave you an injection once a fortnight and you were made to take two Ritalin tablets every day from the age of 9 and you were made to drink a brown liquid called Largactil at night. You were given a lot of medication and you don't know what it was for. You now believe it was anti-psychotic medication, which you have continued to be on for life. As a 9-year-old you should never have been given such medication, as your medical records show that you had no signs of a mental
PRIVATE

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 nurse 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.

6. 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
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. LS 7 and the head doctor usually were present.

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 LS 50 was called LS 50. There was a nice LS 51 called LS 51 but she might have been at LS 51. I recall she taught us some LS 51 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.

HIA 38

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 LS 51. I was there from 11 to 16 (from 1981 to 1986). I believe I was moved to LS 51 on the recommendation of Lissue
I think it is true to say that you were displaying behavioural issues that caused you to be taken to the child psychiatrist in the first place, but one of the things that the Inquiry has heard is that medication was only ever given on prescription by the child psychiatrist in Lissue. It wasn't the case that nurses would have had discretion to give any medication without the consultants and the doctors having said that that medication was to be given to a child. Is there anything you want to say about that, HIA38?

A. That's completely untrue. Medication was given I call it willy-nilly all the time, not just to me, but to a lot of other people.

Q. There's some documentation -- and I will come back to one of those entries about this lady; I will come back to speak about this lady again, because you speak about her later in your statement -- but there is an entry at 512, if we could just look at that briefly, and this is about -- this I should explain is taken from the daily nursing notes that were kept in Lissue. They were handwritten by the nurses. You can see there is a signature down there at the bottom. It is very hard to make out whose it was, but some nurse who was looking after you on 27th and 28th November 1980.
It describes you as being extremely restless at night. It talks about you being given a couple of thumps by a child, a girl child.

"He would still go back for more."

You were also very demanding at bedtime. You were in and out of your room and you wanted to read on and on. It describes you as being rather frightened by two children, whom it names here, and I am not going to give the names out, by their behaviour. You were reassured. You thought the doctor was coming to give you an injection and then you went to sleep after that.

So that's suggesting -- number one, first of all, do you remember those two children at all?

A. I don't, no.

Q. And you were reassured. You obviously seemed to be anxious that you thought you were going to be given an injection by the doctor and that was making it hard for you to settle, but you appear to be reassured in some way.

A. That's because we were injected all the time, so we were. I was always apprehensive, so I was. There is nothing fun about being sat on and having your rear end injected, so there's not, and that was it. You didn't know anything until the next morning. That was you. It was ...
PRIVATE

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.

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6. 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
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.
PRIVATE

several times throughout the years to blend in and be normal like everyone else since being discarded like a piece of rubbish by the authorities. I have no relationship with my family because of the lack of investigation into bullying during my primary school years leading to me being locked up and leading to everything else that was bad happening in life. I don’t sleep and I am on medication from my GP. Alcohol has always played a part in my life. Every time I see abuse on the news it all comes back to me. The only thing I am good at is being a full time daddy to my son. I am over protective of him and I am adamant that nothing or no one will hurt him. My life was destroyed by being placed in these institutions and I have been left to suffer.

Statement of Truth

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

Signed _LS 38_

Dated _15/9/16_
taught My hair had grown quite long because no one had cut it and she made me wear a girl’s hairclip which I found humiliating.

9. Certain members of staff were great and others were quite fearsome. There were three types of people working in Lissue: the gentle and kind people, the neutral people and then the vicious people. The latter were bullies who seemed determined to humiliate and punish at every opportunity as they were disinterested in the children. [LS5] was a member of staff who would grab me by the ear. There was no humanity in the care they provided and I was deprived of any motherly love. One of the ways we were punished was by being put in timeout and you could be left for quite a long time. I think some of the staff over used timeout so they did not have to deal with us. Sometimes they would strip you and put you into bed. You could be left for the rest of the day or until the next meal time. If you resisted you were manhandled. If you fell asleep because you had been left for so long and then couldn’t sleep that night you were punished again for not going to sleep. The boredom and frustration that resulted from being stuck in a room made me hallucinate. I remember looking at the curtains and the images on the curtains melted and changed in to faces. I used to wonder whether the hallucinations were caused by boredom or just the medication that they gave me. I remember going up to the medicine room and being given medication at various times. I remember being fed ice-cream by a member of staff. I was on my own and it was not at a meal time. I believe that the ice-cream was laced with something as it was gritty and tasted of ash. I was told that the ice-cream was pistachio but I do not believe that such an exotic flavour would have been offered to me. I was always paranoid that the staff were doing things to me and then laughing about it.

10. On one occasion I locked myself in to the observation room. The staff eventually talked me round and let them in. When I was opening the door they threw water over me, pinned me to the floor and knocked me out. They pulled my pants down and gave me an injection.

11. On one occasion my mother saw one of the nurses lashing out at me. I think I had kicked the nurse and she pinned me down saying “you little bastard”. I
removed the plastic perspex glass from the window in the
romper room and actually escaped. That's whenever
I went into the kitchen. I had run around the grounds
and went into the kitchen. LS8 came and dragged me back
to my room and threw me on the bed.

Then there was another incident where I had
barricaded the door. I had not tried to get out. I had
just barricaded the door. Then the staff had encouraged
me to unbarricade the door, just get into bed and settle
down, which I eventually inevitably decided to do. As
I pushed the bed away, they burst in through the door,
threw water round me, for what reason I don't know, and
pinned me to the floor and injected me. Whenever I was
kind of cooperating by letting them into the room, why
was there the need for that, you know?

Q. Well, we looked at that. The duty doctor seems to have
considered the need for it that particular evening, but
however it has come about, whether there is some
conflation between two incidents, you can certainly
remember one occasion when LS 84 was sitting
outside the room.

A. Yes. That would have been when I was in the first
bedroom.

Q. You describe the incident with the injection in your
police interview. You talk about when you woke up --
A. Uh-huh.

Q. -- there was a member of staff sitting in a chair.

A. Yes.

Q. So --

A. That was like that one-to-one thing that we were talking about earlier.

Q. You made the point to the police that someone suggested to you at some subsequent time that perhaps the Lego toy that was waiting for you to play with was to buy your silence.

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 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. Additionally when more and more patients arrived, they opened up a green group. There was these corrugated 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
I can remember standing in the corridor with my mum telling her what **LS 8** had done to me. **LS 8** was standing there denying it saying I had done it to myself. I called **LS 8** a bastard, then my mum and I went out. Another time I was misbehaving and I was put to bed. I put my bed up against the door to keep the staff out. I was there for a couple of hours. I removed one of the plastic windows from the frame to try and climb out. The staff encouraged me to move the bed from the door and told me they would say no more about it and they would forget about it all. Thinking it was the best option I had I moved the bed away from the door. The door opened and I got water thrown over me. **LS 84** and **LS 8** were on duty that night. There was also a nurse on who had a ____ accent. I was pinned down to the floor by the above named staff and stripped naked. I was held down on my stomach and given an injection. I was put back into the bed and passed out. I woke up the next day in the afternoon, a brand new box of Leggo was waiting for me, this was my favourite toy. Also cakes, sweets and juice. I was in and out of tissue up until I was 11 years old. I then went into Rathgael just before my 12th birthday. I was sent to House 5 for young offenders, although I was not there for a criminal offence. I often was hit and bullied by the other boys in the unit, receiving black eyes. I complained to staff but nothing was ever done about it. I could not relate to anyone in House 5 because I was not an offender. I remember an incident at breakfast one morning. Someone had spat in my cereal. I complained about it to **RG 50** the ____ who was sitting near me. **RG 50** told me to eat it. I argued and said "No" and he swung round and smacked me in the mouth with the back of his hand. Everyone in the dining room laughed. I went to a mobile classroom and my ____ teacher was **RG 62**. If I didn't get my ____ correct **RG 62** would thump me on my back and
difficulties that HIA172 had as best we possibly could
and we did not treat them like this".

A. No, I don't think it was like an institutional thing.
I think it was just certain members of staff did
those -- behaved in a way that I think anybody would
deam inappropriate.

Q. It looks like -- and I was asking you this earlier --
you know, LS8 has obviously -- he is deceased, as I said
to you. He responded to the police in 1994 that he was
not involved in the type of incident that you were
describing, and I was drawing your attention to the fact
that it looks like there's a duty doctor tasking the
security man to assist a nurse.

A. Uh-huh.

Q. Now obviously LS8 is still a nurse, despite being the
Nurse Officer, but it looks like the security man was
being sent into your room that evening, which ultimately
led to the application of the Valium.

A. So how did they get into my room if it was barricaded?

Q. The question I am more asking about, HIA172, is the
presence or otherwise of LS8, who is --

A. Right. Well, I recall him being there. I recall him
being there. He was there -- LS8 always turned up in
the evening times if there was an incident. If there
was something happening where one of the patients was
21/4/85 detention room 2 - Roger
Quietly settled but very disruptive tonight
locked self in room damaged wall
Talked down from 'high' state by F/N
Apologies for behaviour
Settled 30/4/85 Ran away - Bangor - see notes

6/5/85 V. restless - disruptive last night
Wrecked his bedroom broke glass etc
Doctor ordered Security Man to assist
Duty Doctor ordered Security Man to assist
A bit more subdued this am but easily
out of control - Shirley to staff

Says he is behaving like this because
staff are saying 'don't look
after him properly' - feels they are
mistreating he doesn't care about him.
Also annoyed that has had no
visits from relatives - Bangor

R. Millard 25 yrs QID orally

M. 1 M 5 - stat

13/5/85

If necessary

Mr. Aspley asked
More settled over past 4-5 days
Back in school for last 3 days of last school
week. Doing good work in School today though

Mr. Aspley not keen on continuing

Effect will wear off as gets habituated

Environmental
21/4/85 vision from Roger

Quite settled but disruptive tonight
locked in room damaged wall and table
Talked down from 'high' state by S/N

3/4/85 - Ran away - Banger - see notes
settled 30/4/85

6/5/85 - U. restless - disruptive last night

Wrecked his bedroom (broken glass etc)

Duty doctor ordered Security man in - not

Duty doctor ordered Security man in - not

Eventually

Mus to get him out of room & eventually

Mus to get him out of room & eventually

settled

A bit more subdued this am but easily

A bit more subdued this am but easily

set diff - shelling to staff

Says he is behaving like this because

Says he is behaving like this because

he is being looked after by parents & doctors.

Staff are saying to parents 'don't look after him properly' - feels they are

Staff are saying to parents 'don't look after him properly' - feels they are

nippy & they don't care about him.

Also annoyed that has had no

Also annoyed that has had no

visits from relatives - Banger

R. Milne 25 yrs old male

R. Milne 25 yrs old male

V. Sodium 1 M 5 g stat

V. Sodium 1 M 5 g stat

Dr. McCaig robusted

According to past 4-5 days

Not stable in school for last 3 days of last school

Not stable in school for last 3 days of last school

week. Doing good now in school - feeling

week. Doing good now in school - feeling

depressed. Dr. McParland not keen on continuing

depressed. Dr. McParland not keen on continuing

Dr. McParland not keen on continuing

Dr. McParland not keen on continuing

(5) Effect will wear off as gets disabled

(5) Effect will wear off as gets disabled

(5) Effect will wear off as gets disabled

13/5/85
why I was in Lissue. It felt like I was in [redacted] one minute and the next minute I remember being in a room at Lissue which had big green plastic chairs in it. I think I was admitted twice to Lissue Hospital, for a period of a few months each, between 1985 and 1986.

4. I don’t remember much of my time in Lissue because I spent the majority of my time strapped to a bed. I remember the medical officers strapping me to a bed on several occasions and going out cold. They gave me injections. I could have been under for days and in that time I don’t know what they were doing to me. There was a large mirror in my room and I must have been observed by the medical officers. I was given injections regularly and I do not know how long I was sedated for. That’s how I remember my time in Lissue. I would like to know what injections they gave me to put me out. I feel the injections had a negative impact on my life.

5. I also remember there was another room with lots of cameras in it and they took videos of us playing. There were toys and a sand pit in the room. My step-father [redacted] told me once he remembers that room. He thought it was abnormal. My mother and [redacted] went up to Lissue for an interview once. I think it was an interview about me being allowed home for weekend visits and they recorded that interview.

6. I was kept in a room by myself and was very rarely allowed out to mix with the other children. I can visualise the corridors but I cannot remember where the rooms where as I was kept in my room most of the time. I know the staff office was right beside me so they could observe me. The door was always kept open and I could see out. I remember a boy and girl who were brother and sister. They used to live up by the [redacted] in [redacted]. On one occasion I remember looking out of my room and seeing the girl being followed into a room one day by a member of staff. This particular man was small with dark hair and he was horrible. He walked up the corridor after her and he followed her into one of the dormitories. I always wondered what happened to that girl.
receive no attention which might further aggravate the test situation and were happy to leave the situation in the hands of the nursing staff, they then continued with their work shop.

After approximately three hours, moved off the main roof area onto the roof above the video viewing room, and with myself (forehead blocking his view) back to the main roof.

managed to steep him between no body.

At this stage jumped into an adjoining field and ran off across this towards the railway lines.

Immediately gave chase and managed to catch up with him on the railway lines before he was placed in any further danger, and with the help of nursing staff returned him back to the unit.

On return to the unit was immediately put to bed and received no sign of Diagupamin intravenously by 

instructions giving no time to bring the unit back into its full routine.

A nurse was assigned to maintain constant
IN-PATIENT NURSING NOTES

Name: HIA 251

Doctor: LS 21

e/n: received my special observations at 4.30 p.m.

LS 44

30.5.86 Dr. W. Auley, consultant, requested that any
after child was returned to unit that child was
being given tranquillizer to relieve nursing

Pressure not given as a punishment for being
on the roof, he asked that Nursing Staff were
not to be negative towards the child, but
having said that, said child was to earn all his
privileges back as he earned them (by positive
behaviour). I informed Dr. W. Auley that
Nursing Staff were not negative but other
discipline had not been nothing to arranging
visits from Mother and Dad as had been promised
previously and child had little positive

to look forward to also child was very

immature socially.

At 6.15 p.m. the pm. I was c
until relieved, child sleeping with thumb in her

HIA 251

LS 7

Please ensure that Smear (and top floor botany)
be kept locked, nursing can proceed in aware
LS 21
don’t like it outside. In prison you get three square meals a day, clean laundry and the medical help is a lot better. I find the doctors outside prison unhelpful. The doctors outside tell me I fit the criteria of a ‘junkie’. I don’t like being labelled in that way. I have a drug addiction. My previous GP changed my medication and I am finding it really difficult to cope. I have transferred to a new GP and was referred to the Outreach Team. I am currently living at.

23. My dependency on drugs started at a very young age. I feel that the injections I was given in Lissue contributed to that and messed my head up. I don’t think it was right to strap me to a bed and sedate me the way they did in Lissue. To this day I have problems sleeping. Looking back, I know I had behavioural issues but I do not think I was given the correct treatment. I should not have been put in with the other severely disabled children and I will never forget the incident were the assaulted me.

Statement of Truth

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

Signed

Dated 14/2/16.
IN-PATIENT NURSING NOTES

Name: HIA 251  
Date: 30.5.86

Doctor

e/n

LS 21

relied my special observation at 4.30 p.m.

LS 44

S/n

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after child was returned to unit, that child was
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Nursing staff were not negative but other
discipline had done nothing to arrange
visits from mum & dad as had been promised
previously and child had little positive
to look forward to also child was very
immature socially.

at 6.15 p.m. this p.m. I was -
ununtil relieved, child sleeping in thumb in his
mouth.

Please ensure that small towel top floor bedroom
be kept locked, nursing can proceed in house
LS 7

LS 21

HIA 251

LS 7
IN-PATIENT NURSING NOTES

Name: HIA 251
Doctor: LS 21

5/86 Dr. M. Auley, consultant, requested that any after child was returned to unit that child was being given tranquillizer to relieve nursing. Pressure not given as a punishment for being on the roof. He asked that nursing staff were not to be negative towards the child but having said that, said child was to earn all his privileges back as he earned them (by positive behaviour). I informed Dr. M. Auley that nursing staff were not negative but other discipline had done nothing to arrange visits from Mum & Dad as had been promised previously and child had little positive to look forward to also child was very immature socially.

At 6.15 pm the pm I was c until relieved, child sleeping with thumb in his mouth.

Please ensure that some form of top floor facility be kept locked whilst nursing can proceed in house.
implemented. The notes also show that and Dr McAuley later attended the hospital and that:

a. HIA 251 received Diazepam intramuscularly by “on Dr McAuley’s instructions giving us time to bring the unit back into its full routine.”

b. Dr McAuley had requested that the child was given the tranquiller to relieve nursing pressure;

c. A second injection intramuscularly of Valium was given by – HIA 251 remained elated with pressure of talk and asking if the nurse ‘would observe him if he went asleep in case drug damaged his brain as he had glue sniffed.’

In the HSCB’s submission, HIA 251’s notes do not support a view that he was injected regularly or that nursing staff were given wide discretion to administer prescribed medication.

4.19. Rather, the notes show that the sedative injection was administered by a Senior House Officer on foot of express medical advice and a detailed plan drawn up by the Consultant in overall charge and that this was in response to a serious situation when HIA 251 had been behaving dangerously and presenting a risk to himself and others. At this remove, there may be concern about the note that the child was given the tranquilliser in this instance to ‘relieve nursing pressure’. The HSCB submits that this note should be read in the context of the evident risk posed by the behaviour of HIA 251 to himself, other patients and staff on the Ward. By administering a sedative, those risks would be reduced and the Ward would be brought back under control.

4.20. The Inquiry has also raised a query about some of the entries on HIA 172’s notes contained on pages LIS 1341 and 1343 of the bundle. The injection

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62 LIS 646
63 LIS 649
64 LIS 653
Q. Yes. Just can I ask you then -- you were here this morning when LS7 gave evidence about a young girl who was brought in, was not told she was being brought in and then kicked off, if I can use that expression.

A. Yes.

Q. And she was being held on the bed and you had to give her an injection. Do you remember that?

A. No, I don't remember it. It was a fairly mild sedative she was being given.

Q. Yes. The drug that LS7 had named --

A. Yes.

Q. -- was something that you had said was a mild sedative.

A. Generally used for old people at night.

Q. To help them sleep. To -- just about that matter, just about medication, and would you confirm what Dr McAuley has said is that in those days nurses would not have given injections. That was something a doctor did in the '70s and '80s.

A. Well, sometimes they may have had to, say, during the night, but injection wasn't a very common way of administering drugs or necessary even.

Q. Yes. Most of them would have been tablets or liquid form.

A. Yes, yes.

Q. If --
Q. You didn't see that happening?
A. No.

Q. Some of the other things we have heard about children being sent to their rooms and being put into pyjamas as a form of punishment or having all their clothes taken off them and being put into their room.
A. A child who absconded from the unit might be asked to take their clothes off and put pyjamas on, but more to act as a deterrent to running away again, but again that wouldn't have been -- that was very rare, very rare, and again it might have been with a child who was engaging in behaviours that would have been described as very risky to themselves.

Q. Okay, and children's clothes being taken off them completely?
A. No.

Q. Okay. Thanks very much.
MR LANE: You mentioned that any medication would have been prescribed by one of the psychiatrists --
A. Yes.

Q. -- rather than nurses.
Q. Would that ever have been a sort of what you might call an open prescription, that it was known that in the event of certain things happening the nurses could use medication rather than it being prescribed for specific incidents?

A. My memory is that it was prescribed, you know, for particular times of the day, not for free use for me to interpret as a nurse.

Q. So how do we explain the evidence of people who said they had injections to -- you know, to quieten them down? What would have happened in those instances?

A. I can only speculate, but from a factual point of view what would have happened, from a factual point of view if something was happening that required medication that was not on prescription, the first port of call was you needed to communicate with the doctor, and then and only then would you have taken the prescription, but there would have needed to be that discussion with the doctor.

Q. So would the doctor have been on site or would somebody have rung the doctor?

A. There were doctors on site.

Q. All the time?

A. Yes. Registrars -- well, no, not at night-time, but you had the HSOs and the senior registrars on duty.
either to give medication or to give -- we have heard
LS7 was talking about injections.
A. Uh-huh.
Q. She was saying she could not have given an injection.
A. Uh-huh. Uh-huh.
Q. What do you recall about how much discretion nursing
staff would have had?
A. Well, if children needed medication, whatever it was, it
was written up on the cardex as to whatever it was, with
the dose and the frequency, and that was what would have
been given to children. Now I -- they weren't given any
licence to have free rein with using medication.
Q. Was there a possibility that -- I mean, I think it was
LS21 who actually told us that there was "prescribe as
necessary".
A. Okay. That's a different form of prescription and that
opens the thing a little.
Q. That would have allowed a nurse in a given situation --
A. A given situation.
Q. -- to be able to give medication --
A. Yes, yes, yes. That's right.
Q. -- whether by way of injection or liquid medication.
A. Well, I don't think by injection. I mean, nurses these
days can give injections. In those days --
Q. They didn't?
A. -- that wasn't the case.

Q. There were, however, registrars on site who could have given injections.

A. During the day, yes.

Q. Another matter. Do you ever remember inspections of Lissue?

A. Well, there would have been Mental Health Tribunal inspections and there would have been The Royal College of Psychiatrists' inspections with regard -- because of the trainees who were moving through that area. There would have been also Departmental inspections, in a sense treating Lissue like another children's home. So there would have been those three sets that I can recall. I mean, there may have been others. I am not sure.

Q. I mean, this is a matter that we are going to have to take up with the Department, because what you are suggesting --

A. Uh-huh.

Q. -- is that there was Social Services Inspectorate --

A. Uh-huh.

Q. -- or the Social Work Advisory Group who carried out inspections of Lissue to your recollection.

A. I am quite sure those occurred. I don't know how frequently, but at some time or another.
Q. Yes. Just can I ask you then -- you were here this morning when LS7 gave evidence about a young girl who was brought in, was not told she was being brought in and then kicked off, if I can use that expression.

A. Yes.

Q. And she was being held on the bed and you had to give her an injection. Do you remember that?

A. No, I don't remember it. It was a fairly mild sedative she was being given.

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Q. -- was something that you had said was a mild sedative.

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Q. To help them sleep. To -- just about that matter, just about medication, and would you confirm what Dr McAuley has said is that in those days nurses would not have given injections. That was something a doctor did in the '70s and '80s.

A. Well, sometimes they may have had to, say, during the night, but injection wasn't a very common way of administering drugs or necessary even.

Q. Yes. Most of them would have been tablets or liquid form.

A. Yes, yes.

Q. If --
Q. You did say that the teachers commented to you that you made their job a lot easier --
A. Yes, yes, yes.
Q. -- because by the time they got to school they had settled.
A. They had settled.
Q. One just small example. I was asking whether or not there was just complaints by the children about other children --
A. About staff.
Q. -- but you recall they also complained about staff.
A. Yes.
Q. You gave an example of one child who had been offended when a member of staff broke wind in their presence when that member of staff didn't know the child was present.
A. Yes.
Q. That had to be discussed at length.
A. Yes.
Q. In the police statement -- sorry. I think I have missed a page. Yes. Sorry. Did staff have any -- we were talking about medication of children.
A. Yes.
Q. I was wondering whether staff had any discretion about medication. For example, there's records in respect of a particular boy that the Inquiry has seen that shows...
that after he had been particularly -- misbehaved
I suppose, had climbed on to the roof and caused uproar
within the unit, he was subsequently sedated. I was
asking what the position was with regard to sedating
children that you recall.

A. That potential behaviour would have been evaluated and
assessed and pre-determined at our meetings and some
contingency plans had to be put in place or set up in
order to respond. I'm worried about the word
"discretionary", although I suppose strictly
I interpreted that as, if needed, it has to be given,
but that would have been already designed by the
consultant.

Q. So if I've understood our discussion earlier correct --
A. Yes.

Q. -- and I don't want to get this wrong --
A. Yes.

Q. -- because -- but the situation was that a child's
treatment plan would have been in position, as it were,
for the child --
A. Yes.

Q. -- and that might have included "Sedate as required" --
A. Yes.

Q. -- based on what was known about the child's behaviour
and whether that might prove to be necessary.
A. I think one important point is that it wouldn't have been a reaction to a behaviour. It would have been in order to prevent or ameliorate a difficult situation. You wouldn't want to sedate a child who is already sedated and settled.

Q. No.

A. Sedation was only used if a child was completely out of control and had injured himself or others.

Q. Yes, and in this particular instance where a child is on the roof throwing down slates or glass --

A. Aggressive, abusive.

Q. -- once the child is brought back into the unit, then that would be an appropriate time?

A. If necessary. I mean, it might not have been necessary. Sometimes it can be ...(gestured downwards).

Q. So, I mean, what I am saying is the facility was there for the staff to use if it was necessary?

A. Yes, if necessary.

Q. When we were discussing this earlier, you were saying that if such sedation was administered, it would have been recorded and been the subject of discussion at the next morning's team meeting.

A. Yes, indeed.

Q. You also made the point to me there were senior registrars on site. So if it was not part of a child's
1 A. Yes, Monday to Friday.

2 Q. Right. Okay. Just to make sure that I have understood it properly, you were questioned earlier on about the authorising of sedation and things like that. Now that would have been, as I have understood it from what you have said, that when you were planning the care of a particular child, you would have said, "Right. If he has a big problem, then we will use sedation". Is that the way it would have been planned?

10 A. It -- my responsibility was to record, provide and inform the team.

12 Q. Uh-huh.

13 A. Now it was their -- I mean, the ultimate responsibility of the consultant and the registrar, the medical staff within that team to decide, "This is the treatment we will pursue".

17 Q. Yes. Uh-huh.

18 A. They would have determined what course of medication or intervention was required or necessary.

20 Q. So --

21 A. My responsibility was to implement that.

22 Q. But they would have decided on this in advance rather than at the time that there was the crisis?

24 A. If the potential on admission history was for violence --
1 Q. Yes.
2 A. -- we would have to make plans --
3 Q. Sure.
4 A. -- to accommodate that, and for the most part changes in
5 implementation of treatments and therapies was post
6 occurrence.
7 Q. Right.
8 A. Right. I mean, we didn't know the child who climbed on
9 the roof was a climber. We just learned it when he did
10 it.
11 Q. So on an occasion like that would the registrar have
12 decided sedation was what was needed?
13 A. Yes, on occasion, yes. I mean, that was the advantage
14 of having medical staff as part of -- you know,
15 contemporary.
16 Q. So it wasn't the nurses --
17 A. No.
18 Q. -- enacting what had been decided earlier?
19 A. Inevitably, yes, of course, yes. I have given children
20 injections as part of a treatment scenario --
21 Q. Right.
22 A. -- with the -- never alone, always with the assistance
23 of other members of staff.
24 Q. Yes. Right. Okay. Thank you very much.
25 A. Thank you.
CHAIRMAN: LS21, I would just like to follow up that last question, because I am not entirely clear in my own mind about this.

A. Can you repeat that? I'm sorry.

Q. Yes. The issue about sedation being given by the nurses, as I understand it, there are two possible situations that can arise.

A. Yes.

Q. One is a situation which may be foreseen because of the history of the child when he or she is admitted --

A. Uh-huh.

Q. -- to Lissue --

A. Yes.

Q. -- and a plan be put in place that if that eventuality occurred, then authority had already been given for a particular type of sedation to be administered by the nursing staff. Is that right?

A. Uh-huh. Yes. Uh-huh.

Q. That's the first scenario.

A. Basically, but --

Q. Or, to put it another way, even if there had been thought given to the situation beforehand, did you always, no matter what the circumstances were, have to get the authority of a senior or of a registrar to administer intramuscular sedation before you did it no
matter what had been talked about beforehand?

A. Yes. No. In the event that the senior reg was on site, you know, just there available -- I mean, the registrars and the psychologists had other -- I mean, they had contact and interactions and intermingling with other -- with the parent unit at Belfast. So my responsibility would have been to accept the determinant that out of control behaviour or a child with epilepsy had to receive an intramuscular injection. That was my responsibility to implement the treatment which had been prescribed.

Q. Yes. So in one scenario the doctor had said, "If this happens, you can do this" and then you do it. Is that right?

A. Yes. If my -- if it turns out -- if it transpires that there are no other recourse.

Q. Yes, I understand that --

A. Yes.

Q. -- but were there sometimes occasions, such as a child going on the roof and throwing slates down or whatever, when a totally unforeseen situation had arisen and it was felt necessary to administer some form of sedation? Did you have a certain -- a practice whereby you would do it first and get approval afterwards, or did you always have to go and find a registrar, whether he was
or she was on site in Lissue or in Belfast and say,
"This is the situation. Can I administer an injection?"
A. I would have not needed approval for a treatment plan
already -- as part of that treatment. If a child is out
of control, I can't wait to get a doctor from an office
in the corridor or call for that kind of ... My
responsibility was to implement that treatment plan.

Now there are other ways. There were occasions in
the event of an individual being out of control
behaviourally occasionally you can settle that without
intervention, but I think I've already stated or
suggestion or described my primary responsibility was
the safety of the children and the safety of the staff.
In the event of loss of control of behaviour, this is
a very violent act. Things get hurt. People get hurt.
I couldn't take that kind of responsibility and I had to
use my training and experience to evaluate these
situations, and those who worked with me had that same
potential. I am a bit disturbed by the thought that
this is a restrictive regime intent on causing harm.
I find that offensive. I'm sorry.
Q. Yes.
A. I apologise.
Q. Well, thank you very much for coming to speak to us
today, LS21. We are very grateful. We can see how it
Q. You would have given the medication as prescribed --
A. Yes.

Q. -- in accordance with the dosage. Occasionally you were able to assist the doctors in terms of, "Well, I think that's maybe a bit too much for that child" or, you know, "That child would need a stronger dose" --
A. Yes.

Q. -- that kind of information. Did you yourself have any discretion about giving medication? We have heard some people complain that they were sedated, that they were given an injection to sedate them. Would you have had any discretion about that?
A. Only one child got it, and it was Dr Nelson that gave it. The rest of them, they weren't on injections at all.

Q. No, but I am saying --
A. Except for if somebody -- the doctor would take a blood test for -- to the lab.

Q. I think what I am trying to get at is we know that they may have been prescribed medication either in liquid form or tablet form.
A. Yes.

Q. But in terms of giving an injection, if a child was particularly out of control, would -- I mean, we have heard that the prescription on their treatment plan may
was there and he was the one -- one of the ones that held her down, but she was well-built and she was struggling, and every time she struggled the legs came up and she'd put the heel in and she was moving further down the bed.

The two of them had a busy job holding and bringing her up again, but she would slide down again, and she was screaming at the top of her voice, and when they came up, they came down heavy. I noticed she had come down to the bottom of the bed. So I went round to the bottom and when the leg came down, I put my hand out and her heel came down, and she had the shoes still on, and the heel came down and hit my hand and jammed it against the top of the bed.

Dr Nelson asked for LS21 to take over, and he asked me to go down with him, and he went down and he got Paraldehyde. I got the syringe and the kidney receiver and the pieces of gauze and that, and he looked up a book to see the dosage and he went up and gave her the injection, and she settled very quickly and was out sleeping.

Q. You were telling me, LS7, you still have problems with that hand that was hit after that incident.

A. Yes. Dr Nelson examined it and said there was no bones broken, but the muscle is affected here and I can't grip
IN-PATIENT NURSING NOTES

Name: HIA 251  
Date: 30-5-86

Doctor:  

e/n: LS 21 received my special observations at 4.30 p.m.  

LS 44  

30-5-86 Dr. W. Auley consultant requested that as after child was returned to unit that child was being given tranquillizers to relieve nursing pressure not given as a punishment for being on the roof; he asked that nursing staff were not to be negative towards the child, but having said that, said child was to earn all his privileges back as he earned them (for positive behaviour). I informed Dr. W. Auley that nursing staff were not negative but other discipline had done nothing. We arranged visits from Mum and Dad as had been promised previously and child said little positive to look forward to also child was very immature socially.

At 6.15 p.m. the pm, I was until relieved, child sleeping with thumb in his mouth.

Please ensure that Senior Medical top floor dressing are kept locked, nursing can proceed in normal dressing room.
have eaten the pigeons for meat. Times were hard. We had little food, unsliced bread, and maybe soup and potatoes.

4. I was approximately 9 months old when I took sick with the measles and was admitted to Purdysburn Fever Hospital. I was there for about three weeks and got very sick. I developed Diphtheria, Scarlet Fever, Meningitis and the Whooping Cough. I was transferred to the Royal Hospital in Belfast and then moved to Lissie House in Lisburn. I applied for my medical records for further information. My records state I came out of a tuberculosis house and that my mum died. This is incorrect. My aunt [redacted] died of tuberculosis after I was admitted to Lissie. Unfortunately there is a gap in my medical records and I cannot confirm the date I moved into Lissie House. I think it was just before Christmas 1951 or 1952. I know I also spent a period time in Crawfordsburn Sanatorium where they treated infants with tuberculosis.

**Lissie House (dates unknown)**

5. I was very young but I remember incidents where I was physically abused. I cannot confirm if the abuse happened at Lissie House, the Royal Hospital or Crawfordsburn. I do recall the incidents took place beside a door with a painted glass window and the windows were open and it was cold like a dungeon. I remember always feeling cold and afraid in Lissie which makes me think it was Lissie House. I was in a little ward off to the right and I recall a white metal cot with a dark red rubber mattress. The mattress had no bed clothes and I remember being naked and cold.

6. On one occasion I was standing up holding on to the bars of the cot when a nurse came in and beat me. She shook me very hard. She threw me down on the mattress. I was so scared I wet myself. I had no nappy on and remember standing in a pool of urine. I couldn’t understand what was happening. I was crying and the same nurse came in, lifted me, shook me and threw me down again. A second nurse came in and put me over her shoulder and soothed me. The nurse that shook me cleaned my mattress and put me down again with a slap. She was [redacted] with [redacted] hair and a cross face. I can
Q. Well, might it be that some of the things that you remember happening happened in Crawfordsburn and not Lissue, or do you just not know?

A. I couldn't go either way on that, to be quite honest, but I -- it's stronger to me that it was Lissue House.

Q. Thank you very much.

MS DOHERTY: Thank you. I don't have any questions.

A. Okay. Thank you.

MR LANE: Could I just ask you a bit more about the hitting that you suffered? It was the younger nurses you said that hit you.

A. The heating?

Q. You were hit with a spoon.

A. Oh, sorry. Hit, yes.

Q. You were hit with a spoon by younger nurses I think you said.

A. Aye, that was the younger nurses.

Q. Did they hit all the children?

A. I never seen any other children.

Q. Ah! Right.

A. I never ever seen any other children other than the birthday reception, but I was isolated. I was isolated like a small -- like a large cell, but not a ward.

I was there on my own and they kept coming in -- the nurses kept coming in and out. People visited me in
that room. I didn't get out of that room.

Q. Right. What sort of spoon are we talking about?

A. Well, I think it was maybe a soup spoon type of a thing.

Q. Right.

A. They hit me on the forehead and on the chin presumably because I wouldn't or couldn't eat.

Q. Right.

A. I have had an eating disorder all my life. Even now to this day I have an eating disorder, not bulimia or something like that there. It is just a bad eating disorder. Even my family haven't seen me eating.

I don't eat in public. If I came to visit your house for a week, I wouldn't eat in it, and I wouldn't eat in a cafe. Then I would maybe get something out of a shop and eat it in your back yard or something, you know.

You wouldn't see me eating it. I have an eating disorder from that and I think it stems from.

Q. So were the nurses feeding you then?

A. Well, they must have been --

Q. Yes.

A. -- otherwise I wouldn't have survived.

Q. Yes.

A. They must have been feeding me something, but I don't recall ever eating.

Q. Right.
received the best of treatment in Lissue.

A. She bragged that Lissue House was there for the
superstars, the children -- it was like a sanitorium in
the country for -- you know, "You must have got --
I done the best for you, because it was the best
possible ...", and it just went in one ear and out the
other ear with me, because I always believed I was
abused, but I could never say it to her. There are
a number -- a few reasons why I couldn't say it to her.
She was badly abused in Nazareth Lodge and her story
obviously would have been worse than mine. Also she --
if I had challenged her about Lissue House, it would
have been taking into question her as a mother, as if
"You let this happen" or something like that, but I know
it was out of her power. She was under a false
illusion, but I never told her to three years before she
died in 2005. Three years later she died. She was
astonished. I felt mature enough then to tell her and
her old enough not to strike out.

Q. I just want to clarify one thing. I don't believe -- it
might be in the bundle -- but there is a note in your
medical records from much later in time to say that your
mother died when you were two years of age, but that was
incorrect. Isn't that right?

A. Yes, that was definitely wrong, because it was my Aunt
Lissue House (1976)

5. I remember my first day in Lissue. I was brought into a big building with massive doors and a long corridor. At the time I didn’t know what Lissue was but it felt like a hospital. I remember the staff ushered LS 17 and me away while my mother went down the corridor and left us. I cannot remember how long I stayed in Lissue but I do remember it was a horrible place. It was very strict and there was no care or affection from the staff. I remember lots of children crying and screaming all the time. It seemed like nobody cared that the children were unhappy. It was a cold and frightening place. I went into Lissue wearing my normal clothes and I remember wearing odd pyjamas whilst I was in there. I don’t know where the clothes came from.

6. I shared a room with LS 17 at the start. I was frightened by [Redacted]. He had behavioural problems and was really violent. He was always trying to break and smash things, and trying to escape. I remember the staff tied LS 17 arms in a child’s jacket to restrain him. He would kick out and scream hysterically. He would also thump me and take his anger out on me. I don’t understand why I wasn’t protected from him. I cannot recall how long I shared a room with LS 17 before I was moved to single room.

7. The staff were very physical and rough. They pulled me by my arms and my hair and trailed me down the stairs. I was shoved, dragged, and thrown into my room and locked in on several occasions. It was an awful place to be in. I saw children being dragged along the floor by their arms into their rooms and being restrained. I found it upsetting because I did not know why I was there. I remember on one occasion a staff member pulled me by my neck. I cannot recall if they were female or male. I cannot recall what the staff looked like. I don’t know if it was because I was young or if it’s because I was in Lissue for a short time. I just remember the feeling of being scared and wanting to go home.

8. I wet my bed from when I was really young and I constantly wet my bed in Lissue. The staff refused to change my bed sheets. I would be left wearing the same wet underwear for days. It was sore and when I complained about it the
1. A. Yes.

2. Q. If you could maybe just tell us how they did that to you.

3. A. It was a physical restraint where staff would pin you, pin you to the ground and, like, somebody would be on top of you. They would control your legs and you were like controlled from your neck to your knees. You couldn't move, but then your hands were held. You know, you were held on the ground where somebody was sitting -- maybe two staff three times or maybe three staff at times, you know, depending on how aggressive you were. For the age of me and the way -- I was very strong and I was very aggressive.

4. Q. You were a 5-year-old child --

5. A. Yes.

6. Q. -- but you were quite strong?

7. A. Yes, and quite aggressive as well.

8. Q. You did say to me when we were talking earlier that sometimes you couldn't breathe with the weight of the person who was holding you down.

9. A. Yes, because remember they were big people and when they -- like when you -- all I can describe it is whenever you kind of flipped out, you were angry, I mean, this is the way they dealt with it. I think, you know, with me,
you know, they pinned me down. I didn't get a jacket or
the mummy wrap or nothing like that there. I mean,
I was just pinned to the ground and left to squeal,
squeal out, you know, when it was going on, sometimes
near sick, you know, because you were held that length
of time and the weight on you, you know.

Q. This only -- you were only ever held down on the floor.
Were you ever held down on the bed at all?

A. No. I was never held on the bed. I was sat on the bad
and forced just to sit on the bed and that was it, so
I was, but no, because I would just kick out and, you
know, wriggle and, you know, whatever, you know, bite,
you know. So, no, I was never held down on the bed
apart from when LS17 was -- sorry -- apart from him who
should not be mentioned when he was getting at me. So

Q. Well, you say that you saw other children -- don't
worry. We can use names in here. Don't worry about
that, HIA421.

A. All right. Okay.

Q. I will just remind people that the names aren't to be
used outside the chamber.

A. Right.

Q. It's very difficult not to use people's names.

A. Yes.
PRIVATE

Lissue House (1976)

5. I remember my first day in Lissue. I was brought into a big building with massive doors and a long corridor. At the time I didn't know what Lissue was but it felt like a hospital. I remember the staff ushered LS 17 and me away while my mother went down the corridor and left us. I cannot remember how long I stayed in Lissue but I do remember it was a horrible place. It was very strict and there was no care or affection from the staff. I remember lots of children crying and screaming all the time. It seemed like nobody cared that the children were unhappy. It was a cold and frightening place. I went into Lissue wearing my normal clothes and I remember wearing odd pyjamas whilst I was in there. I don't know where the clothes came from.

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8. I wet my bed from when I was really young and I constantly wet my bed in Lissue. The staff refused to change my bed sheets. I would be left wearing the same wet underwear for days. It was sore and when I complained about it the
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 an [insert] doctor.
PRIVATE

this entry shows that staff hit me otherwise why would I be in fear of getting a slap from staff if it hadn't happened before. I have seen an entry from my records which again states that I was thumped by another resident and that I was frightened the doctor was coming to give me an injection.

15. On the grounds of Lissue House there were barns and stables with horses. There was a wooden hut with a giant sand pit and some of us would try to dig tunnels to escape. On one occasion a boy called [LS 49] had to be taken to hospital because a tunnel collapsed on him.

16. About two or three of us always tried to escape. [LS 47] was one of them. I think one might have been [HIA 172]. I have had no contact with [LS 47] since I left Lissue. We realised that we could walk out through the stables which brought us out onto the main road which was in the country surrounded by fields. The police always brought us back. This happened about three or four times. I think the police were from Lisburn Station but I don't remember any of their names.

17. On one occasion [LS 7] tried to take blood from me. She tried both arms and was unsuccessful but kept tugging at me. The needle came away from the syringe and stuck in my arm. She called me a 'stupid bastard' and gave me a slap across the head. The blood went all over her white coat. I have been petrified of needles ever since.

18. [LS 7] was evil. She would grab you by the scruff of the neck and shove you into your room if you annoyed her. She could be quite nice to you if you did everything she told you to do and acted like the robot she wanted you to be. If you didn't draw her attention she left you alone. I have memories of hearing other residents squealing but I never witnessed abuse directly.

19. The only toys I can remember in Lissue House were in a room next to the interview room. In that room there was a big train set and you had to be
11. On our bedroom doors we each had a chart with stars or ticks for good behaviour. I think they were blue or red marks and points. At the end of the week they would give you a plastic toy if you were well behaved. I did not get a toy very often.

12. I have seen my records from my time in Lissie. One of the documents states 'method: 1 member of staff to set tasks and give red points from 8.00am – 5pm, another from 5 to bedtime. All staff to give blue points. Points: Compliance / Co-op interaction / attention seeking / non compliance / 3 blue points – to in bed in pyjamas. Exchange: 20 red points in a day – 'special attention' for ½ hour. 100 red points at the end of the week. To receive gift.' Another record describes what feeding times were like: 'It was not to be treated the same as the others during meals. If necessary be told once to eat up otherwise the plate is taken away.' This demonstrates the harshness of Lissie – 'eat now or be starved'.

13. A record shows that I as a nine year old child was not allowed to have the staff's attention – 'Usual demanding. Appears to bring out the worst in peers. Receives the odd kick and thump from the older peers. This does not discourage he still goes back for more. Had his arm twisted by for no reason at all.' This shows that the staff knew I was being beaten by other children and they did nothing about it. If anything the tone of this record would suggest that the staff thought I deserved the beatings. I was beaten by other children almost daily. There is another similar record in my notes '1/6/81 on the verge of trouble several times during the evening sometimes heedless of warnings which earned a few thumps from peers. Needed constant supervision.' I think this also demonstrates that the staff did not intervene to prevent other children from thumping me.'

14. An entry from my records interestingly shows my fear of staff '4.3.81 had enough points to gain ½ hour with member of staff. Took to trains with, they both played very well together. seems to watch staff through play as if he was afraid of doing something wrong or turn his back in case he would get a slap, very edgy. I think
PRIVATE

built with [redacted] which he also wore in a side parting. He always wore [redacted] aftershave. To this day, I cannot stand the smell of it and I can't use it.

12. I could never discuss the abuse I suffered with anyone. My mother and father did come to see me once or twice but most of the time I would go home to see them on the weekends. I was allowed home after my first few weeks in Lissieu. I loved getting home at the weekends. I did not want to go back to Lissieu and I remember I was always delighted every time I got sick or something happened that allowed me to stay at home for longer. I never told my mother or father what was happening at Lissieu because I did not think that they would believe me and I was afraid of what would happen.

13. There were other incidents of physical abuse from the staff nurses. All of the nurses were very strict. One day I was not feeling well and I could not finish my dinner. LS 22 asked me why I was not eating my food and I told her that I was not feeling well. She shouted at me that it was a waste of good food and then she hit me on the side of face that knocked me to the floor. LS 22 was a [redacted] woman with [redacted] coloured hair.

14. I recall another incident when I was in the T.V room with LS 28. We were watching Mohammed Ali in a world title fight and I was excited running around the room. LS 23 told me to stop messing about but I did not listen to her. She dragged me into the bathroom beside the T.V room and rubbed soap on my tongue until I was physically sick. LS 23 had a [redacted] complexion with [redacted] hair.

15. The only time I saw another child being abused was when LS 21 and the other nurse called LS 27 force-fed LS 14 in the bed opposite where I slept. LS 27, the nurse, pinned LS 14 down and LS 21 had a tube and a funnel which they forced down his throat. They pinned him to the bed and poured a substance down the funnel and into his stomach.

16. There was a reward system for good behaviour at Lissieu which was based on points and if you got enough points you got a treat, for example, a telephone
call home was 750 points or a trip to the swimming pool required 1050 points. I remember getting to swimming pool once. It would have been very difficult for a child to get 750 points because a lot of them were more rebellious than me. I also remember Miss World visited the children in Lissue one time and the Army use to visit on a weeknight and brought movies to watch in the TV room. I think they were from Thiepval Barracks in Lisburn.

17. If you were caught misbehaving the nurses made you stand in the corner facing the wall. One time I was thrown into the cupboard and locked in the dark. I do not know how long I was in there for. I hated the dark. Whenever I was at home my mum kept my bedroom door open and landing light on because I hated the dark.

18. I ran away once with who was a few years older than me. suggested the plan to me and it was shortly after the sexual abuse I suffered from and . I was delighted with the plan and wanted to get away from Lissue. It was around Spring time and we waited until everyone was in the dining area eating supper. We then left through the play area at the back of the classrooms. We crossed a stream and came to a railway track that ran in front of Lissue Hospital. We were heading along the railway track when the and caught up with us. They grabbed us and put us in the back of a car and took us back to the hospital. They separated us and I do not know what torture they did to that night. They put me in a bath of ice cubes and then threw me into bed while I was still soaking wet and freezing. The next day my bed was totally soaking. I do not know if it was because I wet myself that night or because I was soaking wet when I went to bed. When I look back on my experiences in Lissue Hospital, I often think Lissue should have been a place of safekeeping for children but I was not safe there. I do not think the other children were safe within Lissue either. I remember tried to escape Lissue one time. He kicked the wooden panel of an emergency exit door to try to get out but failed.

19. I did have some talking therapy with Dr Manwell at Lissue. He came to visit me in Lissue but I honestly do not remember any other type of therapy in
The further suggestion that this abuse then happened maybe twice or three times every month is again completely denied by me. Such allegations are completely false.

38. A further allegation which took place at some unknown time maybe about 7.00pm in the evening when HIA 220 alleged that I brought him to a craft room is completely denied by me. All allegations relating to this are completely false. The other persons who allegedly took part in this namely the called LS 27 and LS 26 are people who I believe do not exist. I believe that records should be checked to confirm whether or not these people exist. If they do not exist I would state that this is an example of complete concoction by HIA 220. The only craft room that I recall was very small. In size it was like the police interview room. It could even be smaller than that. There were no toys in it. There was no bed in it. There would have been easels on the floor for painting. Perhaps 5 in number. There would have been a small table with paint and water jars and items for mixing paint.

39. HIA 220 then makes further allegations that he tried to escape with other persons. I do recall having to chase after children who were absconding. I would never have done this alone. I would have had other staff with me. I never chased after absconding children with anyone called LS 27. I would have gone into Lisburn in the car and taken female staff with me if a child had absconded. Although I tried to catch absconders I never succeeded. It was either the police or the army who found them and brought them back. The allegation that I caught HIA 220 and then returned him and threw him into a bath full of ice is completely false. Ice cubes would not have been available outside the kitchen. The kitchen was adjoining the separate paediatric unit. It was closed from 5pm. I had no access to it. Night staff would have been present. They would never have allowed a child to go to bed in a soaking wet cold condition. Children would have been checked in particular by LS 25 in case there were soiling marks on their pyjamas. Other staff would have done similar checks.

40. The suggestion that the following morning I then threw HIA 220 into a bath of cold water and ice cubes is completely false. The night staff would check every hour on the children. Any with particular difficulties would be checked every 15 minutes.

41. I was asked about my clothing while working at Lissieu. I remember wearing black flannels. I remember wearing a black belt but not a brown belt.

42. Throughout my life I have been brought up as a Christian and have tried to live my life according to Christian principles. I completely deny all the allegations made against me. I find the allegations distasteful and disgusting. In Lissieu we had many sex abuse cases which we had to investigate. We had a psychology department with a full armoury of anatomically correct dolls. I believe it is inconceivable that anything such as alleged against me could have happened. If any of these incidents had happened someone’s suspicions would have been triggered. The unit was multi disciplinary and included daily discussions, examining,
other boy LS14, who was anorexic, that maybe that had
been some treatment that he had witnessed, and he
accepted that it may have been, but that as a child he
just thought it was cruel and didn't realise that it was
treatment, but when we were talking, LS21, you said that
that -- there was no such treatment ever given to this
particular boy.

A. Absolutely not, no. That's abuse. That -- I'm sorry.

Q. It's okay. I can see that you're finding this
distressing, but certainly you didn't feel that there
was anything of that nature that went on?

A. I had a relation... -- I'm sorry. I had a relationship
with his parents and I visited them. This child was
very ill. He subsequently died.

Q. Yes.

A. So they needed a lot of support and I -- they would have
been aware if he'd been mistreated like that.

Q. Well, at 0034 I was reading out for him the record that
I have already shown to you that is at LIS1182, which is
the record of him having absconded on 7th June 1976.
Maybe if we just call that up, because I know you want
to comment on it. It is 1182, please. That's it now.
Now if we can scroll down, it is not terribly clear, but
you will recall when we were looking at it, it is 7th or
8th June 1976:
"Absconded from unit at 8.10 pm accompanied by", and
the name is blocked out, but he gave the name. "Brought
back by LS21. Thought it was great fun. No remorse
shown and f***ed and blinded all in sight when he was
put to bed."

Now there's a signature underneath that.

A. Can I say that's not mine and I know why? The date you
will see is "7/8".

Q. Uh-huh.

A. I don't -- my 7 is a European 7. That's not my writing.

Q. It is not clear whose handwriting it is.

A. It is not mine.

Q. You don't recognise it?

A. I can just say it is not mine.

Q. No, I appreciate that, but it doesn't ring a bell with
you as to whose it might have been even?

A. No. I --

Q. But certainly when we were talking earlier, you would
confirm that you were the only LS21 --

A. Yes.

Q. -- on staff --

A. Yes.

Q. -- and so therefore this is likely to have been you who
brought him back on this occasion when he absconded?

A. Yes.
IN-PATIENT NURSING NOTES

Date: 

Doctor: 

Name: 

[Handwritten text]

OFFICIAL-SENSITIVE-

LIS-1182

OFFICIAL-SENSITIVE-

OFFICIAL-SENSITIVE-

OFFICIAL-SENSITIVE-
PRIVATE

built with [REDACTED] which he also wore in a side parting. He always wore [REDACTED] aftershave. To this day, I cannot stand the smell of it and I can’t use it.

12. I could never discuss the abuse I suffered with anyone. My mother and father did come to see me once or twice but most of the time I would go home to see them on the weekends. I was allowed home after my first few weeks in Lissieu. I loved getting home at the weekends. I did not want to go back to Lissieu and I remember I was always delighted every time I got sick or something happened that allowed me to stay at home for longer. I never told my mother or father what was happening at Lissieu because I did not think that they would believe me and I was afraid of what would happen.

13. There were other incidents of physical abuse from the staff nurses. All of the nurses were very strict. One day I was not feeling well and I could not finish my dinner. [LS 22] asked me why I was not eating my food and I told her that I was not feeling well. She shouted at me that it was a waste of good food and then she hit me on the side of face that knocked me to the floor. [LS 22] was a [REDACTED] woman with [REDACTED] coloured hair.

14. I recall another incident when I was in the T.V room with [LS 28]. We were watching Mohammed Ali in a world title fight and I was excited running around the room. [LS 23] told me to stop messing about but I did not listen to her. She dragged me into the bathroom beside the T.V room and rubbed soap on my tongue until I was physically sick. [LS 23] had a [REDACTED] complexion with [REDACTED] hair.

15. The only time I saw another child being abused was when [LS 21] and the other nurse [LS 27] force-fed [LS 14] in the bed opposite where I slept. [LS 27] the nurse, pinned [LS 14] down and [LS 21] had a tube and a funnel which they forced down his throat. They pinned him to the bed and poured a substance down the funnel and into his stomach.

16. There was a reward system for good behaviour at Lissieu which was based on points and if you got enough points you got a treat, for example, a telephone
evaluating and looking at the treatment therapies. The staff responded to all kinds of issues. The particular allegations of anal abuse made against me by someone who at the time would have been perhaps 12 years of age would have been easily investigated and would have had medical repercussions which would have been noticed and reported very quickly. There would have been a very very strict evaluation of any circumstances where a child would present with any of the symptoms of any kind of abuse.

Additional points occurring to me after my police interview:

43. It is my belief that any fire escape referred to by HIA 220 was at least 90 feet from his dormitory and therefore not a short distance as he described.

44. The route between any such bathroom and his dormitory involved the passing of 3 x 4 bedded dormitories. These dormitories had glass windows in their doors and therefore movement would have been visible. If any allegation relates to day time, staff would had to have passed through a busy and occupied day room to get to the dormitory — assuming he was in the 8 bed dormitory. I recall LS 13 was in this 8 bed dormitory to be closest to the office.

45. With regard to the first allegation against me by HIA 220 he states that this took place in the dormitory. That dormitory would have been a matter of a few feet away from a busy office which was constantly occupied throughout the day time by doctors, psychologists, nursing staff seeking treatment plans. In addition after 3.00pm teachers may have used the office. Domestic cleaning staff would have been present from time to time. I estimate that approximately 30 people would have used that office on a daily basis. LS 77 was the daily in this office.

46. During these alleged attacks a severely epileptic child LS 13 would have been present in the same dormitory as described by HIA 220 that child would have required constant supervision and monitoring throughout the day and night because of his severe epilepsy.

47. In describing another incident HIA 220 says it took place in an arts and craft room which he said contained a bed beside a radiator. There was never any bed in any arts and craft room.

48. I would never have gone out from Lissue in my own car with any patient unless accompanied by a female member of staff. Hospital records should verify this.

49. The suggestion at paragraph 15 by LS 14 that I was force fed is wrong. Such a response was never used at the Hospital. The allegation is a complete fantasy.

50. The whole programme at Lissue at the time held complaints was designed to have each child discuss, reveal, report and share every thought that they had with the team.
STATEMENT OF WITNESS

STATEMENT OF:  

HIA 172  

Name  

Rank  

AGE OF WITNESS (if over 21 enter “over 21”):  

20 years  

I declare that this statement consisting of  

seven  

pages, each signed by me is true to the  

best of my knowledge and belief and I make  

it knowing that, if it is tendered in evidence  

at a preliminary enquiry or at the trial of any  

person, I shall be liable to prosecution if I  

have wilfully  

stated in it anything which I know to be false  

do not believe to be true.  

Dated this  

26th  

day of  

October  

1993  

SIGNATURE OF MEMBER by whom  

statement was recorded or  

received  

LS 92  

SIGNATURE OF WITNESS  

HIA 172  

When I was 6 years old my parents separated and I went into  

Children's Home in  

. When I was 7 years old I moved to  

Lissue Children's Hospital in Lisburn. The first incident which I  

can remember in Lissue was where I was misbehaving in the TV room.  

a nurse, grabbed me by my arm and said "Right, you're  

going to bed". When she dragged me down the corridor she was hurting  

me. I was screaming and shouting and I can remember  

coming out of the office to help  

with me. I broke free and fell  

to the ground.  

grabbed me by my hair and  

grabbed my legs,  

they dragged me into the first dormitory. I was stripped naked and  

put into the first bed.  

and  

held the quilt over my body.  

I was still kicking and screaming when  

appeared. I think  

got hurt. I think I kicked her. I was screaming and shouting.  

stood up and  

sat down on the bed and held me down.  

sat down on the bed again and  

put the quilt over my head because  

I was screaming. I can remember being thumped through the quilt  

around my stomach, chest and legs. I do not know who thumped me.  

I started crying and stopped moving.  

pulled away the quilt,  

looked at me and asked if I was going to behave.  

spoke to  

and  

left the room. Then  

left.  

stuck around and  

talked to me about what I had done and said that what they had done to  

me was for my own good.  

asked me if I was going to behave and I
A. It is on the ground floor. I mean, there's like windows. So if you are in the dining area, the kind of recreational dining area where the group therapies sort of take place, there is like these double doors that lead into a corridor. Down at the end of the corridor is the bathrooms that we would use throughout the day. Along this corridor I think there's maybe three or four dormitories. I think there's just three of them. You were always put in the first dormitory if it wasn't occupied. That dormitory had windows quite high up that looked out into the actual dining recreation area. Often you would see kids standing on top of the wardrobes naked in these mirrors or in these windows, you know, just jumping up and down when you were having your lunch. It was quite comical at the time, but yes. That was usually the default sort of room that you were put into.

Q. What you describe here is whenever you are taken into the first dormitory you are stripped naked --

A. Uh-huh.

Q. -- and put into the first bed that's there --

A. Yes.

Q. -- with the quilt put over you, and then another nurse, joins the two who are already there --

A. Uh-huh.
15. I went back to [redacted] during holiday periods and I would stay at my Auntie’s house in [redacted] at weekends. I had stayed with my Aunt shortly before one of my visits to [redacted] and she gave me cigarettes to take to my parents. A [redacted] called [redacted] took me to his house in Lisburn and put me under enormous pressure to give him the cigarettes. They were not my cigarettes to give and my Dad would have been very angry if I had no cigarettes to give him. I thought it was very inappropriate to ask me for them and to put me under pressure to hand them over.

16. I remember my mum coming over from [redacted] to visit me. I knew she was coming and the thought of having her back again made me quite rebellious to the staff. I climbed out the bedroom window one night and was running around the grounds in my bare feet. I climbed in the kitchen window as I was hungry. I was about to climb back out the window with a tin of biscuits when one of the [redacted] found me. She said to me to come on and go back to bed. Just as I was climbing down to go with her [redacted] burst in to the room, grabbed me by the hair and dragged me down the long corridors and up a flight of stairs back to my room. He flung me in to my room and my head bounced off the window sill. I was left with a large bump on my head. My mother visited me the following day and I told her what had happened. [redacted] denied hurting me and told her that I did it to myself. My mother did not have the strength to stand up to them and people in authority do not admit when they are wrong.

17. Eventually my mum left my dad and moved back to Northern Ireland. Lissue became normal to me and going home to my family felt weird. It should have been the other way around. When I was at home I had a room to myself and was not told what to do. It was impossible for me to relate to normal everyday life because I was not used to it. The emotional effects of Lissue have had a deep affect on me. I live in constant fear of the consequences of making a mistake and expect to be beaten and punished when I do.

18. Lissue was a horrible place but there was a [redacted] called [redacted] who made the place much easier. Even when [redacted] was being strict and punishing you by
nodded indicating yes. **LS 7** left the room and I was left there physically hurting. Another incident I can remember in Lissue was when I wanted a pair of white trousers. I didn't get them so I decided to make a pair out of my bedsheets with thread from the carpet to sew them together. **LS 7** found them under my mattress and made me wear them. I was paraded up and down the corridor in them in front of staff and residents. Because the trousers were poorly put together they fell apart on me while I was wearing them and were revealing. I was left holding bits of the material to cover my private parts. A Student Nurse said to staff that she would report the incident to someone more official if they wouldn't put me in proper clothes. At different times during my stay at Lissue if I did not finish my meal, it would be put in a bowl and left until I had actually eaten it, even when it was cold. Other times I was made to sit on the toilet for hours until I had actually gone, even if I didn't need to. If I misbehaved I would be left in my room for long periods of time, all day in some cases. Sometimes when I was left in my room I was left naked. Once I ran out of the building before bedtime. I was still in the grounds. I was hungry so I climbed in through the kitchen window to get biscuits. I switched the light on and one of the nurses caught me. The nurse asked me to go to bed and I agreed. Before I got out of the kitchen door, **LS 8** burst through the door and grabbed me by the hair. He dragged me out of the kitchen on my back. I was screaming and shouting. He dragged me along 3 corridors, through doors where my legs caught on them. I was in my pyjamas and bare feet. **LS 8** dragged me up two flights of stairs on my back. He threw me into my bedroom and left me there. My ankles and back were very sore. My mother visited me the next day and took me out. Staff were not going to let me out because I had run away the
<table>
<thead>
<tr>
<th>Date</th>
<th>Nursing Goals</th>
<th>Review Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>11.3.85</td>
<td>3rd Review&lt;br&gt;To escalate to an acceptable level.&lt;br&gt;Give one-to-one when needed, especially at weekends.</td>
<td></td>
</tr>
<tr>
<td>21.3.85</td>
<td>4th Review&lt;br&gt;Focus on each and any success in peer interaction.&lt;br&gt;Arrange situations in which he can take responsibility and provide appropriate feedback.&lt;br&gt;Expect him to have occasional failures in his interaction with staff and peers. Anticipate emotional 'flare ups' maintain low profile</td>
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<tr>
<td>1.4.85</td>
<td>5th Review&lt;br&gt;On extended leave/hospital to parents&lt;br&gt;Clarification of 21.3.85.&lt;br&gt;Expect to have occasional failures. Anticipate emotional 'flare ups'. Maintain low profile&lt;br&gt;IE do not demand explanations which our training prepares us to understand.</td>
<td></td>
</tr>
</tbody>
</table>
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]. [LS 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.
8. On another occasion I was on a roundabout in the adventure playground which was at the front of the home. **LS 35** was spinning the roundabout. He spun the roundabout very fast and I begged him to stop as I was getting dizzy. He didn’t stop and it was going so fast I fell off. I had to be taken to Lagan Valley Hospital again and my wrist was broken. Again I was told to tell the Doctors it was an accident.

9. At night when I felt scared and frightened I got out of bed and I could never find a member of staff. There should have been staff on duty but I could never find them. I used to dread each day because I didn’t know which staff member was going to be working. I lived in fear of being physically and mentally abused. Every day I was treading on eggshells in fear of being beaten.

10. We had class in portacabins. I think the teacher was called **LS 1**. If you didn’t listen in class or misbehaved, the teacher phoned the main building and one of the staff came and dragged you out of the classroom by the ears and slapped you on the back of the head.

11. I witnessed other children getting abused but I do not want to give their names as it is their decision if they want to come forward to the Inquiry. I don’t think there was a day went past when somebody didn’t get hit or beaten. There was constant shouting in your face. The man **LS 35** was terrible for poking us in the chest.

12. There were people in Lissue who had special needs. On one occasion a girl got hyperactive when eating her lunch. I do not want to give her name. **LS 7** grabbed her by the hair and shook her and put her in the corner and made an example out of her in front of people. If it wasn’t her getting abused it was someone else and if it wasn’t someone else it was me.

13. A psychiatrist called **LS 21** was in charge of Lissue. I think I saw him once. I think I was given tablets but I don’t know what kind of tablets they were. I don’t know what kind of medication I was on in Lissue.
14. My family came to visit me about once a week. I couldn’t tell them what was going on because there was always a member of staff watching me to ensure that I didn’t say anything about the abuse. The staff would tell my family ‘oh he is doing great’. I didn’t get the opportunity to talk privately to my family. I couldn’t tell my family that I hated the place. When my family left the staff’s attitude changed. It was all for show.

15. Sometimes if I was walking on the corridor past staff they would have kicked me or gave me a slap. They beat me and other children for no reason and sometimes laughed when they did it. For example, if we were in the TV room laughing I would be pulled out or dragged out by the staff and I would have got shouted at and the video we were watching would be stopped and everyone would be punished. This went on constantly.

16. LS 7 always made an example out of you if you were caught talking at breakfast time. She made you stand in the corner and she would have told everybody ‘see this is what happens to people who talk too much’.

17. LS 34 took us to the marches in Lisburn on 12th July. The other children who were in the home and I didn’t want to go but she made us and said ‘you’re going whether you like it or not because there’s nobody else to look after you’. She was laughing and cheering while the people were marching. We didn’t want to be here.

18. I don’t know what jobs the staff who abused me performed. I don’t think they were medical staff. They didn’t wear a uniform. They wore ordinary clothes.

19. LS 7 was very wicked. She did a lot of the beating, slapping and pulling hairs. She hit you by the hand or pulled your hair and ears, and slapped you on the back. She was a big woman. She threw me out of the dormitory many times.

20. The other children in Lissue were pleasant and I witnessed them getting slapped and punched.
8. On another occasion I was on a roundabout in the adventure playground which was at the front of the home. LS 35 was spinning the roundabout. He spun the roundabout very fast and I begged him to stop as I was getting dizzy. He didn’t stop and it was going so fast I fell off. I had to be taken to Lagan Valley Hospital again and my wrist was broken. Again I was told to tell the Doctors it was an accident.

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• 11th July 1984 – taken to Casualty Dept LVH, Injured little finger (R) Hand. Finger strapped and sling to be worn for some days
• 1st August 1984 – reviewed and strapping removed
• 29th June 1984 - hurt his toe in swimming pool. Sen by Doctor NAD
• 22nd July 1984 – taken to Casualty LVH injured his wrist (L) arm. POP applied. to be seen at a later date

It is believed “POP” means “Plaster of Parris” see Exhibit 11

23. The FSR for the period 26th June 1984 confirms that an accident report was completed in respect of the incident in which he injured his toe. To date a copy of this report has not been located. In respect of the Applicant’s broken wrist, the Fortnightly Summary Report for the period 10th August confirms the Applicants’ attendance at the Lagan Valley Hospital (LVH) and that “POP” applied. The Applicant remained in Plaster of Parris until the 14th September. It also records an additional further injury to his small finger resulting in strapping having to be reapplied

24. A note recorded in the Applicants In patient medical notes for the 11th July states “R little finger trampled on. Restricted movement. Refer to casualty.” There is no indication whether it was known who had trampled on the Applicants finger, see Exhibit 12

25. The Applicant states he was unable to tell his family what was going as when they visited as there was “always a member of staff watching me to ensure that I didn’t say anything about the abuse”

26. It is known that within Lissue, there were occasions when visits by family may have been supervised by Staff, such as if the child was on 1:1 observation or as part of the therapeutic programme which the child was receiving in which interactions between the child and their family were being observed, However each case was dependent upon the child’s unique set of circumstances
IN-PATIENT NURSING NOTES

Name: HIA 119

Doctor

Date

Summary cont.

11th July, 1984 - taken to Casualty Dept. L.V.H. Injured little finger (R) hand. Finger strapped and sling to be worn for some days.

1st August, 1984 - reviewed and strapping removed.

19th June, 1984 - hurt his toe in swimming pool. Seen by Doctor. N.A.D.

22nd July, 1984 - taken to Casualty, L.V.H. Injured his wrist (L) arm. P.O.P. applied. To be seen at a later date.

S/N: LS 34
PRIVATE

7. The other thing I remember about the boy and the girl is that they had a big meccano set and they used to build cars and motorbikes out of them. They loved it. I remember on one day this same member of staff was walking down the corridor and he kicked the motorbike to smithereens when we were playing with it. I was very upset and they took me back to my room and strapped me to my bed again. After about twenty minutes, my next memory was waking up in bed the next morning.

8. That same member of staff hit me on several occasions also. He would ask me if I wanted a cigarette and when he gave me one he would say "Do you want a light", and when I said yes, he would hit me on the face or head. It was like he was playing mind games with me.

9. I also recall a man who came to the window in my room in the evenings. I think there was a fire escape outside my room. The window hatch was opened slightly and he used to knock and slip cigarettes under the hatch. I don't know who the man was. He was [redacted] The staff at Lissie thought I made this man up. I know I didn't because I remember looking forward to getting a cigarette in the evening and a bit of conversation.

10. I don't recall any particular routine at Lissie. I have no memory of attending school during my time there or being taught school lessons. There was a cookery class and we used to make buns during it. I also remember a teacher taking our photographs with instant cameras.

11. I remember that as a punishment the staff would put me in a room with children who were severely disabled. I know I had behavioural issues but I was not disabled. The staff would make me sit with these children for hours and I could not understand why. I thought that they were playing mind-games with me and were punishing me in some way. These children had special red chairs with sheepskin padding and I remember these chairs very clearly. My mother came to see me regularly when I was at Lissie and when she saw I was sitting with these children she couldn't understand why. I think it upset
Q. A couple of times you mentioned you thought they were playing mind games. What do you think they were trying to do with you?
A. Just teasing — like teasing you with the cigarettes. You know what I mean, like?
Q. Uh-huh.
A. They would have left — as I would say, the ashtrays would have had big nicks in it —
Q. Uh-huh.
A. — you know, and then after getting a cigarette butt it was basically getting a light, but, sure, what other option did I have but to try to run away to get a match, if you know what I mean?
Q. So do you think they were trying to upset you in some way?
A. Aye. They were trying to get me to run away —
Q. Right.
A. — trying to get me to go up on the roof, because it was easier for them, because, as it says, everybody was
her. I remember my mother tried to take me out of Lissue one day. We got as far as the front gate before a member of staff stopped us and I was sent back.

12. I also remember an incident when a member of staff examined me. He put his hands down my trousers and asked me to cough. I do not know if it was a doctor or a psychiatrist. I always wondered if that was inappropriate and I remember asking a GP once for his advice. The GP said if it was a doctor it was mostly like a medical examination. I am aware of the abuse that happened in Lissue and sometimes I wonder if anything happened to me when I was sedated for days.

13. The food in Lissue was ok. It was just like hospital food. I don’t remember where the bathrooms were. I do remember one day we were sent outside to shower. It was a very hot day and we were all lined up against the wall and they showered us with the outside watering hose. I remember the power of the hose was so strong we were scraped against the wall. The wall was rough and it nicked my skin. When they gave me soap or shampoo to wash I remember it seeped into my cuts and stung my skin.

14. I ran away from Lissue frequently and the police would always find me and bring me back. I wanted to go back to my mother. I remember one time I ran back to Carnview and broke in to steal food from the kitchen. I was away for days before the children in Carnview saw me and the staff alerted the police. I would climb onto the roof in Lissue to find escape routes and the staff would call the police. On one occasion, when I was attempting to escape, I remember running down the lane from Lissue. A man, we called the black chased after me. I must have fallen and the black grabbed me and pushed my face right down in a puddle of dirty water. I remember struggling and two policemen and a member of staff ran over and pulled black off me but no report was ever made of it.

15. I was given a medical examination every time I returned to Lissue after running away. I remember the staff would drag me into a particular room. They would give me some medication which knocked me out. The next thing I
Lissue House (02/11/1987 to 19/02/1988)

3. A few of the nurses behaved in a way which was unprofessional. I was mentally and physically abused in Lissue. The staff grabbed and pushed me to get me to do what they wanted. They grabbed my shoulders and the back of my neck. They were physically rough with us. One of the [REDACTED] in particular was a bully. He was either called [REDACTED] or [REDACTED]. He was in his [REDACTED] He punched and shook me any time he saw me. He made fun of us and our problems and said things to me like "is your head still on your shoulders?". He always made sure no other member of staff was watching. I saw him pushing and making fun of another resident called [REDACTED]. He walked around shouting out of the blue. I think he might have had Tourette's syndrome. The staff, particularly [REDACTED] mimicked him. They tortured him and made little of his problem. I witnessed staff being physically abusive to him and on one occasion banging him against a wall. It really annoyed me and it made me feel more depressed. Whilst there was no sexual abuse the staff made suggestive sexual comments to me.

4. Another [REDACTED] called [REDACTED] was friends with [REDACTED] and they were always together. She was nice but at times she was sharp in how she spoke to me. There was a [REDACTED] woman and a girl called [REDACTED] who were the [REDACTED] on duty at night. They were both nice. I can't remember the names of any other members of staff in Lissue.

5. In November 1987 the INLA [REDACTED], who also came from [REDACTED], was captured. It was shown on the news [REDACTED] made fun of me saying 'that boy is not far away from you, he will be after you next'. The other nurses laughed. They tried to scare me. I was vulnerable.

6. I was in Lissue to get better not to be scared. This taunting went on and left me distressed. The people looking after me were not the professional people they were supposed to be.
PRIVATE

Lissue my father lost his temper with me to such an extent that his cousin and his wife had to take me back to Lissue.

12. Every time I saw my mother and father I asked them to take me home. I told them what it was like in Lissue but they wouldn't believe me. They told me to catch myself on and that I was in a good place. My parents put their trust in these professionals in Lissue to help me get better and I feel that that trust was abused.

13. They didn't understand what it was like. It was like a concentration camp. We had to go to bed at a certain time. I think I was in a room on my own when I first went and then I moved into a dorm with about five other boys. Sometimes I couldn't sleep at night with so much going on in my head and I would have got up in the middle of the night and walked around. The staff shouted at me and grabbed me by the shoulders to put me back to bed. I felt there was little understanding or care shown to me.

14. My [redacted] at [redacted] school was called [redacted] and she came to visit me once.

15. I was given medication in Lissue after dinner but I don't know what it was.

16. Eventually I stopped thinking that I was having a brain haemorrhage. I became stronger mentally and after 3 months I was released from Lissue.

Life after care

17. My life was ruined by Lissue. I wouldn't talk to anybody about it. My father and mother wouldn't understand what was eating away at me inside. Any time I tried to speak to my mother and father about the abuse in Lissue they told me to brush it under the carpet and get on with my life so I have never reported the abuse to anyone before now.
Craigavon Area Hospital, the Applicant was subsequently admitted to Lissue on 2 November 1987, see Exhibit 2 above.

3. In his statement, the Applicant discusses his relationship with staff. Records in the possession of the Board would suggest that staff at Lissue endeavoured to assist the Applicant with his anxiety issues. Exhibit 5 details that on the Applicant’s first night at Lissue he cried in bed, stated that he had a sore head and missed his parents. Staff responded by giving the Applicant a glass of milk and telling him that he was not to worry about going to sleep and that he could read his comic in bed. The next day the Applicant attended school and was observed to be having a panic attack during break time. Staff carried out relaxation and breathing techniques with the Applicant as well as talking through his fears. The Applicant then took part in a debate later on in the afternoon and participated well under stress. There are also further reports of the Applicant playing pool with other patients, going swimming and to a fancy dress party, see Exhibit 6.

4. In paragraph 9 of his statement, the Applicant recalls he and his family attending family therapy. He further recalls these sessions being uncomfortable, being asked about his sexuality and his brother leaving during one session due to the degrading questioning. Records in the possession of the Board would seem to suggest that the family group therapy sessions were in depth and emotional. The first interview took place on 12 November 1987, see Exhibit 7. The therapist is recorded as asking questions as to how the parents thought family issues could be resolved and why they thought the Applicant was in Lissue. Exhibit 7 also details that a break was taken after the Applicant began to cry and his mother and sister became upset. The therapist is then recorded as saying, ‘you’ve been a lovely family. The team are very impressed with your loyalties and supportiveness’. It was then stated that whilst on weekend pass, if the Applicant had a panic attack, his father was not to intervene and that the Applicant was to carry out relaxation techniques by himself. Exhibit 2 further records that the family therapy sessions were generally geared towards making parental expectations more in line with the Applicant’s abilities. There are records wherein the Applicant informed the therapist that the questions asked made him feel sad as he felt left
This child to be closely supervised AT ALL TIMES.

HAS THREATENED TO JUMP THROUGH A WINDOW OR TAKE WEED KILLER.

<table>
<thead>
<tr>
<th>Problem</th>
<th>Objective</th>
<th>Intervention</th>
<th>Evaluation</th>
</tr>
</thead>
<tbody>
<tr>
<td>% Severe pains in his head - thinks he is going to have brain damage.</td>
<td>Elevate - minimise</td>
<td>Talking to patient and give reassurance</td>
<td>Ongoing</td>
</tr>
<tr>
<td>Hears crackles in his head when he swallows - Also gets nervous attacks</td>
<td></td>
<td>Relaxation</td>
<td></td>
</tr>
<tr>
<td>Has difficulties getting to sleep - afraid in the dark</td>
<td></td>
<td>Help to settle patient and reassure him</td>
<td></td>
</tr>
<tr>
<td>% Has great difficulties in expressing his feelings</td>
<td>Help talk openly about his innermost fears and worries</td>
<td>Talking to and with</td>
<td></td>
</tr>
<tr>
<td>Headaches</td>
<td>Elevate - minimise</td>
<td>Encourage pt. to talk about himself. Use of relaxation</td>
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3/11/87 -Since able to sleep in room without the light on.

HIA 3

3/11/87 - Now is able to sleep in room without the light on.
9/11/87. Referrred by Dr. [obscured] to [obscured], [obscured] for evaluation. He was referred by [obscured] for [obscured] and his headaches and fear of [obscured].

He was brought into group and continued to cry, but then individual attention the crying stopped as he seemed to fall on general topics.

On going to bed he was quite relaxed, then got a phone call from [obscured] a.m. He was told generally to continue his routine when he came on. He started to cry. The conversation was continued by staff as he was gently encouraged to go to bed. The routine was kept for about [obscured] p.m. He made a short trip to the bathroom and then [obscured] to [obscured], [obscured] to [obscured] his head and said he had a pain over the top of his head, that it was [obscured]. He also mentioned he had a [obscured] of [obscured] and said he could sit up in bed and read his comic and not worry about sleeping.

Around 10 p.m. he said [obscured] and effort to sleep.

9/11/87. Morning [obscured]

 Went to school this morning after attending group meeting. Telephone call received from [obscured], stating that [obscured] had become [obscured]. At [obscured] was observed to be having an anxiety/panic attack. Relaxation
IN-PATIENT NURSING NOTES

Name: HIA 3

Doctor: 
Date: 

Carried out deep breathing exercises through his worries, fears and innermost thoughts. Stated he felt the was going bad. Recognized his Guer decide of milk - said he was feeling very dry. 
Out of school for remainder of morning. Chatted more freely after school. Participated in group relaxation which he enjoyed. Latin group had a debate. Was able to address the chairperson although under some stress. Notice his voice became well. Praised ++, looking a little more cheerful at last time.

LS 34

3/18/7 Depressed, crying, wringing hands & headache. 
Fear of brain haemorrhage. 
Took a small group including bachelor for relaxation, alright until he relaxed, home, only speaking few seconds then said phone call crying. When I asked why his siblings were visiting he might would be there shortly. He felt very homesick and wanted to go home. I took him to an office we discussed his fears and how he could cope with same. Said at school be for anxious did not cry, would tell teacher. He felt sick would be sent to matron or to doctor. Anxious would go away & he could return to class. Said he could talk to someone when he felt down. He felt better, took few pills and slept.
14. My family came to visit me about once a week. I couldn't tell them what was going on because there was always a member of staff watching me to ensure that I didn't say anything about the abuse. The staff would tell my family 'oh he is doing great'. I didn't get the opportunity to talk privately to my family. I couldn't tell my family that I hated the place. When my family left the staff's attitude changed. It was all for show.

15. Sometimes if I was walking on the corridor past staff they would have kicked me or gave me a slap. They beat me and other children for no reason and sometimes laughed when they did it. For example, if we were in the TV room laughing I would be pulled out or dragged out by the staff and I would have got shouted at and the video we were watching would be stopped and everyone would be punished. This went on constantly.

16. LS 7 always made an example out of you if you were caught talking at breakfast time. She made you stand in the corner and she would have told everybody 'see this is what happens to people who talk too much'.

17. LS 34 took us to the marches in Lisburn on 12th July. The other children who were in the home and I didn't want to go but she made us and said 'you're going whether you like it or not because there's nobody else to look after you'. She was laughing and cheering while the people were marching. We didn't want to be here.

18. I don't know what jobs the staff who abused me performed. I don't think they were medical staff. They didn't wear a uniform. They wore ordinary clothes.

19. LS 7 was very wicked. She did a lot of the beating, slapping and pulling hairs. She hit you by the hand or pulled your hair and ears, and slapped you on the back. She was a big woman. She threw me out of the dormitory many times.

20. The other children in Lissue were pleasant and I witnessed them getting slapped and punched.

HIA 119
PRIVATE

same male nurse turned up at Lissue House. Looking back I think he may well have singled me out but I cannot be sure whether or not that is the case.

4. He often took me through an inner courtyard area where there was a raised garden and through a door into a corridor inside the hospital. It was an area of the hospital which did not appear to be used often. He would pin me against the wall in this corridor, not aggressively but tenderly and then he would come up very close against me and he would keep talking and talking but at the same time would be putting his hands down my trousers and masturbating me. I think I was about ten at the time. I remember trying to hide on occasions, sometimes in the bushes or in a cupboard, but he would always find me. I knew at the time it was wrong but you did not want to tell anyone because you did not want to get anyone into trouble and you were also afraid that no-one would believe you and you would get into trouble.

5. The abuse was not a daily occurrence but it was certainly regular. He was called LS 9. I no longer recall his first name. I think he was a full time employee, I have no idea what age he would be now but when I was ten I thought he was about 20 years old but that is just guesswork and I could be mistaken. He had short hair at the time. I also recall he had something wrong with his eye, it was not exactly a squint but there was something not quite right about one eye.

6. I cannot recall exactly the length of my first stay at Lissue House but it was certainly a whole summer. As far as I can recall I returned the next year and this time he started interfering with me again.

7. I only saw LS 9 once after I left care. He was in the centre of town but he did not see me and I did not speak to him.

8. The daily regime at Lissue House was fairly normal. I was never subjected to any physical abuse.

9. I recall one boy there at the time, LS 10, who had been slightly brain damaged and he just sat there all day and rocked back and forward. I also
HIA 294 I remember lying at night sleeping and next thing I got woken up, the faces I couldn’t see.

AF member: Yes.

HIA 294 And I was put onto my stomach.

AF member: Yes.

HIA 294 And there was someone down below and I don’t know if I was or if I wasn’t.

AF member: Yes.

HIA 294 But I can also remember the same thing happening to some other wee boy, the same cries.

AF member: Yes.

HIA 294 Yeah and this is at night time surely they would have come in and explained to me even then what was going on but there was none of that.

AF member: So you were put on your face.

HIA 294 Yeah.

AF member: And they were messing around with your bottom?

HIA 294 Yeah which made me feel very dirty you know.

AF member: Yes.

HIA 294 So me sister me older sister [REDACTED] and [REDACTED] went onto like a family group home in Newtownards.

AF member: Okay
Continuation of Statement of: HIA 220

about 7pm or so when I was in the TV room with LS 28. I remember the girls were watching TV. Mohammed Ali was fighting a world title fight and LS 28 was singing his song. I was messing about just running around the room. I remember that the nurse LS 23 came into the room and shouted at me that I had not listened to her and she would teach me a lesson I would never forget. She had told me to stop messing about but like a typical wee lad I hadn't taken any heed. She dragged me into the bathroom which was connected to the TV room. She started washing my mouth out, and particularly my tongue, with some sort of white soap. I remember crying and gagging to be sick and I remember pulling away from her and begging her to stop. She kept doing it and told me that she would teach me a lesson. It only stopped when I started vomiting. She then hit me on the back of the head with her hand and told me that I had made her do this. She then threw me into bed bed without getting cleaned up. She had a , complexion, hair, or I remember the first time I was sexually attacked and it was by LS 21. I had been at Lissue for a few months. I remember that I was in the dining area and I remember that other patients were eating and playing with toys. I recall LS 19 was there. She was in her teenage years and she was always singing Brotherhood of Man. I recall that LS 21 came over to me and told me that he was my friend. I asked him if he was. He told me to come with him and that he would make me better. He brought me to my dormitory, locked the door and then told me that I was sick. He sat down on the bed and then he put his hand on the inside of my thigh and started rubbing his hand on my genitals through my clothes. I asked him to stop and that I didn't like that. He said that he was trying to make me better. He slipped his hand inside my trousers and trunks and started rubbing my penis. I was crying. He told me he would show me his "thing". He asked me to "play with my thing". He took his penis out of his trousers

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<th>Signature of witness:</th>
<th>HIA 220</th>
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and he had a full erection. I realise this now but at the time I had never seen an erection before. I rubbed his penis as he had asked. He then took down my trousers and trunks. I was standing up beside the bed, he was sitting on the bed and I was still crying. I begged him not to hurt me. He told me he wasn't going to hurt me, that I was sick and he was trying to help me. He grabbed my arm and threw me on the bed face down and he got on top of me and he raped me. I felt his penis around my backside and I felt soreness and my backside being wet. It was a soaring pain which is why I know he penetrated me. He told me that this would be our little secret. He put my trunks and trousers back on. He also told me that if I told anyone he would kill me and that I would never see my mother or father again. This was very intimidating and made my heart sink. He unlocked the door of my dormitory and left. I never left the dormitory that evening and I curled up in a ball and cried on the bed. This would have happened maybe twice or three times every month for the remainder of my stay and had no pattern to it. I remember that after the second or third time I knew what was coming to me. I didn't tell anyone else at Lissue about this because of the threats he made against me. I recall another incident after the first time that had raped me. I cannot recall how much longer afterwards, maybe some weeks later. It was evening time after my dinner, maybe about 7pm or so. I remember coming up to me and I was playing. I cannot remember if I was in the dining room or just outside in the playground which was just outside the dining room. said to me "we have got new toys down in the craft room". I asked him if he had. He asked me to see them and I said yes. I went with him, and the other called down the main corridor past the nurse's station office, through the double doors into the left into the craft room. There was a new train set in the craft room mounted onto the table. There were other toys and things to paint with but there was also a bed towards the radiator. This was the first time I had seen the bed
why did you think -- how did you know that there were other children being abused and why did you think that staff knew about it?

A. I thought it was only me, and then there was other children in my own mind were sitting and keeping themselves to themselves. They would have been -- they wouldn't have been outward. They were just keeping themselves to themselves and ...

Q. And you thought that that was the reason --

A. Yes.

Q. -- why they were doing that?

A. Yes.

Q. Why do you think staff knew what was going on?

A. Because at that time my own opinion of it was turn a blind eye. "I didn't" -- didn't want to get involved, saying, "I didn't see" -- "Did you see that?" "I didn't see what." Deny all liability.

Q. But is this something that you think -- is this something you heard staff say or is it something that you just think now?

A. In my own opinion that's what I think.

Q. But there was nothing at the time that you -- that led you to believe that they knew this was going on?

A. No.

Q. You go on to talk in paragraph 10 about another incident
his knee and rubbed his hands up and down my legs. He slipped his hands into my genitals and touched me. I was crying and tried to push his hands away but he kept telling me that he was my friend. I knew it was wrong because my father had never touched me like that.

9. The second time [LS 21] attacked me, it was more violent. He attacked me from behind and raped me in my dormitory. He told me that this was 'our little secret' and threatened that if I ever told anyone he would kill me and I would never see my mother or father again. [LS 21] continued to abuse me two, maybe three, times a month until I left Lissue. I know there were other children being abused but we did not speak about it. We would have been too afraid. I believe the other staff members knew what was happening but they turned a blind eye.

10. There was another incident when I was raped by [LS 21] and [LS 27]. There was an arts and crafts room at Lissue which was a quiet room away from the main part of the hospital. It was kept locked when it was not in use. One evening they told me that there was a new train set in the room. I loved trains so I went down with them to see it. There was a new train set there and I was allowed to play with it. There were also other toys there and a bed beside the radiator. When I went into the room I heard the door lock behind me and I knew I was in trouble. [LS 26] put me on the bed, took my trousers off and started rubbing my genital area. He grabbed my arm and put me down on the bed and raped me first [LS 27]. Then raped me while I had to put [LS 21] penis in my mouth and masturbate [LS 26] penis. I thought I was going to die that day. [LS 26] or [LS 27] never touched me again after that incident.

11. I don't know [LS 27] surname but he had [LS 26] hair and [LS 21] skin. [LS 21] was a [LS 26] and he was well built and had a rasping sound to his voice. He had [LS 26] hair which he wore in a side parting. He always wore a [LS 26] and I remember he drove a [LS 26] vehicle. [LS 26] was in his well
evaluating and looking at the treatment therapies. The staff responded to all kinds of issues. The particular allegations of anal abuse made against me by someone who at the time would have been perhaps 12 years of age would have been easily investigated and would have had medical repercussions which would have been noticed and reported very quickly. There would have been a very very strict evaluation of any circumstances where a child would present with any of the symptoms of any kind of abuse.

Additional points occurring to me after my police interview:

43. It is my belief that any fire escape referred to by HIA 220 was at least 90 feet from his dormitory and therefore not a short distance as he described.

44. The route between any such bathroom and his dormitory involved the passing of 3 x 4 bedded dormitories. These dormitories had glass windows in their doors and therefore movement would have been visible. If any allegation relates to day time, staff would had to have passed through a busy and occupied day room to get to HIA 220 dormitory – assuming he was in the 8 bed dormitory. I recall LS 13 was in this 8 bed dormitory to be closest to the office.

45. With regard to the first allegation against me by HIA 220 he states that this took place in the dormitory. That dormitory would have been a matter of a few feet away from a busy office which was constantly occupied throughout the day time by doctors, psychologists, nursing staff seeking treatment plans. In addition after 3.00pm teachers may have used the office. Domestic cleaning staff would have been present from time to time. I estimate that approximately 30 people would have used that office on a daily basis. LS 77 was the daily in this office.

46. During these alleged attacks a severely epileptic child LS 13 would have been present in the same dormitory as described by HIA 220. That child would have required constant supervision and monitoring throughout the day and night because of his severe epilepsy.

47. In describing another incident HIA 220 says it took place in an arts and craft room which he said contained a bed beside a radiator. There was never any bed in any arts and craft room.

48. I would never have gone out from Lissue in my own car with any patient unless accompanied by a female member of staff. Hospital records should verify this.

49. The suggestion at paragraph 15 by HIA 220 that LS 14 was force fed is wrong. Such a response was never used at the Hospital. The allegation is a complete fantasy.

50. The whole programme at Lissue at the time of HIA 220 complaints was designed to have each child discuss, reveal, report and share every thought that they had with the team.
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11. I don't know the surname but he had brown hair and brown skin. He was well built and had a rasping sound to his voice. He had brown hair which he wore in a side parting. He always wore a vehicle and I remember he drove a well
RESTRICTED (when complete)

Continuation of Statement of HIA 220

Page 5 of 6

the table. There were other toys and things to paint with but there was also a bed towards the radiator. This was the first time I had seen the bed there. LS 21 went into the craft room first and he opened the lock. I was behind LS 21. They let me play with the train set for a bit. LS 21 said to me “we are all your friends and are all here to help you”. I was frightened by this and had a feeling in the pit of my stomach. LS 21 put me onto the bed and kept telling me I’m your friend, we are your friends, you are sick and we are here to help. He took off my trousers and trunks and rubbed my genital area with his hand. He grabbed my arm and put me onto the bed, this time sideways facing towards the wall and then LS 21 raped me first, penetrating my anus with his penis. Then the three of them came at me at once. LS 27 was behind me and raped me while I had to masturbate. LS 28 LS 21 put his penis into my mouth and rubbed it under my lip. I don’t know how long this lasted for. The only thought I had was that I wanted it to stop. I was told that this was our secret and that they would find me and kill me if I told anyone. LS 28 LS 27 never touched me again after this incident. It was after this I tried to run away with another patient called LS 29. LS 29 was a lot older than me, I think he was in his teens at the time and I recall that this was around springtime 1976. It was the idea to escape but we hatched a plan together. It was supper time, about 9pm or so and we would have got biscuits and milk in the dining area. We told everybody that supper was ready and LS 29 and I bolted while everybody crowded into the dining room. I remember there were green colour wrought iron railings and a gate which opened because he was taller than me. We went straight down the lane like the hammers. I recall specifically there was a railway track which ran across the front of the dining room and a stream which my foot went into. I believe that we crossed the railway tracks and turned left and walked up the tracks assuming this would take us to Belfast. I recall that LS 21 and LS 27 caught up with us and trailed and

Signature of witness: HIA 220

Signature witnessed by: (Appropriate Adult)
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up beside the bed, he was sitting on the bed and I was still crying. I begged him not to hurt me.

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

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

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

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

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

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

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

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

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

37. The specific allegation of sexual abuse carried out by me against [HIA 220] in the dormitory is completely denied by me. The threats and intimidation alleged against me by [HIA 220] is again completely denied by me. All these allegations are completely false.
The further suggestion that this abuse then happened maybe twice or three times every month is again completely denied by me. Such allegations are completely false.

38. A further allegation which took place at some unknown time maybe about 7.00pm in the evening when alleged that I brought him to a craft room is completely denied by me. All allegations relating to this are completely false. The other persons who allegedly took part in this namely the called and are people who I believe do not exist. I believe that records should be checked to confirm whether or not these people exist. If they do not exist I would state that this is an example of complete concoction by The only craft room that I recall was very small. In size it was like the police interview room. It could even be smaller than that. There were no toys in it. There was no bed in it. There would have been easels on the floor for painting. Perhaps 5 in number. There would have been a small table with paint and water jars and items for mixing paint.

39. then makes further allegations that he tried to escape with other persons. I do recall having to chase after children who were absconding. I would never have done this alone. I would have had other staff with me. I never chased after absconding children with anyone called . I would have gone into Lisburn in the car and taken female staff with me if a child had absconded. Although I tried to catch absconders I never succeeded. It was either the police or the army who found them and brought them back. The allegation that I caught and then returned him and threw him into a bath full of ice is completely false. Ice cubes would not have been available outside the kitchen. The kitchen was adjoining the separate paediatric unit. It was closed from 5pm. I had no access to it. Night staff would have been present. They would never have allowed a child to go to bed in a soaking wet cold condition. Children would have been checked in particular by in case there were soiling marks on their pyjamas. Other staff would have done similar checks.

40. The suggestion that the following morning I then threw into a bath of cold water and ice cubes is completely false. The night staff would check every hour on the children. Any with particular difficulties would be checked every 15 minutes.

41. I was asked about my clothing while working at Lissie. I remember wearing black flannels. I remember wearing a black belt but not a brown belt.

42. Throughout my life I have been brought up as a Christian and have tried to live my life according to Christian principles. I completely deny all the allegations made against me. I find the allegations distasteful and disgusting. In Lissie we had many sex abuse cases which we had to investigate. We had a psychology department with a full armoury of anatomically correct dolls. I believe it is inconceivable that anything such as alleged against me could have happened. If any of these incidents had happened someone’s suspicions would have been triggered. The unit was multi disciplinary and included daily discussions, examining,
this entry shows that staff hit me otherwise why would I be in fear of getting a slap from staff if it hadn’t happened before. I have seen an entry from my records which again states that I was thumped by another resident and that I was frightened the doctor was coming to give me an injection.

15. On the grounds of Lissue House there were barns and stables with horses. There was a wooden hut with a giant sand pit and some of us would try to dig tunnels to escape. On one occasion a boy called LS 49 had to be taken to hospital because a tunnel collapsed on him.

16. About two or three of us always tried to escape. LS 47 was one of them. I think one might have been HIA 172. I have had no contact with LS 47 since I left Lissue. We realised that we could walk out through the stables which brought us out onto the main road which was in the country surrounded by fields. The police always brought us back. This happened about three or four times. I think the police were from Lisburn Station but I don’t remember any of their names.

17. On one occasion LS 7 tried to take blood from me. She tried both arms and was unsuccessful but kept tugging at me. The needle came away from the syringe and stuck in my arm. She called me a ‘stupid bastard’ and gave me a slap across the head. The blood went all over her white coat. I have been petrified of needles ever since.

18. LS 7 was evil. She would grab you by the scruff of the neck and shove you into your room if you annoyed her. She could be quite nice to you if you did everything she told you to do and acted like the robot she wanted you to be. If you didn’t draw her attention she left you alone. I have memories of hearing other residents squealing but I never witnessed abuse directly.

19. The only toys I can remember in Lissue House were in a room next to the interview room. In that room there was a big train set and you had to be
crying, calling his mother names and rolling on the floor. The Social Worker visiting the home suggested that the Applicant was pushing his parents to see how far he could go as well as trying to manipulate them.

6. In paragraphs 8 - 11 of his statement, the Applicant recalls being sexually abused by LS 21, LS 26, and a man named LS 27. There are no records in the possession of the Board which detail these incidents. The Board has further carried out searches under the name LS 26, which are currently ongoing. Without further details of LS 27 the Board is unable to carry out searches on this individual. The Board notes paragraph 19 of the Applicant’s statement wherein he says he never told his Social Worker about the abuse he suffered at Lissue.

7. In paragraphs 13 and 14 of his statement, the Applicant makes allegations of physical abuse against LS 22 and LS 23. There are no records in the possession of the Board which detail these incidents. The Applicant’s file would suggest that any reprimand took the form of a ‘time-out’ and deductions from the points system which then resulted in loss of privileges, see Exhibit 7. The Board believes that the description given in paragraph 17 by the Applicant refers to a ‘time-out’ but does not believe that he would have been ‘thrown in a cupboard and locked in the dark’. The Board notes paragraph 124 of its overview statement wherein Exhibit 6 details that periods of five minutes were appropriate periods of time-out for young children, LIS 161. Exhibit 6 above details that the Applicant’s parent were aware that ‘time-out’ was utilised at Lissue and were ‘quite happy about this’. The Social Worker further commented that ‘time-out’ was fairly effective at the hospital.

8. In paragraph 15 of his statement, the Applicant refers to seeing LS 14 being force fed. The Board understands from the admission records at LIS 11252 – 11252 that LS 14 was admitted to Lissue as a result of anorexia and as such, what was perceived as ‘force feeding’ may actually have been a part of his treatment plan.

9. In paragraph 18 of his statement, the Applicant recalls absconding once with another patient. He states that after being brought back by LS 21 and
Response to the allegations:

6. When I was contacted by the police I attended [redacted] 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 Lissieu from in or around 1971. I was a [redacted] Then I was promoted and was a ward manager. I moved from Lissieu to [redacted] in or about [redacted]

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
PRIVATE

Lissue House (1976)

5. I remember my first day in Lissue. I was brought into a big building with massive doors and a long corridor. At the time I didn't know what Lissue was but it felt like a hospital. I remember the staff ushered **LS 17** and me away while my mother went down the corridor and left us. I cannot remember how long I stayed in Lissue but I do remember it was a horrible place. It was very strict and there was no care or affection from the staff. I remember lots of children crying and screaming all the time. It seemed like nobody cared that the children were unhappy. It was a cold and frightening place. I went into Lissue wearing my normal clothes and I remember wearing odd pyjamas whilst I was in there. I don't know where the clothes came from.

6. I shared a room with **LS 17** at the start. I was frightened by **[REDACTED]**. He had behavioural problems and was really violent. He was always trying to break and smash things, and trying to escape. I remember the staff tied **LS 17** arms in a child's jacket to restrain him. He would kick out and scream hysterically. He would also thump me and take his anger out on me. I don't understand why I wasn't protected from him. I cannot recall how long I shared a room with **LS 17** before I was moved to single room.

7. The staff were very physical and rough. They pulled me by my arms and my hair and trailed me down the stairs. I was shoved, dragged, and thrown into my room and locked in on several occasions. It was an awful place to be in. I saw children being dragged along the floor by their arms into their rooms and being restrained. I found it upsetting because I did not know why I was there. I remember on one occasion a staff member pulled me by my neck. I cannot recall if they were female or male. I cannot recall what the staff looked like. I don't know if it was because I was young or if it's because I was in Lissue for a short time. I just remember the feeling of being scared and wanting to go home.

8. I wet my bed from when I was really young and I constantly wet my bed in Lissue. The staff refused to change my bed sheets. I would be left wearing the same wet underwear for days. It was sore and when I complained about it the
taught... My hair had grown quite long because no one had cut it and she made me wear a girl's hairclip which I found humiliating.

9. Certain members of staff were great and others were quite fearsome. There were three types of people working in Lissue: the gentle and kind people, the neutral people and then the vicious people. The latter were bullies who seemed determined to humiliate and punish at every opportunity as they were disinterested in the children. [LS5] was a member of staff who would grab me by the ear. There was no humanity in the care they provided and I was deprived of any motherly love. One of the ways we were punished was by being put in timeout and you could be left for quite a long time. I think some of the staff over used timeout so they did not have to deal with us. Sometimes they would strip you and put you into bed. You could be left for the rest of the day or until the next meal time. If you resisted you were manhandled. If you fell asleep because you had been left for so long and then couldn’t sleep that night you were punished again for not going to sleep. The boredom and frustration that resulted from being stuck in a room made me hallucinate. I remember looking at the curtains and the images on the curtains melted and changed in to faces. I used to wonder whether the hallucinations were caused by boredom or just the medication that they gave me. I remember going up to the medicine room and being given medication at various times. I remember being fed ice-cream by a member of staff. I was on my own and it was not at a meal time. I believe that the ice-cream was laced with something as it was gritty and tasted of ash. I was told that the ice-cream was pistachio but I do not believe that such an exotic flavour would have been offered to me. I was always paranoid that the staff were doing things to me and then laughing about it.

10. On one occasion I locked myself in to the observation room. The staff eventually talked me round and I let them in. When I was opening the door they threw water over me, pinned me to the floor and knocked me out. They pulled my pants down and gave me an injection.

11. On one occasion my mother saw one of the nurses lashing out at me. I think I had kicked the nurse and she pinned me down saying “you little bastard”. I
23rd July, 1985

Mrs. I. Jefferson,
Social Services Sub-Office,
Eastern Health & Social Services Board,
Newtownards Road,
BANGOR BT30 4LB.

Dear Mrs. Jefferson,

You will recall HIA 172 was readmitted to Lisgue on 13th September, 1984 after he had been sent home from school by his parents. The history was that he had been uncontrollable in his behaviour in the school and had not attended school there for some time. His parents were having considerable difficulty coping with his behaviour in the home as well. The details of his behaviour at home were outlined by the mother in a letter to her sister which she had asked to show to you so that you would be aware of what was happening prior to his being sent back to you. Dr. McAuley had agreed to an admission here on the basis of a need to assess his educational needs and the most appropriate school placement for him in the long run.

When I first interviewed him he told me he thought he was here because he had been bad at school and because he was bad to his mother. He told me he wished he could be good for his mother. I asked him why does she let him be bad to her and he replied "because she isn't strong enough to stop me being bad to her". At this point he broke down in tears. When talking about his father he said that his father gave him presents but he would like his father to spend more time with him together.

In the first few weeks after coming to the Unit he was volatile, attention seeking, keen to impress peers both in the class and in the ward, and in class, although not actually unwilling to do work, he was unable to settle to it, being constantly distracted by noises etc. When settled he could be pleasant and interested and usually this was most noticeable when he had much one to one attention.
Mrs. I. Jefferson
23rd July, 1985

and he seemed to thrive on one to one situations with lots of affection which he got both from teaching and nursing staff.

By mid-October it was clear that he was trying to behave himself both in the class and in the ward. He thrived on praise and showed in group discussions with peers and staff the ability to think about his behaviour and its effects on others. By the end of November the teacher was able to comment that he had made great strides with his concentration, was trying much harder to apply himself to his work and to complete Maths and English tasks. He was also managing to ignore quite a lot of uncomplimentary remarks from peers. Our impressions by Christmas 1984 were that this boy was beginning to mature. His mother returned home in late November and Dr. McMeel discussed with her options for educational placement in the long term, and presented her with information about maladjusted schools for her to take back to discuss with her husband. At that stage the parents were not sure whether the father's contract in \[\text{HIA 172}\] would be renewed and therefore it was not clear whether or not they would be returning to Ireland permanently in 1985 or staying on in Ireland for a further three years. \[\text{HIA 172}\] returned to with the mother for the Christmas break.

After his return in January he was somewhat unsettled for the first few weeks. With constant firm management he had settled somewhat by the middle of the term but towards the end of the Easter term as his imminent return to \[\text{HIA 172}\] for the Easter holiday approached, he became very unsettled and disruptive again. In the middle of the Easter term the teacher had written up "Overall has been taking pride in his school work and shows a keen desire to begin allocated tasks and see them completed. He revels in praise and reinforcement and also in individual attention. Still can be belligerent and cheeky but will apologise now. Gets on with peers somewhat better." His behaviour on the ward during the second term was more unsettled and restless. His peer interaction was
Child Psychiatry Unit

Mrs. I. Jefferson

23rd July, 1985

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remember watching over the courtyard at the back when my mum visited. She was not allowed to come through the front entrance or the school entrance. When she left I used to run down the corridor to look out the window to see her leave. I would be upset and crying and I remember a person called LS 6LS 6 telling me that my mum didn’t love me and to shut up and stop crying. It did not matter what was said because it was not going to change the way I felt about my mum. I loved my mum.

12. I was always keen to look smart and dress well so I admired the man from Del Monte. I wanted to have a pair of white trousers like his. I made myself a pair of white trousers out of a white sheet and carpet threads. I was quite proud of them and I put them under my mattress to hide them. One of the people called LS 7LS 7 found them and made me parade up and down the corridor wearing them. I was taken to every room and she said “look at HIA 172 trousers”. It was humiliating. I was not allowed to go down to the school and I was made to wear them for the rest of the day. They were falling apart on me and were revealing my genitals. I remember one of the student nurses being quite upset about me being paraded up and down and saying that she was not going to stay and watch such a thing. The student nurses would only be there a short period of time but they were all really nice.

13. Towards the end of my time in Lissue I was getting weary of what was happening to me and less tolerant of it. I started to resist being dragged to my room for no reason to be left for prolonged periods of time. I went to_______ for a short time before we moved to_______

14. After my mum and dad separated my dad moved to_______ to work. He returned to Northern Ireland and my parents got back together. My father got a job in_______ and wanted us to start a new life there. I remember being very stressed on the flight_______ because I did not want people to know I was from Lissue. I put on shorts, a shirt and a jumper on the plane because I thought that if it looked like I was dressed in a school uniform people would think I had attended an ordinary school. I lived in_______ for over a year and then my mum sent me back to Northern Ireland where I was returned to Lissue.
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for over a year and then my mum sent me back to Northern Ireland where I was returned to Lissie.
they did not eat then what was put in front of them, that there was no further food going to be available at that sitting. I have no recollection that I or any of my colleagues compelled a child to eat cold vegetables in the manner described. I do not believe that it happened.

4. I note at paragraph 9, that time out was one of the methods to be used. I believe this is and was, totally defensible.

5. I have reflected carefully on the incident of the white trousers. These in fact were black, as a matter of detail. I dealt with them in my police statement the police having investigated this matter. [HIA 172] and his brother came from a household in where there seemed to be only one parent, a mother who sadly did not take a great or more interest in her children. There was a noticeable absence of affection. The two boys, and particularly the eldest, could be quite troublesome. [HIA 172] and both had rather unfashionable clothes that might be described as old fashioned.

6. I apprehended on one occasion where he had taken wrongly [without permission] trousers from a store of extra clothes. Parents who generally provided clothing for their own children but sometimes this was not possible and social services were asked to intervene and provide clothing. In any event, the home always kept a supply of additional clothing for emergencies. In this instance had cut the legs off the pair of trousers so far up that they were not even shorts any longer but were utterly inappropriate and would have made him the object of ridicule by the other children. I wished to save him from that ridicule which I know would have happened as this was in the summer. The boys were in short trousers and he did not have any such short trousers. He had cut the black trousers away to such a level that it would have nearly have been indecent. His version of events is utterly at odds with my memory. He was neither exposed to ridicule, nor was his

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private parts on display. My effort was entirely to save him, from himself. This was not the only incident in which [redacted] did not behave in an honest manner.

7. As regards the police interview (enquiry reference LIS-31047) while I was a senior member of staff as the years went on I did not trail [redacted] into a room nor did I strip him and put him to bed. He would have been escorted to his room in the prescribed manner by two members of staff and left upon his bed. This was the invariable procedure, in my entire experience.

8. As to the reference of my mode of dress (LIS-31049) I countered that by inviting the enquiry to consider the photographic evidence showing myself and colleagues and our mode of dress at the various functions, events and work days that are captured therein.

9. As regards a suggestion made (LIS-31144) that I used a jif lemon on a small infant child, this is partially correct. The child in question had difficulty eating and Dr. McCauley [who was the clinician supervising her care] had suggested that I put a couple of drops of lemon juice on to her tongue in order to try to stimulate the child to eat. The infant had great difficulty masticating and swallowing. The doctor thought it worth a try that if she had bitter taste in her mouth, she might thereafter welcome other food, which did not have the sharp flavour of lemon. Unfortunately, this strategy did not work but the whole purpose was humane and done under medical supervision. Ultimately, that infant needed surgery to correct her swallowing reflex. The use of the jif lemon was under medical direction and suggestion. It was a part in graduated care of most minimal intervention first. I appreciate [redacted] as a young boy may not have appreciated what was taking place, and misunderstood the reasons for my directed and supervised actions with the infant.
A. Yes.

Q. One other thing just in terms of holding children on the beds. We have heard -- I think it might have been in one of the documents -- that someone had said that there were gloves that could be used to restrain children and keep them not actually tied to the bed but some sort of gloves to keep them in the bed. Anything like that you remember?

A. No way. No, there wasn't.

Q. The first person who complained about you, and that's HIA172 and his first name is HIA172, you do remember him.

A. Yes.

Q. At 70078 -- I am just going to go through the various -- not his entire transcript, but just so we can follow this. He speaks about you, and you were telling -- he made an allegation that he had made himself a pair of white shorts from a bed sheet and that you had taken those off and humiliated him. You are saying well, no. There was an episode involving him and sports, but they were black shorts -- a pair of black trousers that he had taken out of the store and cut up and cut too short. He was going to humiliate himself because they were so short was really what you were saying. You spoke to the
police about that and you also spoke about it in your Inquiry statement.

When he was asked about that here, he said --

Mr Aiken is saying to him:

"Now I am right in saying that even as we've discussed it today, this potential cutting up of trousers to create black shorts, you have no memory of that at all?

A. No.

Q. And you were saying to me, 'Is there no record of me cutting up a white sheet?'

He was saying there was a record of him cutting up a shirt at home but not a white sheet in Lissue.

A. No. He stole a pair of black trousers out of the linen cupboard. When the night staff had been getting clean sheets for some of the beds he had went in and got it. We were going out. I went up to see where he was. He had his -- he was dressed, but he had a pair -- he had a pair of trousers and he had cut them, and they were cut right up to the groin and they weren't even in a straight line and he wanted these. All the -- in summer all the other boys were in shorts, and I says, "You can't wear them", and he went to start crying and all the rest of it, and LS99 was there.

Q. LS99 you were telling me was one of the
assistant nurses.

A. One of the assistant nurses, and I told him to get into his own trousers and to come down, and LS21 came up and spoke to him. Then he came down and went out with us, but the mother kept the clothes clean, but the other boys would be running about with Bay City Roller jumpers on and different shirts, whoever they admired, singers or actors or that, and he was dressed in the plain clothes and he was out from the other boys and dressed well.

Q. Well, you go on to -- you do remember him. One of the things you told me was you remembered him being on the roof and that there was a visiting consultant there that day and his car was damaged by HIA172 throwing slates off the roof at the cars and at staff.

A. Yes.

Q. You also -- if I can go on to the next page, which is at 70086, he is, in fact, talking about other members of staff making comments to him about:

"'Your parents don't give a damn about you'."

If we can scroll on down there, and comments:

"'Your mother doesn't care and she doesn't want you. Your parents don't give a damn about you'."

He said:

"These would be -- would all be the likes of LS7 --
Q. -- by not letting you go to school.
A. Uh-huh.
Q. You also describe if we can look at --
A. I know you referred earlier to sometimes the school couldn't accept me in class because of my behaviour. So whenever I say the school punished -- or whenever I say LS7 punished me, I am referring to the fact that I didn't actually go to school. Now maybe at that time I could have been on restriction to be kept on the ward regardless of whether I had the white trousers or not, but by not being allowed to go down to school, that was a form of punishment that would frequently happen, but I can't recall if I was being punished. All I know is that not being allowed to go down to school was being -- was part of being punished. So I presumed from my recollection of it that, yes, I was being punished as well.

LS7 made it her mission to punish me as frequently as she could. I could not step out of line or make any sort of mistake whenever she was around or I would be put in my room, or I would be standing with my nose in the corner, or there would be something, something, anything. Anything would set her off, and I would face the consequences because of it, and I wasn't the only one. There was lots of other kids, you know, and most
of them probably haven't come forward because most of them don't want to go through this, don't want to read and hear about how they are denying what they did to kids.

I mean, I can understand. I can understand if they felt now how I felt. If I knew I would feel like this here before this Inquiry started, I probably would have had second thoughts. You know, the fact that, you know, I don't feel any sort of gratification because I don't see any sort of ending to this here or anything coming out of this here where people go, you know, "That's terrible what happened to you and we are sorry". It's just everybody is just denying, "Well, there is no evidence here". I can't provide evidence that these things happened. I can only tell you what I remember happening and I can tell you how I feel about it and how I feel about it today.

Q. Equally, HIA172, you can understand that people who you make allegations against --

A. Uh-huh.

Q. -- are entitled to have an opportunity to say what they want to say --

A. Yes.

Q. -- and if they don't accept something, they don't accept something --
PRIVATE

Lissue House (02/11/1987 to 19/02/1988)

3. A few of the nurses behaved in a way which was unprofessional. I was mentally and physically abused in Lissue. The staff grabbed and pushed me to get me to do what they wanted. They grabbed my shoulders and the back of my neck. They were physically rough with us. One of the nurses in particular was a bully. He was either called [REDACTED] or [REDACTED]. He was in his late 30s. He punched and shook me any time he saw me. He made fun of us and our problems and said things to me like "is your head still on your shoulders?". He always made sure no other member of staff was watching. I saw him pushing and making fun of another resident called [REDACTED]. He walked around shouting out of the blue. I think he might have had Tourette's syndrome. The staff, particularly [REDACTED] LS 41, mimicked him. They tortured him and made little of his problem. I witnessed staff being physically abusive to him and on one occasion banging him against a wall. It really annoyed me and it made me feel more depressed. Whilst there was no sexual abuse the staff made suggestive sexual comments to me.

4. Another nurse called [REDACTED] LS 34, was friends with [REDACTED] and they were always together. She was nice but at times she was sharp in how she spoke to me. There was a [REDACTED] woman and a girl called [REDACTED] LS 42, who were on duty at night. They were both nice. I can't remember the names of any other members of staff in Lissue.

5. In November 1987 the INLA [REDACTED], who also came from [REDACTED], was captured. It was shown on the news [REDACTED] LS 39 made fun of me saying 'that boy is not far away from you, he will be after you next'. The other nurses laughed. They tried to scare me. I was vulnerable.

6. I was in Lissue to get better not to be scared. This taunting went on and left me distressed. The people looking after me were not the professional people they were supposed to be.
A. If I asked somebody in this room for their name, maybe half an hour later I would be asking them the same question, because I've a head on me like a sieve, but stuck in my mind, and that's why I got it muddled up with LS1 --

Q. The teacher's name?

A. -- the teacher's name, you know, and ...

Q. Well, as I say, now that we understand who you are talking about, the Inquiry will take steps to try to locate him and let him know what it is that you say about him, HIA3.

A. Yes.

Q. You say that he always made sure no other member of staff was watching. You saw him pushing and making fun of another resident, whose name you give here. I will just use his first name. That is LS41.

A. That's right.

Q. You knew LS41 from where -- you say he was from .

"He walked around shouting out of the blue."

You think now as an adult he might have had Tourette's Syndrome. You say:

"The staff, particularly this man, mimicked him.

They tortured him and made little of his problem."

You witnessed staff being physically abusive to him
and on one occasion banging him against a wall. It really annoyed you and made you feel more depressed. While you certainly didn't experience any sexual abuse, the staff would make suggestive sexual comments to you. I asked you a little bit more about that and you say they asked you questions such as whether you masturbated or not. You found that uncomfortable to be asked that as a 13-year-old.

A. Well, as a 13-year-old and in a place to get better and to -- it was very downgrading and very confusing. "Why are these people in professional nursing or care workers asking me this question? What's this got to do with my recovery of alcoholism" -- sorry -- "of getting better?"

Sorry.

Q. You go on then in paragraph 4, HIA3, to talk about a nurse. I am going to just use her first name. That's LS34. You say that she was friends, and when we were talking earlier -- I will use the name LS44 --

A. Yes.

Q. -- for this other staff member -- you say they were always together.

A. Uh-huh.

Q. That's what you remember. You say she was nice, but at times she was sharp in how she spoke to you. You also remember a Canadian woman working there and a girl,
when he directed. Thinks easily when teased and
tells press to shut up, appears to have a short
fuse but hides back. Appears to be
afraid to show feelings."

3/18/84

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

\[Hide Report. 3/19/84.\]
All family attended. Therapist informed he previous
wound and discussed how they dealt with
scene attacks. Parents & children
were asked: When changes needed to
take place in the family. In order for
be well again. Mom don't know.
agreed with Dr. (who said
HIA 3
major change will be to selfish
wanting everything for himself. Also Roderick said
the family must change. Must talk more
rather than argue & fight. Dad said the
must try to control his temper. He
stated that
LS 34
"HIA3 unable to share a joke with his peers and staff. He likes to sit and have a laugh at other peers but doesn't like the joke to be on him. Tonight staff teasing him and he was unable to take it, ran out of the room and began to cry. When spoken to firmly, he settled quickly."

Then there's -- the thing that interested me about that was that it was recorded and that --

A. I am not happy about that.

Q. No, no, and I appreciate that isn't in line with what you would -- but that -- I mean, you would accept that that doesn't seem a very helpful way to work with a child?

A. No, no. It's not. It's not.

Q. No. Okay.

A. I share your concern about that.

Q. Okay. Thank you very much.

MR LANE: Just to follow up on that one, would you have read those sort of records when you did your ward round?

A. You would have read some of the records. You wouldn't have read them all, because, I mean, if you consider the ward round was once a week, you've got a week's long records. So you are looking for your nursing staff to summarise the -- mainly to summarise the happenings in
personal questions about his sexuality and was asked if he masturbated. HIA 3 found these questions to be degrading. He also found the experience of family therapy to be humiliating and degrading.

3.42 HIA 3 recalls feeling ‘belittled’ by a [redacted], LS 44, and a [redacted] LS 1. Neither LS 44 or LS 1 has given evidence to the Inquiry and there are no records that corroborate HIA 3’s complaints about physical abuse. In fact, the records show that HIA 3 did very well at school in Lissue and won a number of prizes. However, there is a record dated 3 December 1987 that says HIA 3 was “unable to share a joke with his peers and staff. He likes to sit and have a laugh at other peers but doesn’t like the joke to be on him. Tonight staff teasing him and he was unable to take it. Ran out of the room and began to cry. When spoken to firmly he settled quickly. Parents and rest of family attended for family therapy.”

When this note was brought to Dr. McAuley’s attention by Ms Doherty on Day 201, he immediately said “I am not happy about that” and agreed with the Chairman that this did not seem a very helpful way to work with a child. The HSCB agrees with this and submits that it was not appropriate for staff to have teased a patient who was receiving in-patient treatment for anxiety related issues. However, the HSCB also submits that the full context may not be apparent from the notes.

HIA 251

3.43 HIA 251 was placed had two in-patient admissions to the Child Psychiatry Unit at Lissue. His first admission was between December 1985 and March 1986 and his second was between May 1986 and August 1986. HIA 251 recalls being strapped to a bed and being given injections regularly.

3.44 There is no mention of the use of straps in the contemporaneous records of

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34 LIS 20144
PRIVATE

7. We went to school in a portacabin. The was a man who I think was called LS 44 He would have been in his late and I felt he was very effeminate. He would ask us suggestive questions.

8. LS 44 was a bully. If you didn’t learn or answer any questions he would threaten to make you stay behind after class or put you in detention or prevent you from getting home at the weekend.

9. Every so often my family and I had to attend family group therapy. It was held in a big glass house at the back of the main building. I remember on one occasion my brother walked out in the middle of a session because they were asking many degrading questions about our personal lives. They asked my family personal questions and asked me about my sexuality. I felt the questions were too deep and were humiliating. The sessions left me and my family feeling very uncomfortable. My parents never queried this because they thought that it was part of my therapy and they trusted that Lissue were doing the right thing for me.

10. There was a in Lissue. I think he may have been called He was an evil man. One day I asked if I could see him and she said ‘no he’s not in a good mood today’. I felt that he didn’t make himself available depending on his temperament and that was wrong. He was supposed to be there to help me when I needed him. I don’t think he was very professional. When I did see him he was not very pleasant or helpful. He would ask me degrading questions which belittled me and affected my self-esteem.

11. My mother and father were allowed to come and visit me during the week. I used to get home every Friday and my parents took me back the following Sunday. I always cried when I was being taken back on the Sunday. I didn’t want to go back. My parents would not listen to what it was like in Lissue. My father was a very straight-laced who refused to believe anything bad of professional people. One Sunday night when I was refusing to go back to

HIA 3

PRIVATE
back of the main building."

You remember on one occasion your brother walked out in the middle of a session:

"... because they were asking many degrading questions about our personal lives. They asked my family personal questions and asked me about my sexuality. I felt the questions were too deep and were humiliating."

A. Uh-huh.

Q. "The sessions left me and my family feeling very uncomfortable. My parents never queried this, because they thought it was part of my therapy and they trusted that Lissue were doing the right thing for me."

Certainly I have talked to you about the family therapy notes that I have seen. They appear to have been -- the questions that I have seen would be more about how you behaved at home or how your siblings interacted with you. Your brother, there is no record of him actually walking out of the therapy, although there is a note of him being sick on one day. That's -- I don't need to call it up, but it is 20149.

So your memory, though, of these sessions was that they were humiliating and degrading. It certainly would seem that there were tensions within the family dynamic with regard to your mother's view being different to
occasions when I had concerns, and I passed this on to my own manager, line manager, that I had worried that perhaps our resources were being stretched with the admission of a new individual with the potential for violence. That was my greatest worry, bringing in children who were potentially likely to intensify the ambience.

Q. One of the suggestions that we have seen -- the Inquiry has seen is as time went on, Lissue was used by Social Services to place those children who could not be 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 experience, that -- I am using very emotive language and I don't mean to, but was Lissue something of a dumping ground for some children, do you think?

A. I would not have been happy with that, and I am trying to remember if that -- if a child in a children's home setting had been proving difficult, the first thing would have been to refer that to The Adolescent and Child Psychiatry Department at RBHSC, where a determination would have been made whether this child is psychiatrically, emotionally out of control and needing help. In that case it would be a legitimate resource to use the in-patient unit. I don't --
PRIVATE

Lissie my father lost his temper with me to such an extent that his cousin and his wife had to take me back to Lissie.

12. Every time I saw my mother and father I asked them to take me home. I told them what it was like in Lissie but they wouldn't believe me. They told me to catch myself on and that I was in a good place. My parents put their trust in these professionals in Lissie to help me get better and I feel that that trust was abused.

13. They didn't understand what it was like. It was like a concentration camp. We had to go to bed at a certain time. I think I was in a room on my own when I first went and then I moved into a dorm with about five other boys. Sometimes I couldn't sleep at night with so much going on in my head and I would have got up in the middle of the night and walked around. The staff shouted at me and grabbed me by the shoulders to put me back to bed. I felt there was little understanding or care shown to me.

14. My [REDACTED] at [REDACTED] school was called [REDACTED] and she came to visit me once.

15. I was given medication in Lissie after dinner but I don't know what it was.

16. Eventually I stopped thinking that I was having a brain haemorrhage. I became stronger mentally and after 3 months I was released from Lissie.

Life after care

17. My life was ruined by Lissie. I wouldn't talk to anybody about it. My father and mother wouldn't understand what was eating away at me inside. Any time I tried to speak to my mother and father about the abuse in Lissie they told me to brush it under the carpet and get on with my life so I have never reported the abuse to anyone before now.
1     details --
2     A.  Right.
3     Q.  -- but you can be assured that they have been read.  At
4     paragraph 25 you describe how you told your wife and
5     your parents after there was press coverage about Lissue
6     in 2011.
7     A.  Yes.
8     Q.  You then spoke to the police in early 2012.
9     A.  Yes.
10    Q.  Your police statement can be found in the bundle at
11        31280 to 31285.  That was on 12th January 2012.
12        Now the police did interview, as I have said, LS21
13        in response to the allegations you made and he clearly
14        from the interview was very upset by and he denied the
15        allegations and his interview is at 30602 to 30655.
16        A.  Sorry, ma'am.
17        Q.  Sorry.
18        A.  You just said he was very upset.
19        Q.  Yes.
20        A.  What about my life?  Upset?  My whole life has been
21        totally destroyed by the Lissue Hospital and the
22        institutes that was supposed to protect children, and he
23        was upset?
24        Q.  Well, I can see me even telling you that has upset you,
25        HIA220 --
I will say it again, I am afraid of Sir Anthony's report when it’s submitted to Stormont next year, that when Sir Anthony hands the report over, it is put in file 13, ie it is binned, and for the MLAs in Stormont, they are just saving face for a paper chasing exercise. So they are spending millions of pounds on an Inquiry that's not going to go nowhere, because all the hard work from the team here, it has been for nothing, because they are just saying, "It's a PR exercise. We are doing this, that and the other".

Q. Well --

A. That's what I am worried about.

Q. Well, assuming that doesn't happen, HIA220, is there anything that you would like to see in the report in terms of recognising what happened to children in institutions?

A. I was going to say compensation there, but what I have been through it wouldn't compensate me for it, but yes, there's some sort of compensation has to be made to children. It doesn't matter whether it is Lissue Hospital or another institute. Those kids through no fault of their own went into a place of safety and they came out totally destroyed. As you know, ma'am, kids have committed suicide, turned to drugs and everything. For myself it's a daily struggle. It's a daily
your view, HIA3? What would you like to see happen?

A. Sorry isn't good enough from -- yes, it's a help, but them years that has been wasted -- the rest of my siblings, my brothers and sisters, went on to do degrees

and I just left at fourth year, no qualifications, wasn't happy with -- couldn't settle to study, couldn't settle to get on with my life, was a very lonely person, never really went out.

I know I was let out at 16 and I was introduced to alcoholism. I am off drink now nine years and I attend AA, but all them years in between I never really -- I was afraid of crowded places. I could never really -- I was very shy. I didn't trust anybody in authority. I didn't know how to trust anybody, full stop, and fearful, and I thought the IRA was after me. I am not in any paramilitary organisation, but this was my head. I thought the IRA was out to get me and the UVF, all the paramilitaries of the day, full of paranoia, and I used drink to block it out all through my -- my whole 20s was a black-out with drink and into my early 30s. I am off it now nine years this August, which is the only good thing that's come out of it. As
have it resolved.

6.1.4 Humiliation

The exercise of control by the strong/or those in authority over the weak/or those with no authority i.e. by staff over patients is perhaps, one of the most disturbing elements of this review. Children were reduced to their most vulnerable state i.e. having their dignity taken from them, by being undressed by staff or supervised at bath time or accompanied to the toilet (for unstated reasons ) by staff who were strangers to them. While boys were generally subject to this form of control; it was also applied to girls.

The review identified 11 children’s cases where humiliation appears to have been used, 3 boys and 9 girls. The boys ranged in age from 6 to 13 (average 9 years), much younger than the girls who ranged in age from 4 to 15 (average age 12 years). With the exception of a 4 and 10 year old girl the remainder were teenage girls. Details are available of the incidents set out in Appendix 8.

Issues arising fell within the following broad categories:
- showering and bathing of older patients, including removal of sanitary towel;
- strip searching
- insensitivity to symptoms of illness and housing of children
- standing child against wall for 1½ hours;
- forcing a child to bed

General Issues arising regarding Bathing and Showering

The majority of the incidents included in this section relate to bathing of children. From the records it was unclear how observation was carried out. Did staff remain discreetly or did they directly observe the bathing/showering process, or did they actually wash children? Was there a different approach dependent upon the age and assessed illness of a child? Did children’s treatment plan address the need for supervising these activities? Was consideration given to the gender of staff given the greater number of girls identified as falling within this category?

6.1.5 Supervision / Staffing Levels

The difficulties in providing the level of supervision required by children with complex needs, particularly at Lissue, a large rambling country house set in a country estate, should not be underestimated given that there were few restrictions on children’s movements throughout the complex.

The Review examined the records of children cared for over a period extending from 1979 to 1995. Thirteen children were noted as needing varying levels of supervision over this period, but they were not all in residence at the same time. It
Lissue House (1976)

5. I remember my first day in Lissue. I was brought into a big building with massive doors and a long corridor. At the time I didn't know what Lissue was but it felt like a hospital. I remember the staff ushered LS 17 and me away while my mother went down the corridor and left us. I cannot remember how long I stayed in Lissue but I do remember it was a horrible place. It was very strict and there was no care or affection from the staff. I remember lots of children crying and screaming all the time. It seemed like nobody cared that the children were unhappy. It was a cold and frightening place. I went into Lissue wearing my normal clothes and I remember wearing odd pyjamas whilst I was in there. I don't know where the clothes came from.

6. I shared a room with LS 17 at the start. I was frightened by [redacted] He had behavioural problems and was really violent. He was always trying to break and smash things, and trying to escape. I remember the staff tied LS 17 arms in a child's jacket to restrain him. He would kick out and scream hysterically. He would also thump me and take his anger out on me. I don't understand why I wasn't protected from him. I cannot recall how long I shared a room with LS 17 before I was moved to single room.

7. The staff were very physical and rough. They pulled me by my arms and my hair and trailed me down the stairs. I was shoved, dragged, and thrown into my room and locked in on several occasions. It was an awful place to be in. I saw children being dragged along the floor by their arms into their rooms and being restrained. I found it upsetting because I did not know why I was there. I remember on one occasion a staff member pulled me by my neck. I cannot recall if they were female or male. I cannot recall what the staff looked like. I don't know if it was because I was young or if it's because I was in Lissue for a short time. I just remember the feeling of being scared and wanting to go home.

8. I wet my bed from when I was really young and I constantly wet my bed in Lissue. The staff refused to change my bed sheets. I would be left wearing the same wet underwear for days. It was sore and when I complained about it the
staff would drag me into the bathroom and throw me into the bath. I was bathed in cold water with disinfectant. It smelt like something a cleaner would mop the floors with. I remember my skin was roaring red when they washed and scrubbed me down. It was very sore. After my bath I would be left standing freezing with no towel. This happened frequently because I was a constant bed wetter. I had to sleep on the floor quite a lot when my bed was wet. The sheets were never changed and it smelt appalling. I could not sleep properly and I found it hard to cope during the day because I was so tired.

9. I also found it difficult to eat in Lissance. If I refused to eat my meals the staff would leave the food sitting until it was eaten the next day. It could have been sitting for a day or more. Sometimes when I was so hungry I would eat it. Some of the food did not taste good. I remember getting cereal or toast in the mornings and potatoes for dinner. Morning times were mayhem. I remember children screaming and banging at the table.

10. I remember sitting in a group room where I used to stare out the window. I never interacted or bonded with anyone. The children were not allowed to talk and communication was not encouraged. I cannot recall any specific staff members. I just remember them all as unkind and uncaring. I had no one to talk to about my bed wetting. I had blisters from wetting the bed and I was never given any cream to soothe my sores. I felt I was being locked up in a dungeon because I was strange or because I had upset people or because nobody cared. It was like a nightmare. My mother did not visit me and I don't know how long I was in Lissance for. After Lissance, I just remember living back home with my mother, my brothers and my sisters again.

11. My life went from one extreme to another after I left Lissance. When I was back in my mother's care, we lived in [redacted] on the [redacted] where I suffered horrific physical and sexual abuse. My brother [redacted] was in and out of care and he was sexually abused by Father Brendan Smyth. When he was at home, he and his friends sexually abused me and my sisters. I was approximately 6 or 7 years old when the sexual abuse started. [redacted] was approximately 8 or 9 years old. My mother also allowed her boyfriends, and married men, to come in
CASE REVIEW

SHORT-TERM UNIT

19.5.86

[Redacted]

NAME: HIA 421 [Redacted]

D.O.B.: [Redacted]

D.O.A.: [Redacted]

HIA 421 [Redacted] and [Redacted] were transferred from [Redacted] to St. Joseph's, which was previously with [Redacted] (Short term foster-parents) before his admission on the 17.4.86.

INITIAL PERIOD OF ADJUSTMENT AND SUBSEQUENT BEHAVIOUR:

HIA 421 - the eldest of the four is clearly a very damaged child, she is extremely attention seeking, often throwing tantrums apparently without reason and is prone to sulking. HIA 421 is loud and at times aggressive, she is in constant conflict with her peers and is particularly antagonistic towards her male peers. Evidence of the extent of disturbance is seen in HIA 421 bouts of bed-wetting and restless sleeping patterns: she often talks in her sleep and has at times awakened from sleep in tears. HIA 421 has a very low self-esteem, she has a total disregard for her personal hygiene, is stubborn in eating and is generally grim and unsmiling.

In spite of difficult and disturbed patterns of behaviour, HIA 421 has expressed a desire to remain in Care, this desire comes almost as a sigh of relief and though she still bears a burden of trauma, HIA 421 is enjoying relative "freedom", for example, she has said...

"...it's nice to come home to something good for a change" and ..."I've been wanting to get away from our house for a long time."

Staff have observed [Redacted] behaviour to have undergone some stabilization, particularly in the past two weeks.

[Redacted] - has made no reference whatsoever to the situation at home prior to her present placement. Her appearance and demeanor could be set in direct contrast with HIA 421; she is generally neat and tidy and is more careful with regard to personal hygiene. [Redacted] can be stubborn and defiant, her behaviour patterns are more subtle and cautious than HIA 421 but nonetheless difficult. [Redacted] is observed to be quite flirtatious and giddy in the presence of her male peers and more often seeks the company of the boys in the Unit. The Staff-team are very conscious of [Redacted] interaction with the boys and thus monitor her relationships very closely.

[Redacted] - is very small and underdeveloped for her age (12 years) and in spite of a very bright, lively exterior, would seem to be a rather deep, intense child. She often breaks away from periods of constant chatter (loud) to moments of relative silence when we've often had to speak to her several times before she could respond.
staff in Lissue were violent. HIA 421 described the staff as very strict and very cold and she recalls being left in her room “all day”. HIA 421 also said that staff refused to change her wet bed and described how she was left in a wet bed and wet underpants “for days” and had to sleep on the floor when her bed was wet.

3.13 There are no contemporaneous records relating to HIA 421’s stay in Lissue. The HSCB accepts that HIS 421 may well have perceived staff to be strict and cold. It is also known that restraint was used in Lissue, a topic which will be discussed later in this submission. However, HSCB does not accept that staff were violent towards HIA 421 or that nursing staff refused to change her wet bed or underpants or that she had to sleep on the floor when her bed was wet.

HIA 220

3.14 HIA 220 was admitted to Lissue for an eight-month period between November 1975 and June 1976 for ‘intensive therapy treatment’ although he had home leave at the weekends. It is also known that HIA 220 had two episodes of day patient treatment in Lissue in 1976. HIA 220 alleges that he was indecently assaulted and raped by LS 21 and, on a subsequent occasion, he was raped by LS 21, LS 26 and LS 27 who were acting in a joint enterprise. The police have investigated HIA 220’s allegations against LS 21 but no prosecution has been directed. He also alleged physical abuse by LS 22 and LS 23 and recalls being put into the corner for 45 minutes.

3.15 HIA 220’s allegations against LS 21, LS 26 and LS 27 are of an extremely serious nature. The HSCB notes that the police have investigated the allegations against LS 21 and no prosecution has been directed. Contemporaneous records are available but they offer no indication of what HIA 220 now complains about.
4. When I was in Lissance 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 were LS 1 and LS 2
   
   LS 2 and LS 3 and LS 4. The were all professionals and I do not have any complaints about the school apart from LS 4 who

HIA 172
staff would drag me into the bathroom and throw me into the bath. I was bathed in cold water with disinfectant. It smelt like something a cleaner would mop the floors with. I remember my skin was roaring red when they washed and scrubbed me down. It was very sore. After my bath I would be left standing freezing with no towel. This happened frequently because I was a constant bed wetter. I had to sleep on the floor quite a lot when my bed was wet. The sheets were never changed and it smelt appalling. I could not sleep properly and I found it hard to cope during the day because I was so tired.

9. I also found it difficult to eat in Lissie. If I refused to eat my meals the staff would leave the food sitting until it was eaten the next day. It could have been sitting for a day or more. Sometimes when I was so hungry I would eat it. Some of the food did not taste good. I remember getting cereal or toast in the mornings and potatoes for dinner. Morning times were mayhem. I remember children screaming and banging at the table.

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11. My life went from one extreme to another after I left Lissie. When I was back in my mother’s care, we lived in [redacted] on the [redacted] where I suffered horrific physical and sexual abuse. My brother [LS 17] was in and out of care and he was sexually abused by Father Brendan Smyth. When he was at home, he and his friends sexually abused me and my sisters. I was approximately 6 or 7 years old when the sexual abuse started. [LS 17] was approximately 8 or 9 years old. My mother also allowed her boyfriends, and married men, to come in.
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.

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Summary of Involvement with
HIA 172 and [redacted]

Formulation:
HIA 172 is a 7 year old boy who had been presenting both his mother and the school he attended with behavioural difficulties. Mrs. [redacted] became afraid that she may injure HIA 172 sought the help and advice of social services and an F.P.O. was made.

Aetiological Factors in Child
HIA 172 has a history of convulsions between the ages of 17 months and 3 years. He is of average intelligence but there is a discrepancy between his verbal I.Q. and performance.

Aetiological Factors in family
Mr. and Mrs. [redacted] are now separated but prior to this there was a great deal of marital disharmony. Also Mr. [redacted] worked in [redacted] only returning home for weekends. Mr. [redacted] has always had an extremely negative attitude towards HIA 172 with Mrs. [redacted] often having to protect him from his father.

Environment
HIA 172 has experienced quite a few homes for a youngster - [redacted] [redacted]

Diagnosis
HIA 172, a boy of average intelligence presents with a behavioural disorder.

HIA 172 at Lissance (without mother)
HIA 172 was admitted to Lissance on [redacted] 1980 with the aim of settling his behaviour before Mrs. [redacted] joined him for three weeks. Observation showed HIA 172 to be extremely restless, distractible, attention seeking and very noisy in his eating habits. His peer interaction was not good with HIA 172 annoying them and taking toys there were playing with. He also soiled occasionally.

Apart from overall ward management, two programmes were introduced to help HIA 172 -

(a) Meal-times
HIA 172 did not appear to know what his knife and fork were for and used his fingers to eat his food. He stuffed his mouth full of food and then proceeded to spatter it over everyone! A programme was instituted to help HIA 172 eat appropriately by way of staff modelling correct behaviour at the meal table and on the whole this has improved his eating skills and behaviour at meal times greatly.
the case that that child would have been encouraged to calm down using the methods as set out above.

4. As to paragraph 19, I completely deny any beating, slapping or pulling of hair, pulling of ears or slapping on any part of the body by me or other member of staff.

1. As material to me, I will deal with the various suggestions. Just because I do not specifically reject or deny something, it does not mean that I agree with it, but simply I do not have direct evidence, or that it is out of my experience.

2. With regard to paragraph 4, I remember clearly that there was a strategy in place to try to deal with children who were wetting the bed. As I did not work on the night shift due to my own family commitments, I was not involved in the implementation of this strategy. An sensor alarm was fitted to the bed and the night staff who told me of this and I believe to be true, that when the alarm went off because a child having urinated, that the child would be raised from bed and changed, put into clean night clothes and a clean bedding put upon the bed. Children were encouraged not to wet the bed for obvious reason of hygiene, their own comfort and sleep pattern. If a child soiled itself or wet itself plainly it may have to have been washed with antiseptic or other cleaning fluid. I do not recall Dettol, which would not appropriate in those circumstances, being used but other fluids and cleaning agents were used to ensure the child’s cleanliness and comfort.

3. Pertaining to paragraph 7, as regards this allegation over a bowl of peas, I would state that children were not forced to eat all types of food though they were encouraged to do so. A child could not be pandered to and there was a set diet. Certainly a child would be encouraged to eat, with the admonition if
they did not eat then what was put in front of them, that there was no further food going to be available at that sitting. I have no recollection that I or any of my colleagues compelled a child to eat cold vegetables in the manner described. I do not believe that it happened.

4. I note at paragraph 9, that time out was one of the methods to be used. I believe this is and was, totally defensible.

5. I have reflected carefully on the incident of the white trousers. These in fact were black, as a matter of detail. I dealt with them in my police statement the police having investigated this matter. [HIA 172] and his brother came from a household in [redacted] where there seemed to be only one parent, a mother who sadly did not take a great or more interest in her children. There was a noticeable absence of affection. The two boys, and particularly [redacted] the eldest, could be quite troublesome. [HIA 172] and [redacted] both had rather unfashionable clothes that might be described as old fashioned.

6. I apprehended [HIA 172] on one occasion where he had taken wrongly [without permission] trousers from a store of extra clothes. Parents who generally provided clothing for their own children but sometimes this was not possible and social services were asked to intervene and provide clothing. In any event, the home always kept a supply of additional clothing for emergencies. In this instance [HIA 172] had cut the legs off the pair of trousers so far up that they were not even shorts any longer but were utterly inappropriate and would have made him the object of ridicule by the other children. I wished to save him from that ridicule which I know would have happened as this was in the summer. The boys were in short trousers and he did not have any such short trousers. He had cut the black trousers away to such a level that it would have nearly have been indecent. His version of events is utterly at odds with my memory. He was neither exposed to ridicule, nor was his...
Because she wasn’t sitting at a table, she was sitting here beside this trolley thing, in a, in a chair and I can remember seeing these doors behind her, you know so she was probably sitting around this area here.

Uh-huh.

And so, I think she was a little blonde haired girl, I think just, and I remember her getting grabbed by the face whenever she’d put her fingers in her mouth and made herself sick and they grabbed her by the face and jammed this Jiff lemon in her mouth and squirted that there -

-Right -

-It burst out through her nose and everything and it was, it’s like you know.

Do you, do you remember who did that.

I think LS 7 did it, I think it happened on quite a few occasions this was something that we all witnessed at meal times, this was, you know everybody was in, this was meal time.

Right.

You know.

Uh-huh.

And I think I was actually, I think I was maybe sitting there or maybe even sitting over here but I, I can, it happened on a few occasions you know but the one that struck me
private parts on display. My effort was entirely to save him, from himself. This was not the only incident in which [HIA 172] did not behave in an honest manner.

7. As regards the police interview (enquiry reference LIS-31047) while I was a senior member of staff as the years went on I did not trail [HIA 172] into a room nor did I strip him and put him to bed. He would have been escorted to his room in the prescribed manner by two members of staff and left upon his bed. This was the invariable procedure, in my entire experience.

8. As to the reference of my mode of dress (LIS-31049) I countered that by inviting the enquiry to consider the photographic evidence showing myself and colleagues and our mode of dress at the various functions, events and work days that are captured therein.

9. As regards a suggestion made (LIS-31144) that I used a *jif lemon* on a small infant child, this is partially correct. The child in question had difficulty eating and Dr. McCauley [who was the clinician supervising her care] had suggested that I put a couple of drops of lemon juice on to her tongue in order to try to stimulate the child to eat. The infant had great difficulty masticating and swallowing. The doctor thought it worth a try that if she had bitter taste in her mouth, she might thereafter welcome other food, which did not have the sharp flavour of lemon. Unfortunately, this strategy did not work but the whole purpose was humane and done under medical supervision. Ultimately, that infant needed surgery to correct her swallowing reflex. The use of the *jif lemon* was under medical direction and suggestion. It was a part in graduated care of most minimal intervention first. I appreciate [HIA 172] as a young boy may not have appreciated what was taking place, and misunderstood the reasons for my directed and supervised actions with the infant.
PRIVATE

staff would drag me into the bathroom and throw me into the bath. I was bathed in cold water with disinfectant. It smelt like something a cleaner would mop the floors with. I remember my skin was roaring red when they washed and scrubbed me down. It was very sore. After my bath I would be left standing freezing with no towel. This happened frequently because I was a constant bed wetter. I had to sleep on the floor quite a lot when my bed was wet. The sheets were never changed and it smelt appalling. I could not sleep properly and I found it hard to cope during the day because I was so tired.

9. I also found it difficult to eat in Lissue. If I refused to eat my meals the staff would leave the food sitting until it was eaten the next day. It could have been sitting for a day or more. Sometimes when I was so hungry I would eat it. Some of the food did not taste good. I remember getting cereal or toast in the mornings and potatoes for dinner. Morning times were mayhem. I remember children screaming and banging at the table.

10. I remember sitting in a group room where I use to stare out the window. I never interacted or bonded with anyone. The children were not allowed to talk and communication was not encouraged. I cannot recall any specific staff members. I just remember them all as unkind and uncaring. I had no one to talk to about my bed wetting. I had blisters from wetting the bed and I was never given any cream to soothe my sores. I felt I was being locked up in a dungeon because I was strange or because I had upset people or because nobody cared. It was like a nightmare. My mother did not visit me and I don't know how long I was in Lissue for. After Lissue, I just remember living back home with my mother, my brothers and my sisters again.

11. My life went from one extreme to another after I left Lissue. When I was back in my mother's care, we lived in [redacted] on the [redacted] where I suffered horrific physical and sexual abuse. My brother [redacted] was in and out of care and he was sexually abused by Father Brendan Smyth. When he was at home, he and his friends sexually abused me and my sisters. I was approximately 6 or 7 years old when the sexual abuse started. [redacted] was approximately 8 or 9 years old. My mother also allowed her boyfriends, and married men, to come in
CASE REVIEW

SHORT-TERM UNIT

19.5.86

NAME: [Redacted]

D.O.B.: [Redacted]

D.O.A.: [Redacted]

HIA 421 was transferred from [Redacted] to St. Joseph's, [Redacted] was previously with [Redacted] (Short term foster-parents) before his admission on the 17.4.86.

INITIAL PERIOD OF ADJUSTMENT AND SUBSEQUENT BEHAVIOUR:

HIA 421 - the eldest of the four is clearly a very damaged child, she is extremely attention seeking, often throwing tantrums apparently without reason and is prone to sulking. HIA 421 is loud and at times aggressive, she is in constant conflict with her peers and is particularly antagonistic towards her male peers. Evidence of the extent of disturbance is seen in HIA 421 bouts of bed-wetting and restless sleeping patterns; she often talks in her sleep and has at times awakened from sleep in tears. HIA 421 has a very low self-esteem, she has a total disregard for her personal hygiene, is slovenly in her eating and is generally glum and unsociable.

In spite of difficult and disturbed patterns of behaviour, HIA 421 has expressed a desire to remain in Care, this desire comes almost as a sigh of relief and though she still bears a burden of trauma, HIA 421 is enjoying relative 'freedom', for example, she has said..."it's nice to come home to something good for a change" and ..."I've been wanting to get away from our house for a long time."

Staff have observed HIA 421 behaviour to have undergone some stabilization, particularly in the past two weeks.

[Redacted] - has made no reference whatsoever to the situation at home prior to her present placement. Her appearance and demeanor could be set in direct contrast with HIA 421 she is generally neat and tidy and is more careful with regard to personal hygiene. [Redacted] can be stubborn and defiant, her behaviour patterns are more subtle and cautious than HIA 421 but nonetheless difficult. [Redacted] is observed to be quite flirtatious and giddy in the presence of her male peers and more often seeks the company of the boys in the Unit. The Staff team are very conscious of [Redacted] interaction with the boys and thus monitor her relationships very closely.

[Redacted] - is very small and underdeveloped for her age (12 years) and in spite of a very bright, lively exterior, would seem to be a rather deep, intense child. [Redacted] often breaks away from periods of constant chatter (loud) to moments of relative silence when we've often had to speak to her several times before she could respond.
1. Q. Another person you have described is LS6.
2. A. Yes.
3. Q. You describe her as motherly -- a motherly lady and being very caring. You also remember LS7.
4. A. Uh-huh.
5. Q. You say that again she would have been motherly, compassionate, but firm. So again another person who might have used time out as a first resort?
6. A. I do.
7. Q. And again if you had seen any of them behaving inappropriately towards a child, from what you have just said you would have reported that?
8. A. I would.
9. Q. We -- one of the -- as I was saying, in the police material one of the members of staff who was spoken to said that the older staff would have been firmer and stricter than the younger staff. Would that have been your experience?
10. A. Yes.
11. Q. And when we were also talking you talked about the distinction between using your discretion about going to time out or using a diversionary tactic, which would in your case you would have assessed that on the basis of what risk the child was posing to themselves or to
Q. I think when we were -- the expression that I used when talking to you about how a child would have been taken for time out --
A. Uh-huh.
Q. -- it was guidance rather than force that was used.
A. Absolutely, and that would have come from the training that I would have been exposed to. You know, it was definitely that it was meant to be a supportive activity, not a forced activity.
Q. Just coming on to the Stinson review -- and I am not going to go into the details of it, but obviously you read that -- you worked in Lissue at a time when that review was -- sorry. I should say the review was much later, but it was relating to the period of time you worked in Lissue. Were you yourself ever approached --
A. No.
Q. -- about any of the case notes --
A. No.
Q. -- or case studies? To your knowledge were any other members of staff asked about anything before the review was published?
A. Not that I'm aware, but certainly I wasn't approached.
Q. But certainly some of the scenarios that are given in
assessment and adjust the medication, if they thought in their judgement it was correct to do so.

12. I have had an opportunity to consider the statements and interviews given by 3 complainants, who allege wrong behaviour on my part. I refute all and every such allegation from the most minor, to the most serious.

Pertaining to any allegations of misconduct on my part, I respond as follows:

(a) The medication [being Ritalin and Largactil] was prescribed by the medical staff in line with their experience as to the selection or dosage. These were matters for the doctors though I saw nothing that would have indicated to me in my experience that their choices were anything other than proper. Some major drugs in fact had to be signed as received by two nurses when delivered by the porters from the pharmacy at Lagan Valley Hospital. Nurses had no ambit of discretion in the administration of medication. This was a matter of clinical judgment by the doctors.

(b) As regards the smoking of cigarettes, this was actively discouraged and all cigarettes were put in the bin if any were smuggled into the unit. I recall one occasion, a father suggesting that his daughter's behaviour was improved by smoking cigarettes and the unit agreed that she would be allowed to smoke but this was never compulsory, quite the contrary. We would have preferred if she did not smoke. I strongly disagreed with the view that any minor should be given cigarettes. I never allowed my children or my grandchildren to smoke.

(c) Our method of trying to create an orderly atmosphere was that if a child was beginning to lose his or her temper, or behave in a manner that was disruptive then they would be invited in reasonably firm terms to stand facing a corner. That is entirely correct and true and it worked in the most instances as standing facing a corner for 3 minutes does have a calming, and
plainly does not have a beard. I do not recollect ever seeing him with a beard. This inexact recollection of detail is indicative of other misremembering by this witness to the inquiry.

**Conclusion**

- I finally invite the enquiry to consider the photographs which show the children content and generally very happy. They had activities arranged, had holidays provided for them at Garron Tower [a Roman Catholic boarding school on the North coast] that was given to us to use for a period in the summer. The army at Thiepval Barracks were regular guests who provided entertainments, such as fancy dress and musical performances for the children.

- To reiterate, I enjoyed my entire time at Lissie. I thought at the time, and still believe, that the work was very valuable for the children. It was pleasing to me that in the great majority of children’s care we brought about a positive outcome. I had very good colleagues, who were both highly professional and very pleasant to work with. I have no doubt that my time and what I witnessed, that they behaved with total dedication, professionalism and respect, for the children under our care. I believe I did also.

Dated this 4th day of April 2016

Signed

LS 7
salutary effect upon a child. The second stage of that strategy, if the first failed to produce calm, then the child, would be taken by 2 members of staff in an established planned method to his/her room and placed upon their bed. They would not be stripped of their clothing and would be told that they would return upon amendment of their behaviour. I was trained in restraint techniques at that time and these would have been used if the situation required it for the safety of the child in question, the other children and the staff members, but a child would not have been struck by me or nor was a child struck in my presence. Equally children's hair was not pulled, nor were they nipped. I disagree entirely with any suggestion by any witness that this behaviour took place either through me, or by any of my colleagues;

(d) I did not have any specific animosity towards HIA 38. I found all the children that we worked with to be engaging to varying extents and almost all save one were capable of engendering affection and warmth from me and from my colleagues. That boy [who I will name to the Inquiry if asked] was a vicious deceitful bully who wound other children up to misbehave and stood back then to witness the after effects;

(e) I did not take blood in a manner set out at paragraph 17, nor use the language suggested. I dislike the use of swear words and would not use them myself;

(f) Equally I did not grab a child by the scruff of the neck and shove any child into its room, rather that a child would be restrained in the proscribed manner to remove that child from causing further disruption, upset and spreading his or her behaviour among the other children which was unsettling for the entire unit. No children were abused and any squealing was out-with my experience. I do not believe it happened;

(g) Parents were treated respectfully. We tried were we could to explain our various strategies to both parents of the in-patients and the day patients. Some parents took some time to understand the ideas that were co-ordinated by the medical/nursing staff to the benefit of their children. For example, I do recall a mother objecting to our strategy where her child would lie immobile on a bed. In order to get that child to mobilise and toilet herself, we
1 A. Yes.
2 Q. -- and red and green might have been the same age
groups, but just split between two groups?
3 A. Yes, yes. Puberty, post-puberty.
4 Q. Just -- I am just checking one -- yes. We were just
talking about -- when we were talking about staff
qualifications and that, you remember someone -- and
again I am going to use the name, but again not to be
used outside -- that was a LS7 , who you said
you forcefully applied for her status to be upgraded,
because of her competence and skill.
5 A. Uh-huh.
6 Q. And is that possibly because she did not have the RMN
qualification?
7 A. My initial memory is that she was a general trained
nurse, but really -- I'm sorry -- I can't remember.
8 Q. I appreciate, LS21, that we are talking about a very
long time ago --
9 A. Yes.
10 Q. -- but doing the best we can.
11 A. She was a very competent individual.
12 Q. I was asking about student nurses. We know that there
were records kept in respect of permanent staff --
13 A. Uh-huh.
14 Q. -- in their personnel file and that, but student nurses,
11. On our bedroom doors we each had a chart with stars or ticks for good behaviour. I think they were blue or red marks and points. At the end of the week they would give you a plastic toy if you were well behaved. I did not get a toy very often.

12. I have seen my records from my time in Lissance. One of the documents states 'method: 1 member of staff to set tasks and give red points from 8.00am – 5pm, another from 5 to bedtime. All staff to give blue points. Points: Compliance / Co-op interaction / attention seeking / non compliance / 3 blue points – to in bed in pyjamas. Exchange: 20 red points in a day – 'special attention' for ½ hour. 100 red points at the end of the week, to receive gift.' Another record describes what feeding times were like: 'He is to be treated the same as the others during meals. If necessary be told once to eat up otherwise the plate is taken away.' This demonstrates the harshness of Lissance – 'eat now or be starved'.

13. A record shows that I as a nine year old child was not allowed to have the staff's attention – 'Usual demanding [HIA 38] Appears to bring out the worst in peers. Receives the odd kick and thump from the older peers. This does not discourage [HIA 38] he still goes back for more. Had his arm twisted by [LS 48] for no reason at all.' This shows that the staff knew I was being beaten by other children and they did nothing about it. If anything the tone of this record would suggest that the staff thought I deserved the beatings. I was beaten by other children almost daily. There is another similar record in my notes '1/6/81 on the verge of trouble several times during the evening sometimes heedless of warnings which earned a few thumps from peers. Needed constant supervision.' I think this also demonstrates that the staff did not intervene to prevent other children from thumping me.'

14. An entry from my records interestingly shows my fear of staff '4.3.81 [HIA 38] had enough points to gain ½ hour with member of staff. Took to trains with [HIA 172], they both played very well together. [HIA 38] seems to watch staff through play as if he was afraid of doing something wrong or turn his back in case he would get a slap, very edgy. I think
interactions with staff and peers. The red & blue points system was used to encourage or discourage certain behaviours such as attention seeking or non-compliance. The Applicant’s ‘gains and losses’ can be seen at exhibit 9. Exhibit 10, records that when reminded about the points system, the Applicant’s behaviour would improve. Exhibit 8 records that the Applicant was to be treated the same as others during meal times and that if necessary he was to be told to eat up once otherwise the plate was to be taken away. The Board notes that the Applicant’s issues with eating prior to admission to Lissue and thereafter are well recorded, see exhibit 3 above as well as exhibit 11 which notes his ability to eat large amounts in contrast to his weight loss which resulted in the Applicant being in less than the 3rd percentile. The entry of 17 November 1981 records that the Applicant would only eat what he liked, i.e. sweets or biscuits.

7. In paragraph 13 of his statement, the Applicant describes his relationships with his peers in Lissue and references the document at exhibit 12. The records would appear to show that the Applicant had a poor relationship with his peers in Lissue, see exhibit 13, which records that on one occasion each and every peer complained about him or told him to leave them alone. It is recorded that HIA 172 advised him to try to behave. There are also recorded instances of violence by peers towards the Applicant, see exhibit 14. The entries from June 1981 record that the Applicant was rejected by the boys in Lissue and played up because of this but that he could niggle them to the point of anger thus requiring protection from them. The Board does not believe that these records illustrate that staff felt that the Applicant deserved to be beaten by his peers but that they were concerned that he ‘brought out the worst’ in them, as detailed in exhibit 12 above. The notes do not record what action staff took in these instances and so cannot comment on whether or not they intervened, although the Board believes this is likely to have happened.

8. Exhibit 15 contains the record the Applicant references in paragraph 14 of his statement. There are no recorded instances of staff physically chastising the Applicant and the Board notes that the primary method of reprimand for children in Lissue was a either a time out or being sent to bed early, see exhibit 6 above. The Board further notes the recorded instances of physical chastisement that
IN-PATIENT NURSING NOTES

Name: HIA 38

Date: 26/11/80

in usual demanding behaviour. Played frustration game and also parts for a period. Doesn't seem to take no for an answer.

26.11.80 Always wanting,ulked at lunch time to day did not like his dinner and would not join in with other children at play. Enjoyed food this afternoon mot as demanding as demanding last night. Likes still attention.

27.11.80 Usual demanding appears to bring out the worst in people. Because he odd kick a thump from the older peers. This does not discourage Christopher he still goes back for more. Had his face twisted by [REDACTED] for no reason at all.

27/11/80 still requires to be reminded about eating and talking and talks non-stop.
IN-PATIENT NURSING NOTES

Name

Doctor

HIA 38

Date

mattered how long he is given to read will demand more minutes.

When given praise for good behaviour doesn’t accept it as such,

but rather sees it as a way to

more demands and more

attention.

HIA 38

Totally blesses at times on time not

tried today, also at break time and

lunch time had school work to finish

is my little baby in ways not well

liked by his teachers for some of his eating

habits.

27/26.3-81. Each and everyone feed

tonight either complained about

you told him to leave

them alone and not annoy them.
and sleep charts and so forth were kept. The allegation was that it happened on three occasions certainly.

A. Uh-huh. Uh-huh.

Q. None of that is ringing any bells?

A. Not really. Not really. I mean, you know, it's obviously a fairly serious --

Q. Yes.

A. -- thing to happen in an in-patient unit. I mean, I just wonder about the supervision at night-time. If it was every fifteen minutes, how was it not discovered? I mean, there were only I think, if it serves me right, two nurses on maybe during the night shift. It certainly was a lot less than during the day shift. So, you know, supervision of it may have been quite difficult.

Q. Certainly there was an investigatory nursing report prepared.

A. Uh-huh. Uh-huh.

Q. That can be seen at 1416. I know you have looked at that.

A. Uh-huh.

Q. It makes the point in that that, you know -- at 1422 it talks about:

"It must be accepted that if this allegation is true, then our policies and systems did not protect this
child."

A. Uh-huh.

Q. It gives four possibilities of how that occurred. I am not going to go through that, but clearly one would assume that that nursing investigatory report --

A. Uh-huh.

Q. -- ought to have been shared at the very least with yourself and with Dr Nelson.

A. Well, I mean, I am not -- I can't recollect whether it was or not at this stage unless there's some documentation to say so, you know.

I mean, the other thing I would add is that -- this doesn't excuse the thing -- but Lissue was operating from 1971 through to '89, and if we look at all of the allegations that are there to date, this would look like the most serious one that has been openly admitted by the abuser. When you consider the populations that we have coming through Lissue over that number of years -- I don't know what the numbers are -- but something like this is bound to happen from time to time. It's just an unfortunate thing. You can try all you like to avoid it, but -- I am not saying that excuses it, but it's a reality.

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

91. In 1993, following the closure of Lissue, a disclosure was made to Dr Hilary Harrison by [redacted], who was then in her [redacted] and who knew Dr Harrison as she was a former patient of Tara Lodge, Barnardo’s. [redacted] was an inpatient in the Child Psychiatry Unit from April 1979 to March 1980. She made an allegation of sexual abuse against [redacted], Charge Nurse. The following sequence is known in relation to same:

a. The initial disclosure was made to Dr Harrison on 19 May 1993, with further details given on 26 May 1993. This was reported to Dr K F McCoy and Mr N Chambers by Memo dated 27 May 1993. See Exhibit 22;

b. The police were contacted, and a statement of complaint was taken by police from [redacted] on 29 May 1993 – Exhibit 23;

c. Police carried out a full investigation, including interviewing two members of staff from the relevant period (1979 – 1981);
2.

Decisions made at the previous Case Review were stated to both [Redacted] and [Redacted] who agreed to abide by these decisions regarding NICU and family support and to co-operate fully with this Department.

The family appeared to be more settled over the last 4 months. The couple certainly were stating that they were not drinking and were co-operating with Social Services in adhering to the contract drawn up with the previous social worker regarding their contact with outside agencies e.g. NICU and Bernard's Mother's Group and their home management practices. Also over the summer months [Redacted] and [Redacted] went away on separate holidays which may well have taken some of the pressure off [Redacted] and [Redacted] in coping with all four children constantly over eight weeks.

Following the first review the Family Support [Redacted] increased her visits to 3 per week and this involved encouraging [Redacted] to involve [Redacted] in activities like shopping and has discussed the management of and control of discipline with the couple in respect of [Redacted] stealing.

No further incidents of inappropriate touch have been noted by the Family Support. The previous incident of sexualised behaviour exhibited by Christopher was discussed with Child Care Centre, on 19th June 1990, who felt that further monitoring was needed of the family situation and behaviour patterns but did feel that a referral to the Child Care Centre per se would be appropriate.

Events precipitating [Redacted] Reception into Care on 2nd October 1990:

Over the last four weeks concerns have come to light through individual social work carried out with [Redacted] as to the poor routine and management within the home and [Redacted] own feelings about living at home.

It appears on considering the critical events record that there have always been difficulties in the tripartite relationship between [Redacted] and [Redacted] and [Redacted]. The pattern of bizarre behaviour exhibited by [Redacted] e.g. over-eating, stealing food and money and lying appears to be prevalent up to the present time and is perhaps both the cause and effect of the emotional strain in the home.

In August [Redacted] expressed concern that [Redacted] was stealing the child having lost £25 of her mother's Income Support. Several weeks later [Redacted] and [Redacted] discovered a packet of frozen sausage rolls missing from the freezer. [Redacted] admitted to stealing these in the middle of the night and leaving them outside to defrost by morning when she took them to school for her break.

This incident and the subsequent punishment which constituted [Redacted] being grounded from all activities in the evening; pocket money being stopped and not being allowed to watch television would appear to have been the catalyst for [Redacted] to disclose further information during individual work with her.

1. During her stay in Tissue in June 1986 she was approached by a male member of staff in her bedroom and inappropriately touched in the vaginal area... Inspector Burns, Dunsurry R.U.C. Dunsurry, has been informed of this incident and a M.P. has been identified who will undertake joint interview with [Redacted] and Social Services.
Level of Alcohol Abuse in this family has been severe in the past and although little evidence of drinking is forthcoming from contact with the family, it appears that and have continued to drink spirits and have been able to hide this from professionals.

Vulnerability to previous incidences of sexual abuse and the present disclosure highlight an inability in the family to protect or even to recognise the need for protection. Instead and appear to have scapegoated into assuming blame for any problems or difficulties in their relationship with maintaining the standards demanded by outside agencies.

Previous incidents of physical abuse as result of over-zealous discipline of appear to have been replaced by threats to lock her in her room or to deprive her of all treats eg TV, money, meetings.

Concerns regarding child care practices and hygiene have been highlighted by disclosure that she would take on the 'mother' role quite often. Also, to prevent from ever eating and have locked and potty and no light. These statements may have been validated by concerns expressed by NINE regarding the smell of urine in the upstairs rooms necessitating a new floor in a bedroom and the neglect and dirt throughout the house which was noted following the families recent housing transfer.

and attitudes to this Departments concerns re an incident of sexualised behaviour noted by the family support appear to have been gliss and unconsidered. Both parties appear to lack insight into the significance and seriousness of this behaviour or of bizarre eating habits and what may be causing these behaviours.

response to recent allegations of abuse in issue would also reflect this attitude.

Conclusions

is currently in care in Adelaide Park under Section 103 CAYPA and is happy to be there. Therefore any emotional or physical risks to her have been minimised by her removal from the home situation. It is necessary to examine how able or willing are and to recognise and accept the concerns regarding behaviour and how able they are to protect her and to understand the reasons behind that behaviour.

It is unclear at what level and are drinking, it is certain that it is being well hidden by both parties and therefore the risk to the childrens safety is uncertain.

Due to and inability to understand and accept professional concerns and thus improve their poor level of routine and care for the children it is likely that the children are at risk of being physically and emotionally neglected.

Issues to be considered at present case conference.

1 Consideration of future care arrangements for

2 Consideration of future investigation of disclosure of sexual abuse while resident in LEnterprise Hospital.

3 Consideration of the risks inherent in the home situation for and in light of the recent disclosures by and subsequent concerns that may not be totally open and honest in their dealings with the professionals involved with the family.
2. To review the situation further to disclosure with regard to sexual abuse in Lisieux Hospital.

3. To examine the physical and emotional care which was afforded prior to admission to care.

4. To examine the implications of disclosures for the younger children.

5. To look at control of her alcohol problem.

It was agreed that future arrangements for care should be reviewed through the C.111 procedure in Adelaide Park Children’s Home.

1. With regard to disclosures of sexual abuse which occurred in Lisieux Hospital the R.U.C. have not yet interviewed the Social Worker is continuing to carry out individual work with the parties in an attempt to gain more information about the abuse. Throughout this work it has remained consistent about the fact that indecent assault did occur however investigations of these allegations was retarded by the intake into Care and her disclosures of abuse within the home situation. It would appear that the incident of abuse occurred within the Lisburn R.U.C. patch and therefore the allegations had been referred to the Police Care Unit in Lisburn. The R.U.C. are content to allow Social Services to continue to work individually with at her own pace.

With regard to the parental attitude towards disclosure it would appear that and were both concerned and annoyed that had not informed them of the alleged incidents when they had occurred. However, their current attitude is one of disbelief because of the scarcity of details with regard to the alleged abuse. There is evidence to suggest that neither nor are prepared to accept that an incident has occurred with regard to.

2. was received into Care following allegations about the level of physical abuse used by within the home. Prior to admission had admitted slapping however no bruises were noted during the medical examination. Deterioration of behaviour within the home setting lead to concern about the type of sanctions being imposed or threatened by.

pointed out that since admission to Adelaide Park Children’s Home appears to be relieved to be in Care and to be a contented girl. The normal expectation of a negative reaction consequent to admission to Care has not been evident and has proven herself to be quite open in discussion about her home life. Within the Unit talks positively about her mother however contact between and her mother is not good at present, visits tend to be very short and at present are supervised by Adelaide staff.
present it was felt to be inappropriate to involve another Agency with the family. It was accepted that the school was doing very well at school and that she had friends. The girls now do not appear to be as dependent on their parent figures as did the two girls, who currently attend Barnardo's Support Unit four times per week. It would appear that LS67's school have been unaware of problems within the home situation prior to her divulging that she was going into a Care setting. LS67 has never presented a management problem at school and it was suggested that school may have represented a safe haven. It would appear that LS67 and LS69 have attempted to respond appropriately to the children's misbehaviour but that this response has gone overboard and the couple have been over-zealous in their punishments.

Summary:

1. Concern was expressed about LS67 recent allegations that an incident which had occurred in Lissy. It is necessary to further investigate this incident and to help LS67 to deal with it.
2. There was evidence of real neglect for all four children within the home situation.
3. There was some evidence to suggest that the children's basic needs were not being met i.e. in terms of the appropriate purchase of food because of the needs for the adults to pay off debt.
4. Improvements have been noted in the physical conditions within the home since the family had moved house.
5. The threats to reinstate old sanctions used within the family had not actually been used.
6. LS67 did not appear to contribute to the emotional care of the children.
7. LS67 appeared to be making efforts to discipline the children appropriately however she tended to go overboard in her punishments and had difficulty in obtaining the right balance.
8. There was evidence to suggest that LS67 had been scapegoated to a great degree within the home.
9. It would appear that the younger 3 children have not been subjected to the same degree of scapegoating or sanctions within the home however it was clear that neither parent appears to be aware of what is appropriate in order to meet the children's needs.
10. Barnardo's Family Support Unit have reported that LS67 has a positive relationship with his mother and that he has reached an appropriate developmental milestones.
11. It was recognized that both parents have continued to attend NICA.

Decisions Taken:

1. Future arrangements for LS67 long term care will be reviewed through the C.11 procedure at Adelaide Park Children's Home.
2. There is a need to monitor the care of the LS67 children within the home. However given that the parents have demonstrated
From Hilary R Reid
Date 27 May 1993

DR K F MCCOY cc N J Chambers

REPORT OF ALLEGATIONS BY LS 66 AGAINST LS 21 IN LISSUE HOSPITAL

LS 66 is a former resident of Tara Lodge residential hostel, for which I had management responsibility from 1981 to 1987. She is one of a number of young people with whom I have occasional informal contact. LS 66 is now 19 years old.

In the course of an informal evening in my home on 19 May 1993, Kathleen alleged that a member of staff in Lissue had acted towards her in a sexually inappropriate way. I responded to LS 66 by explaining that if she revealed any details, I would have to pass these on to the relevant authorities and explained to her what the process would be if she herself wished to take the matter any further.

After a few days LS 66 contacted me to say that she wished to talk about what had happened to her and was clear about the implications of this for herself and the member of staff concerned. Her motivation was that she was concerned that other children had been subjected to similar treatment.

26 May 1993 - Discussion with LS 66

LS 66 stated that she had been admitted to Lissue Hospital when she was 17 years old. Her recall of the first incident, shortly after her admission, is hazy in parts as she remembers that she was very heavily sedated. LS 66 stated that she remembers lying on a floor with LS 21. He took his penis out and got LS 66 to fiddle it. LS 66 recalls that it was erect and she has a clear picture of other physical details. She vaguely recalls that he also had his hand down her pants on this occasion.

LS 66 first admission to Lissue lasted about a year. During this time LS 66 stated that she was frequently 'placed in isolation' as a punishment. In practice this meant that she was sent to the dormitory or the observation room to spend an hour or more on her own. When she was sent to the dormitory no other staff or patients would have been present.
stated that on about 3 occasions, again when she was drowsy on medication, came and lay fully on top of her, pressed himself into her, petted and kissed her.

On another occasion, accompanied him on a walk with younger children. He kissed her and held her hand throughout the walk which lasted about an hour.

was discharged from Lissue when she was about yrs. and was readmitted when she was . On Boxing Day night she recalls that there were only 2 other young children in the hospital. and were in the medication room. She stated that she remembers hugging him and he carried her into the observation room where he laid her on the bed. He kissed her several times and put his hand up her jumper. He then put his hand up her skirt and felt in between her legs. was wearing a sanitary towel and this appeared to discourage him. He stopped and went into the bathroom to wash his hands.

stated that she was worried about what had happened to her and the next day she told an that had kissed her. does not recall having done anything about this.

was admitted to Tara Lodge around her birthday.

stated that during her time at Lissue she had suspicions about behaviour towards other young female patients. Viewing the situation as an adult, she has grave concerns that his relationship went further with some of them. She is prepared to supply the names of patients who were there at the time.

has also voiced concerns about the violence of this member of staff towards the children.

Hilary R Reid
Well, we know that wasn't your status, and he thought he might have been called LS39, but then, as I say, when he gave evidence, he corrected the name.

"He was an evil man. One day I asked LS34" -- that was another staff member -- "if I could see him and she said, 'No, he's not in a good mood today'. I felt that he didn't make himself available depending on his temperament and that was wrong. He was supposed to be there to help me when I needed him. I don't think he was very professional. When I did see him, he was not very pleasant or helpful. He would ask me degrading questions" -- and he expanded that was, "Do you masturbate?" -- "which belittled me and affected my self-esteem."

A. That is a complete fabrication.

Q. Well, certainly in terms of it relating to you it's a fabrication --

A. It is --

Q. -- is what you are saying.

A. -- and I cannot for the life of me imagine any of the medical staff, the consultants, behaving in such a way. Inconceivable. I'm sorry.

Q. Another allegation -- set of allegations that I am going to come to is that of a girl called LS66, LS66. That
dates back to 1993. Now she spoke to police when she was an adult and her statement is at 31575. If we could just look at that, if we may. You will see again names are here. I am not going to go through it. They will be redacted in due course. Her statement is dated 29th May 1993.

She talks about how she came to Lissue and she says:

"I remember a nurse called LS21. The second day I was in Lissue I was having my dinner. LS21 stood and stared at me. I don't know what it was, but I got a terrible feeling about the way he looked at me. Because of my illness I was kept heavily sedated. I remember that I was very weak and would have fainted. LS21 grabbed me by the hair because I fell and pulled me along. My hair was much longer than it is now.

A couple of weeks after I had arrived in Lissue I was lying in a bed in the first dormitory. This was the dormitory for younger children. I remember LS21 coming into the dormitory and he lay down on top of me."

She describes what she says you were wearing:

"He was always well dressed. While he was lying on top of me, he gave me a passionate kiss on the lips. I remember him touching my chest. This was on top of my clothes. I remember these things through a haze, because of the tablets I was on. LS21 was always
hanging about the girls' dormitories. I remember seeing him dry his hair in one of the girls' rooms. The girl wasn't in the room at the time."

Then she goes on to talk about another member of staff and she said:

"If they had done anything wrong ..."

She said:

"LS21 and another nurse", who she names, "were always violent with the children, especially children over six years of age. If they had done anything wrong, LS21 or the other nurse would grab them by the hair and pull them down the corridor. There were times when other staff were present when the other nurse or LS21 would grab the children by the hair. The staff never ever done anything about it.

During the stay at Lissue I got injections. Usually LS21 gave me them, but sometimes the other nurse did. I always got the injection in the hip. One day when LS21 was taking me to school, I said to him about how violent he was to the younger children. I will always remember his answer: 'I'm sure I'll be forgiven for that'. There was no need for the violence LS21 and the other nurse used, especially on children as young as six.

I remember one day all the staff were at
a conference. I was in the day room. Although I was heavily sedated, I can remember lying on the floor in front of the settee. LS21 was lying beside me. He opened the zip on his trousers and took out his penis. He made me touch it. Because of the medication I was on, I was unable to control my hands to masturbate him. I just fondled him. I had never seen a penis before that day. He had an erection. At first when I thought back, I thought LS21 may have been wearing a Durex, because of the knob at the end of his penis, but I now know the difference. I think LS21 may be circumcised. I remember there was semen. So I take it he must have come. I then went to the toilet, which was beside the day room. Again because of medication I could not do up my trousers when I had been at the toilet. I remember standing at the door and LS21 fixing my trousers. I was discharged when I was 14 years of age."

Now I can see that even me reading that, LS21, has caused you some distress, and it wasn't my intention to do so. As I explained to you, this material has not been opened to the Inquiry before and that was why I felt it important just to put it on the record, but if you feel you need a break, please just say. We can take a short break.

A. Please may I ask for a short time?
having had their knuckles rapped in 1983, they were not
going to make that mistake again, even if this did not
go anywhere. Would that be, do you think, a likely
scenario?
A. Yes. I think --
Q. I ask the Board representatives a little bit more about
this obviously --
A. Yes.
Q. -- but from a departmental point of view do you think
the Department having said, "Look, you ought to be
reporting these things to us", then the expectation on
the Department's part would be such a matter would be
reported from then on?
A. Yes. I think to be fair to the Board there would have
been that heightened awareness on the part of all
statutory and voluntary agencies by that stage that
things had to be reported.
Q. The next matter is a matter that you yourself became
aware of and you address that at 17.7. If we can just
scroll on down, please. That's the LS66 matter from
1993, when you were a Social Services Inspector at that
point in time, and a young woman, who had been a former
resident of the Adolescent Unit that you had worked in,
but whom you also had kept in contact with over the
years, disclosed to you that she had been assaulted by
a male nurse, whom she named. You then provided a report on that to Dr McCoy, who was then the Chief Inspector, and to Mr Chambers, the SSI Assistant chief Inspector. You remember speaking to them at a meeting about the matter, and also the Assistant Secretary of the Childcare Policy, Mr Kearney, was at that meeting.

A. Yes.

Q. You then contacted police, and you understand that a senior official within the DHSS Management Executive contacted the Board. If we can just scroll on down, please. The member of staff was then put on a precautionary suspension and the police investigation ensued. The Inquiry has seen the police documents and ultimately no prosecution was directed and he was reinstated.

Now you at that stage did not know about the previous two complaints -- isn't that right --

A. That's right.

Q. -- from 1983 or 1986? We know then that shortly after that you then receive another piece of information about another girl, who is LS68, and that was when a social -- yes, a social worker, BAR8, who was employed at Barnardo's, contacted you to say that a patient -- a former patient of Lissue alleged that she had been sexually assaulted by a male member of staff.
THE INQUIRY INTO HISTORICAL INSTITUTIONAL ABUSE 1972 TO 1995

WITNESS STATEMENT OF LS 21 (ADDITIONAL)

LS 21 will say as follows:

1. I have had disclosed to my Solicitor a statement of LS 66 and a statement from Sergeant McAuley of the RUC dated 5 August 1993. I confirm and adopt the contents of the statement of Sergeant McAuley in relation to my comments after caution concerning the allegations made by LS 66.

2. I deny any allegations of sexual assault, assault or any inappropriate behaviour with LS 66.

3. I was advised that no further action would be taken against me and I confirm that I was never prosecuted for any matter arising out of any allegation made by LS 66 or any other person.

Dated this 7th day of April 2016

Signed.............

LS 21
28 May 1993

Dear Sir,

I am writing in connection with your employment as a [redacted] in the Family and Child Psychiatry Unit at Forster Green Hospital.

The Trust has been advised that a criminal allegation has been made against you that will be the subject of a police investigation.

In the light of this information I am to advise you that it has been decided to place you on precautionary suspension with immediate effect. During this period of precautionary suspension you will remain on full pay and receive your normal allowances in connection with your employment. I am to advise you that during this time you are required to stay away from your place of work.

The suspension will remain in place pending the outcome of the police investigation.

Yours faithfully

[Signature]

Mr A Finn
Director of Patient Services
into the matter.

17.4 On the advice of the EHSSB by letter dated 27 October 198714, the NHSSB challenged a police decision communicated to Lisburn Social Services on 8 April 198715, not to pursue the matter any further as [REDACTED] had made a written statement in January 1987 withdrawing the original complaint. As a consequence, the police confirmed to the NHSSB in November 1987 that the investigations were being reopened and that the findings would be submitted to the Director of Public prosecutions16. The CSWA (now the Chief Inspector, SSI) was copied into correspondence between the NHSSB, the EHSSB and the police in relation to these events and requested by letter dated 7 December 1987 to be kept informed of any further developments17. The Department does not hold any additional information in relation to this case.

17.5 The Department holds no further information regarding the [REDACTED] complaint.

17.6 The following information regarding the [REDACTED] complaints has been drawn from documentation which was shared with the EHSSB by the DHSS, which was retained by the Board and submitted in its evidence to the HIAI. The DHSS’s own file in relation to these complaints is not available, having most likely been disposed of in accordance with the Departmental file management systems.

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

17.7 In May 1993 during my tenure as a DHSS Social Services Inspector, [REDACTED], then a [REDACTED] year old woman and a former resident of Barnardo’s Tara Lodge Adolescent Unit which I had previously managed, alleged to me that while she had been a patient in Lissue some [REDACTED] years previously, she had been sexually assaulted by a [REDACTED] whom she named. I provided a report on the matter to Dr K McCoy, the then Chief Inspector (CI) and Mr N Chambers, an SSI Assistant Chief Inspector (ACI)18. I recall that the contents of the report were discussed with me at a meeting between the CI, the ACI, the then Assistant Secretary within the DHSS’s Child Care Policy Branch, Mr J Kearney.

17.8 Following the meeting, I contacted Sergeant W McAuley of the RUC Care Unit on behalf of [REDACTED]. I understand Mr P Simpson, a senior official within the DHSS Management Executive contacted the EHSSB and the Green Park
Trust, where the member of staff was then working as Child Psychiatry Unit. He was temporarily suspended and a police investigation ensued. I understand no charges were preferred due to lack of corroborating evidence.

17.9 At the time of the complaint, I was not aware of the previous complaint made by in November 1986, which also had been reported to the DHSS. I did not become aware of this complaint until very recently when the Departmental files relating to Lissue, which had been had copied to the HIAI were provided to me to read.

The complaint made in 1994 relating to June-August 1986

17.10 On 18 December 1994, I was informed by telephone by BAR 8, a social worker employed by Barnardo’s and attached to the Sharonmore Project that a young girl resident who had formerly been a patient in Lissue had alleged she had been sexually assaulted by a male member of staff. The DHSS had not yet received any formal notification of this but in view of my knowledge of the complaint, I wrote by letter dated 19 December 1994 to the Barnardo’s Assistant Divisional Director responsible for the Project, seeking assurance that the allegations were being pursued with Social Services and that Social Services would also be made aware of the recent police investigation into similar allegations led by Sgt McAuley.

17.11 By memo dated 4 January 1995, the ACI wrote to Mr P Simpson of the DHSS Management Executive to advise him of the situation. (Barnardo’s) confirmed by letter dated 5 January 1995 that the relevant HSS Trust was pursuing the current allegation and was liaising with the RUC in relation to the previous allegation.

17.12 According to a letter dated 7 August 1996 from Mr J Veitch (Family and Child Care Services Manager, South Eastern Trust) to the RUC that MA’s allegations made in December 1994 could not be pursued because of her refusal to be interviewed by the police. She was further interviewed by a social worker from the Trust in August 1996 by confirmed that she did not wish the matter to be pursued. I note that I wrote by letter dated 2 October 1996 to Mr Veitch in which I refer to pursuing a matter with the RUC, seemingly of an original statement of complaint made by in 1990 which I perhaps had not
I can remember standing in the corridor with my mum telling her what LS 8 had done to me. LS 8 was standing there denying it saying I had done it to myself. I called LS 8 a bastard, then my mum and I went out. Another time I was misbehaving and I was put to bed. I put my bed up against the door to keep the staff out. I was there for a couple of hours. I removed one of the plastic windows from the frame to try and climb out. The staff encouraged me to move the bed from the door and told me they would say no more about it and they would forget about it all. Thinking it was the best option I had I moved the bed away from the door. The door opened and I got water thrown over me. LS 8 was on duty that night. There was also a nurse on who had a ______ accent. I was pinned down to the floor by the above named staff and stripped naked. I was held down on my stomach and given an injection. I was put back into the bed and passed out. I woke up the next day in the afternoon, a brand new box of Lego was waiting for me, this was my favourite toy. Also cakes, sweets and juice. I was in and out of tissue up until I was 11 years old. I then went into Rathgael just before my 12th birthday. I was sent to House 5 for young offenders, although I was not there for a criminal offence. I often was hit and bullied by the other boys in the unit, receiving black eyes. I complained to staff but nothing was ever done about it. I could not relate to anyone in House 5 because I was not an offender. I remember an incident at breakfast one morning. Someone had spat in my cereal. I complained about it to RG 60 the RG 60 told me to eat it. I argued and said "No" and he swung round and smacked me in the mouth with the back of his hand. Everyone in the dining room laughed. I went to a mobile classroom and my RG 62 teacher was RG 62 If I didn't get my ______ correct RG 62 would thump me on my back and
a member of staff who I can remember only as RG 49 would squeeze my hand or wrist or put my arm up my back in order to get me to do things which maybe I was refusing to do. I was moved to House 3 where I was bullied a lot by boys. I suffered assaults from RG 49. He would punch me, mainly in the stomach, sometimes he would just threaten me with a punch. RG 54 punched me a couple of times. Once he punched me in the ribs, another time he wouldn't let me go outside he swung for my head. But I ducked and he missed. RG 54 would do things like taking his time when you asked him to do something, even if you were in a hurry. He would walk slowly and muddle with the keys. The staff in Rathgael took children's privileges as in their food, ie butter, cakes and biscuits. The staff in Rathgael allowed us to smoke while we were underage and had no concern for our health. We were only allowed to smoke in a small room of about 4' x 8' and 8' high. Staff in general would make me clean in the morning, then Hoover again at lunchtime and again at night before we went to bed. I couldn't grasp why we had to Hoover before bed time and again in the morning when no one was using the building during the night and we were all in bed. I started suffering from emotional effects of the abuse I suffered at Lissieu and from a sexual assault that happened to me in my aunt's house in Bangor, on an occasion when I had run away from home. I realised I would not get any support from the staff in House 3 so I wanted to phone "Childline". RG 49 the Housemaster denied me this. In frustration I ran out of the building and hid behind it. When I eventually returned I was taken upstairs, stripped and put into my pyjamas. I went to bed. Before I got to sleep two members of staff returned and held me with my arms up my back and walked me over barefoot to House 4. This was the offenders' Secure Unit and I was not an offender. Previous to that incident I was doing dangerous life-threatening things to my
so unhappy, had no one to talk to and got no support. Once I drank bleach attempting to kill myself. I was not given any support or asked why, I was just punished. By running away from House 3 that was the last straw for the staff and I was sent to House 4 which was 24-hour lock-up. Just after Christmas I ran away for a week or so. When I was caught in Bangor I was returned to House 4. I was in the office with RG 48. He told me that RG 66 was worried for me. I said "So what" and RG 48 punched me in the face. I did not complain because I knew nothing would be done about it. RG 48 constantly threatened me with physical violence and generally bullied me. Another incident involved a member of staff named RG 48 I had a party whistle. I sneaked up behind him and blew it in his ear. He jumped over the seat and punched me everywhere except my face. I was restrained by other members of staff and taken upstairs to my room where I was locked in. In anger I tore the door apart. I was moved from my room into another room where I tore down a smoke detector and smashed it open and consumed bits in order to get to hospital. The next day I was sent to Downshire. I was there for 2 months. There was nothing mentally wrong with me so I was sent back to Rathgael to the care side Secure Unit where I should have originally been. Female members of staff intruded on my privacy in the bathroom. These were RG 48 and RG 66. When I was locked in my bedroom staff would make fun of me and laugh at me through the observation slot in the door. Senior Staff told me that I would only be back in Rathgael for 2 weeks, this was in June or July when I got back from Downshire. I was there until January the next year. Senior Social Worker got me an interview for the Cotswold Community in England. I was turned down and felt that I was never going to get out of Rathgael so I tried to hang
found me and cut me down. Staff cleaned everything out of my room. I was left with only a quilt, I had nothing on. I was lying on a rubber mattress and left in the room locked up for approximately 1 week. I got no emotional support and feel I was being punished for what I had done. Eventually I was accepted into [REDACTED] in England, a therapeutic community. The school burned down and I was returned to House 3 in Rathgaela, where I suffered the same kind of abuse which I mentioned before. When I was in bed one night [REDACTED] another resident, booted me in the face when I was asleep wearing DM boots. The only reason staff did anything about this assault was because a member of staff from [REDACTED] was coming over to see me and he would have questioned my injuries. While in House 3 I went to the main school. The [REDACTED] teacher [REDACTED] often skelped me around the legs or back with a flipper or plimsoll if I annoyed him or made mistakes. Another incident was where I was given detention. I was left in a room of about 5' x 4' which had a table and a chair in it and made to write out a book. When it came to dinner time I asked [REDACTED] the [REDACTED] if I could go for dinner. He asked if I had wrote out the book. I said "No". He said I was to stay until I had finished. I slammed the door in anger and before I sat down he burst through the door and began punching me around the head and body in the room. [REDACTED] then stood at the door with his back to me. I jumped up, pushed him out of the way and ran down to House 3 where I told [REDACTED] what had happened. Nothing was done about it. I eventually left Rathgaela and went to [REDACTED] again. I was asked to leave [REDACTED] On the way home at Heathrow Airport I took an overdose because I didn't want to go back to Rathgaela. When it was discovered I was sent to hospital but taken back to House 10 in Rathgaela where I got no support. I was moved to House 3. On 6th
told me he had applied for a 6 month extension. I discovered 2-3 months later that there was no such thing as a 6 month Extended Care Order, so I was lied to and held under false pretences. I was then asked by [REDACTED] to stay voluntarily or I could leave and he would have the police pick me up and I would be put under a 15 week Place of Safety. By staying voluntarily I was allowed complete freedom and allowed to do my own thing.
HIA 172 was first referred to Bangor Social Services in 1978 due to his extremely disruptive behaviour and his mother's inability to cope.

In 1980 aged HIA 172 was placed in Lissieu Children's Hospital, Lisburn. He remained there until 1986 when he was transferred to the Rathgael Centre, Bangor.

A report from the Principal Social Worker at Rathgael, (Part IV, Page 7) outlines HIA 172 extreme behaviour and subsequent management difficulties. describes HIA 172 as "one of the most disturbed and demanding cases Rathgael has ever had to work with."

HIA 172 has made allegations of physical abuse/ill treatment during his 9 years in care and has implicated 13 members of staff from both Lissieu Hospital and the Rathgael Centre, these are:-

1. 2. LS 8 3. RG 48
   4. 5. RG 62 6. LS 6
   7. 8. RG 33 9. LS 84
   10. 11. RG 17 12. RG 54
   13. LS 85

Each of the above have been interviewed after caution and all emphatically deny assaulting HIA 172.

There is no other evidence available to corroborate HIA 172 allegations, I therefore respectfully recommend no further action.

I certify that all witness statements taken by police in connection with this investigation are included in this file. S. Cootes
Department of the Director of Public Prosecutions
Royal Courts of Justice Belfast BT1 3NX
Belfast 235111

RUC Ref: C94/17/94
DPP Ref: 1726/94

Subject: ALLEGED PHYSICAL ABUSE AT LISSUE CHILDREN'S HOME, LISBURN AND THE RATHGAEL CENTRE, RANGOR

HIA 172

Chief Constable

DIRECTION

Given the total absence of any independent evidence to corroborate the complaints which have been alleged, the evidence is quite insufficient to establish that any criminal offence was committed.

I direct no prosecution.

The police investigation file is returned herewith.

B H DONNELLAN
Eastern Circuit for Director of Public Prosecutions

11th April 1994
LS7 said at 31583 that, first of all, you were never left alone with children. She saw nothing that would have made her suspicious of you and you would have been on duty with other female staff.

LS25 -- and again I am using names that aren't to be used outside -- in her statement at 31585 said LS66 never complained to her. She said you were good with children and some of the children were very fond of you.

Your line manager, LS8, at 31586 said he never had any reason to complain about your skills. You were a highly regarded role model and he never had any reason to be suspicious. He said you may have given LS66 injections. That wasn't unusual and it would have been with the help of other staff.

In their police -- one of the things, though, in their statements that they did say was force was used on children, but only what was reasonable.

Ultimately the PPS directed no prosecution. It would have been the DPP then. That's at 31564. That was on 4th October 1993.

Now in your Inquiry statement, the additional statement you gave, which is at 60526, you deny the allegations again in that statement.

A. Yes.
Trust, where the member of staff was then working as a [REDACTED] in the Foster Green Child Psychiatry Unit. He was temporarily suspended and a police investigation ensued. I understand no charges were preferred due to lack of corroborating evidence.

17.9 At the time of the [REDACTED] complaint, I was not aware of the previous complaint made by [REDACTED] in November 1986, which also had been reported to the DHSS. I did not become aware of this complaint until very recently when the Departmental files relating to Lissue, which had been had copied to the HIAI were provided to me to read.

The [REDACTED] complaint made in 1994 relating to June-August 1986

17.10 On 18 December 1994, I was informed by telephone by BAR 8, a social worker employed by Barnardo’s and attached to the [REDACTED] Project that a young girl resident who had formerly been a patient in Lissue had alleged she had been sexually assaulted by a male member of staff. The DHSS had not yet received any formal notification of this but in view of my knowledge of the [REDACTED] complaint, I wrote by letter dated 19 December 1994[19] to the Barnardo’s Assistant Divisional Director responsible for the Project, Mrs L McClure, seeking assurance that the allegations were being pursued with Social Services and that Social Services would also be made aware of the recent police investigation into similar allegations led by Sgt McAuley[20].

17.11 By memo dated 4 January 1995[21], the ACI wrote to Mr P Simpson of the DHSS Management Executive to advise him of the situation. Mrs McClure (Barnardo’s) confirmed by letter dated 5 January 1995 that the relevant HSS Trust was pursuing the current MA allegation and was liaising with the RUC in relation to the previous allegation[22].

17.12 According to a letter dated 7 August 1996[23] from Mr J Veitch (Family and Child Care Services Manager, South Eastern Trust) to the RUC that [REDACTED] allegations made in December 1994 could not be pursued because of her refusal to be interviewed by the police. She was further interviewed by a social worker from the Trust in August 1996 by confirmed that she did not wish the matter to be pursued. I note that I wrote by letter dated 2 October 1996[24] to Mr Veitch in which I refer to pursuing a matter with the RUC, seemingly of an original statement of complaint made by [REDACTED] in 1990 which I perhaps had not

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[19] LIS 10115
[20] LIS 307
[21] LIS 10116
[22] LIS 10117
[23] LIS 10118
[24] LIS 10119
15. **Was any other form of discipline employed in Lissue, if so, what form did this take?**

15.1 Please see paragraph 19.1 below.

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

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

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

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

**The complaint made in November 1986 relating to the mid 1970s**

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

17.3 The Chief Social Work Adviser (CSWA) was notified by letter dated 22 December 1986 from the Northern Health and Social Services Board (NHSSB), that a girl aged years who was in the care of the Board had alleged she had been sexually assaulted by a male member of staff at Lissue when she was a patient in the hospital some 10 years previously. The NHSSB had notified the EHSSB who in turn had referred the matter to Lisburn RUC. The EHSSB appears to have ascertained that the person against whom the allegation had been made was a who had left the service a year previously on the grounds of ill-health. The DHSS made a written request dated 8 January 1987 to the NHSSB to be kept informed and requested a further update from the NHSSB on 24 March 1987. By letter dated 14 April 1987 the NHSSB responded indicating that refused to make a formal statement of complaint to the police but that the EHSSB was inquiring further.
into the matter.

17.4 On the advice of the EHSSB by letter dated 27 October 1987, the NHSSB challenged a police decision communicated to Lisburn Social Services on 8 April 1987, not to pursue the matter any further as had made a written statement in January 1987 withdrawing the original complaint. As a consequence, the police confirmed to the NHSSB in November 1987 that the investigations were being reopened and that the findings would be submitted to the Director of Public prosecutions. The CSWA (now the Chief Inspector, SSI) was copied into correspondence between the NHSSB, the EHSSB and the police in relation to these events and requested by letter dated 7 December 1987 to be kept informed of any further developments. The Department does not hold any additional information in relation to this case.

17.5 The Department holds no further information regarding the complaint.

17.6 The following information regarding the and complaints has been drawn from documentation which was shared with the EHSSB by the DHSS, which was retained by the Board and submitted in its evidence to the HIAI. The DHSS’s own file in relation to these complaints is not available, having most likely been disposed of in accordance with the Departmental file management systems.

The complaint made in 1993 relating to the 1970s

17.7 In May 1993 during my tenure as a DHSS Social Services Inspector, , then a year old woman and a former resident of Barnardo’s Tara Lodge Adolescent Unit which I had previously managed, alleged to me that while she had been a patient in Lissue some 14 years previously, she had been sexually assaulted by a male nurse whom she named. I provided a report on the matter to Dr K McCoy, the then Chief Inspector (CI) and Mr N Chambers, an SSI Assistant Chief Inspector (ACI). I recall that the contents of the report were discussed with me at a meeting between the CI, the ACI, the then Assistant Secretary within the DHSS’s Child Care Policy Branch, Mr J Kearney.

17.8 Following the meeting, I contacted Sergeant W McAuley of the RUC Care Unit on behalf of . I understand Mr P Simpson, a senior official within the DHSS Management Executive contacted the EHSSB and the Green Park

14 LIS 10063
15 LIS 10056
16 LIS 10065
17 LIS 10067
18 LIS 10076
Trust, where the member of staff was then working as a [redacted] in the Foster Green Child Psychiatry Unit. He was temporarily suspended and a police investigation ensued. I understand no charges were preferred due to lack of corroborating evidence.

17.9 At the time of the [redacted] complaint, I was not aware of the previous complaint made by [redacted] in November 1986, which also had been reported to the DHSS. I did not become aware of this complaint until very recently when the Departmental files relating to Lissue, which had been had copied to the HIAI were provided to me to read.

The [redacted] complaint made in 1994 relating to June-August 1986

17.10 On 18 December 1994, I was informed by telephone by BAR 8, a social worker employed by Barnardo’s and attached to the [redacted] that a young girl resident who had formerly been a patient in Lissue had alleged she had been sexually assaulted by a male member of staff. The DHSS had not yet received any formal notification of this but in view of my knowledge of the [redacted] complaint, I wrote by letter dated 19 December 1994¹⁹ to the Barnardo’s Assistant Divisional Director responsible for the Project, Mrs L McClure, seeking assurance that the allegations were being pursued with Social Services and that Social Services would also be made aware of the recent police investigation into similar allegations led by Sgt McAuley²⁰.

17.11 By memo dated 4 January 1995²¹, the ACI wrote to Mr P Simpson of the DHSS Management Executive to advise him of the situation. Mrs McClure (Barnardo’s) confirmed by letter dated 5 January 1995 that the relevant HSS Trust was pursuing the current [redacted] allegation and was liaising with the RUC in relation to the previous allegation²².

17.12 According to a letter dated 7 August 1996²³ from Mr J Veitch (Family and Child Care Services Manager, South Eastern Trust) to the RUC that [redacted] allegations made in December 1994 could not be pursued because of her refusal to be interviewed by the police. She was further interviewed by a social worker from the Trust in August 1996 by confirmed that she did not wish the matter to be pursued. I note that I wrote by letter dated 2 October 1996²⁴ to Mr Veitch in which I refer to pursuing a matter with the RUC, seemingly of an original statement of complaint made by [redacted] in 1990 which I perhaps had not

¹⁹ LIS 10115
²⁰ LIS 307
²¹ LIS 10116
²² LIS 10117
²³ LIS 10118
²⁴ LIS 10119
94. On 9 January 1997 Dr Harrison wrote to Chief Inspector Cardew noting the two allegations, and detailing that the “Social Services Inspectorate’s concern is that there may be information in the 1990 investigation, may well have wider child protection implications”. See Exhibit 31

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

96. In 2008 allegations were made by [redacted] of abuse by a number of staff at Lissue Hospital. [redacted] was an inpatient at Lissue during the following periods: 23 - 27 March 1987, 17 September 1987 – 23 October 1987 (when she became a day patient), 9 February 1988 – 31 March 1988. She also had admissions to Forster Green Hospital from 20 July 1989 – 12 August 1989, 11 September 1989 – 9 February 1990. The sequence of information becoming known and steps being taken is as follows:

a. Whilst in inpatient at the Psychiatric Unit of the Mater Hospital, [redacted] had mentioned to a Staff Nurse that she had been abused by staff whilst an inpatient at Lissue Hospital and Forster Green. This was referred to the Child Protection Team in Belfast Trust on 19 February 2008;
b. A complaint was made to Police and a clarification interview had been conducted on 28 March 2008 under joint protocol procedures.
c. A strategy meeting between Belfast Trust and the PSNI was convened on 3 April 2008 – See Exhibit 34. This detailed the agreed actions, which included checks to be undertaken with the Human Resources Department regarding the staff named in the clarification interview, and the submission of a Serious Adverse Incident report to the Department of Health;
d. On 9 April 2008 a further Strategy Discussion was held, attended by Belfast Trust, South Eastern Trust and PSNI. This confirmed the outcome of initial checks undertaken regarding the employment status of staff named in the complaint and identified agreed actions. See Exhibit 35;

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

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

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

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

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

j. Belfast Trust continued to keep under review situation and any information she was able to give relevant to her complaint throughout 2011 and into 2012, at which time she was in a specialist placement in London.
99. During work by a Strategic Management Group, as described at paragraph 112 et seq below, it was identified that there had been 11 individual approaches to the Police Service of Northern Ireland in relation to complaints relating to Lissue Hospital. The Board is seeking to identify the identity of these complainants.

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

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

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

102. By July 2008 a three strand process was agreed to explore the issues arising in detail:
   a. Strategy meetings were to continue in relation to the individual complainant;
   b. Belfast Trust took forward an investigation in relation to allegations against two named staff that remained within the employment of the Trust: [LS 69 LS 79 LS 117]. This was to ensure that no current employee posed a safeguarding risk for children or vulnerable adults. South Eastern Trust was to consider the issues arising in respect of staff remaining in their employment, particularly [LS 78];
   c. The Eastern Health and Social Services Board took the lead on the investigation of historic complaints.

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

Minutes of Strategy Discussion Regarding

Held on Thursday, 3rd April 2008 at Nore Villa, Knockbracken Healthcare Park

Present:
Mrs Carol Duffin, Children’s Services Manager Gateway
Mr John Toner, Assistant Director, South Eastern Trust
Mr Paul McConnell, PSNI, CAIU Antrim
Ms Dorothy Lindsay, APSW, BHSC, 414 Ormeau Road
Ms Anne McClean, APSW, BHSC, Lawthor Buildings

Apologies:
Mr Reuben Black, PSNI

Mrs Duffin welcomed everyone to the meeting and outlined that the purpose was to review the information that had been passed to the Child Protection Team in relation to [LS 69] and to consider what action is required arising out of this.

Ms McClean advised that a referral had been received by the Child Protection Team, Lawther Buildings, on 19th February 2008, in relation to [LS 69] made by [LS 69] Social Worker, Mater Hospital. Ms [LS 69] had advised that [LS 69] had been an inpatient at the Psychiatric Unit of the Mater Hospital and had mentioned in passing to Staff Nurse [LS 69] that she had been abused by staff whilst an inpatient at Lisieux Hospital and Foster Green. No details of the staff member or the nature of the abuse was known although [LS 69] had stated that the abuse had taken place between the age of 10 – 16 years. The Child Protection Team had been advised that [LS 69] may make a complaint to the PSNI.

Ms McClean had checked socare and advised that [LS 69] had had extensive involvement with Social Services – Physical Health and Disability Programme 1992 – 2006. [LS 69] had been admitted to the Mater more recently following an overdose. The Mater Hospital closed involvement on 18.02.08, [LS 69] is now 17 years of age. Ms McClean had contacted the PSNI who had advised that [LS 69] was not known to them. Ms Lindsay confirmed that [LS 69] is not known to South and East Belfast.

Mr McConnell, PSNI, advised that [LS 69] had subsequently made a complaint to the PSNI and a clarification interview had taken place on 28.03.08 by Stephen Pilson, Grosvenor Road PSNI and Mary O’Brien, Care Manager, Everton. During the clarification interview [LS 69] named the following seven staff from Lisieux / Foster Green:-

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