THE HISTORICAL INSTITUTIONAL ABUSE INQUIRY

MODULE 13 – LISSUE HOSPITAL

SUBMISSIONS ON BEHALF OF

***THE DEPARTMENT OF HEALTH***

**("The DoH")**


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| *Solicitor for the DoH* | *Mrs. Tanya Stewart*<br>*Departmental Solicitor's Office* |
| *Counsel for the DoH* | *Andrew McGuinness BL* |

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## Introduction

1.1. This thirteenth module has considered the Lissue Hospital, which operated as a child psychiatric hospital from 1971 until 1989.

1.2. The initial statement of Dr. Harrison[1] on behalf of the Department of Health, Social Services and Public Safety, "the DHSSPS"[2], has set out evidence of the engagement of the DHSSPS with Lissue Hospital. Further statements[3] have been lodged to deal with an erroneous comment by HIA220 and issues that arose during the evidence of Dr McAuley and Dr Nelson.

1.3. This module is unusual within this Inquiry as it considered a children's hospital rather than a children's home. The legislative background and the context of this institution are therefore considerably different from the others considered to date.

[1] At LIS-791.
[2] DHSSPS was renamed the Department of Health with effect from 8th May 2016 – see the Departments Act (NI) 2016 and S.R. 2016 No. 89
[3] Statements from Eilis McDaniels at LIS-784, Dr Kevin McCoy at LIS-1450 and Professor Martin Bradley at LIS-1451.

## 2. Legislative background and Inspection.

2.1. As a hospital Lissue was governed by different legislation to that governing the children's home. From 1948 hospitals were operated under the authority of the Northern Ireland Hospitals Authority[4], the "NIHA", a body corporate which reported to the Ministry for Health and Local Government, the "MHLG", later the Department of Health and Social Services. Individual or groups of hospitals were administered day to day by a Hospital Management Committee[5]. Following the significant restructuring of health and social services established under the Health and Personal Social Services (Northern Ireland) Order 1972, the "1972 Order", in 1973 the management of Lissue Hospital became the responsibility of the newly established Eastern Health and Social Services Board, the "EHSSB"[6].

2.2. It is of note that having delegated the exercise of functions to the Boards under the 1972 Order the Department, properly, did not become involved in the exercise of those delegated functions. The transfer of administrative control of Lissue from the North and West Belfast District to the Lisburn District of the EHSSB in 1973 illustrates this. The MLHG suggested that Lissue might be a *"special case"*[7], where the administration of a facility should remain the responsibility of a district other than the one in which it existed. The EHSSB, within whose power this decision lay, did not accept the suggestion. It has been suggested that this was *"a triumph of bureaucracy over common sense"*[8].

2.3. Section 63 of the Health Services Act (Northern Ireland), 1948, the "1948 Act", afforded the MHLG a power to inspect and report on

[4] The Health and Social Services Act (Northern Ireland) 1948; Section 20 at LIS-9011.
[5] The Health and Social Services Act (Northern Ireland) 1948; Section 28 at LIS-9019.
[6] The Health and Personal Social Services (Northern Ireland) Order 1972, Section 16 at LIS-9130.
[7] LIS-816.
[8] Love H, The Royal Belfast Hospital for Sick Children: a History 1948-1998. LIS-817.

hospitals[9]. This was replicated in Section 70 of the Health Services Act (Northern Ireland) 1971[10]. Article 50 of the 1972 Order contained a more general power of inspection of *"any home for persons in need or other premises in which a person is or is proposed to be accommodated under arrangements made by the Ministry"*[11]. It is of note the more widely drafted Article 50 power was not directed specifically towards hospitals, rather any arrangement under the 1972 Order. Dr Harrison has described this as a backstop power[12].

2.4. There is no information available to suggest the power to inspect was ever used other than in a Social Services led inspection of services for disabled children in 2005[13]. Dr McAuley, who retired in 2000, whilst giving oral evidence dealing with the various groups that inspected Lissue, referred to the Mental Health Tribunal and Royal College of Psychiatrists and suggested that there was Social Services Inspectorate (SSI) or Social Work Advisory Group inspection of Lissue[14]. He had not raised this issue within his statement. Dr Nelson when asked in oral evidence did not have any recollection of SSI or SWAG attending at Lissue[15]. Dr McCoy who retired as Chief Inspector of SSI in 2000 has subsequently confirmed that neither SSI nor SWAG inspected Lissue. Dr Nelson suggested he recalled an inspection by Martin Bradley, who subsequently became the Chief Nursing officer. Mr Bradley has subsequently provided a statement in which he suggests he did not lead or carry out any inspection of Lissue and does not in fact recall ever visiting it.

2.5. It is of note the former Chief Medical Officer in his statement to the Inquiry[16] confirmed the role of the Department was more by way of

[9] Section 63 at LIS-9034.
[10] LIS-9096.
[11] LIS-9142.
[12] Day 200 Page 24 should read, "backstop" rather than "stopgap".
[13] LIS-795.
[14] Day 201, page 101.
[15] Day 201, page 149.
[16] LIS-696

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

2.6. Unlike children's homes, Lissue was a hospital with many layers of oversight. The psychiatric unit was a multidisciplinary, consultant led unit, with daily attendance by doctors, nurses, social workers, psychologists and consultant psychiatrists. This resulted in significant layers of oversight and consideration of the practices and procedures by medical professionals who were registrants of their professional bodies, with a professional code and duty to identify acts or omissions of concern and report these. This was confirmed by a former member of the nursing staff[17].

2.7. Unlike children in children's homes who had been removed from the care of parents and did not often have the benefit of stable supportive families, the children in Lissue went home frequently. Many went home every weekend, families were encouraged to visit during the week and many families took part in family therapy sessions. There was also provision on site for parents to stay. HIA3 confirmed that his mother and father came to visit him during the week and he would get home at weekends. HIA3's mother spoke to staff about a complaint HIA3 had made to her that staff had used the term *"angry"* in a report written[18]about her son. This parental interaction provided a significant opportunity for children to report any abuse, albeit within the social and cultural context of the time parents might have been less likely to believe a child's complaint or to challenge medical professionals.

2.8. Multidisciplinary team meetings were held every day of the week[19] and two half-day ward rounds held weekly. Dr Nelson, one of the two

[17] LS81 Day 198 Page 99
[18] Day 199 Page 18.
[19] Dr McAuley Day 201 Page 107.

consultant psychiatrists, visited Lissue every day at different times of the day and at night, including unannounced visits during which he discussed issues with staff and toured the unit[20].

2.9. The nature of the treatment itself involved psychiatrists speaking to the children to identify issues or factors that might be of concern and to address these. Children also attended a 'children's meeting' every morning with nursing staff and at times a psychologist and registrar. During these meetings children were encouraged to discuss problems and occurrences the previous day[21].

2.10. Lissue Hospital was also visited by the Belfast Hospital Management Committee and later the Area Executive Team of the EHSSB. Ms. Mary Hinds for the Health and Social Care Board suggested in oral evidence that whilst there was no written evidence available the *"Health and Social Care Board and Public Health Authority view is that there would have been inspections carried out on Lissue at Board Level."* [22]

2.11. The Mental Health Commission for Northern Ireland established by the Mental Health (Northern Ireland) Order 1986[23] pursuant to its duty to *"keep under review the care and treatment of patients"* visited Lissue in 1987 as part of an intended programme of annual visits to each hospital by the Commission[24].

2.12. Dr Harrison in oral evidence intimated that inspection per se is ultimately a blunt instrument and that unless inappropriate practice had been observed or information communicated to inspectors it is

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20 Day 201 Page 132.
21 Day 199 page 44.
22 Day 200 page 79.
23 Article 85 (not section 20 as referred to at LIS-794).
24 LIS-088.

unlikely any abusive practices would have been identified[25]. In the case of Lissue where there was a multidisciplinary team of professionals who were tasked to build up trust with the children to enable them to share fears and concerns, this is particularly true. It must be more likely that disclosures or observations of abuse would in the first instance have been made to or noted by these people with whom children were familiar and who themselves were familiar with accepted standards of practice.

[25] Day 200 Page 28.

## 3. Ministerial comment.

3.1. HIA220 made a statement to the Inquiry containing an erroneous suggestion that the then DHSSPS minister, Mr. Edwin Poots, *"said words to the effect that individual stories of abuse were "a figment of those people's imagination".[26]"*

3.2. When contacted by the DHSSPS, the former Minister emphatically denied any such comment. When speaking to the Assembly on 7th November 2011 he stated

*"Most importantly, today, we recognise the importance of listening to children and vulnerable adults and of taking seriously what they tell us. That fundamental right for children and vulnerable adults to be heard is the cornerstone of making services as safe as possible.*

*It is important that we understand and learn from the past and that we acknowledge that there is pain and suffering. It is important that those who inflicted abuse are identified and held to account, and it is also important that we all work together to ensure that the safeguards to protect children and vulnerable adults today are the best that we can make them"[27].*

3.3. When approached in 2011 by a former Lissue resident regarding abuse, Mr. Poots contacted the PSNI and the HSCB about the matter[28]. Mr. Poots responded to the former resident expressing his concern and informed him of the action that he had taken.

3.4. HIA220 accepted in oral evidence to the Inquiry that the Minister had not said what he had alleged[29].

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26 LIS-029.
27 LIS-785.
28 LIS-40016 and LIS-40017
29 Day 197 Page 42.

## 4. The Strategic Management Group.

4.1. A complaint of historical sexual abuse by a former patient of Muckamore Abbey in 2005 led to an extensive investigation by the EHSSB. Following this exercise the DHSSPS asked the Health and Social Services Trusts to conduct a wider retrospective sampling exercise across adults' and children's files from all mental health and learning disability hospitals in Northern Ireland to consider if there was other evidence of historical abuse of patients. The aims were to determine if there was any evidence that similar incidents were common elsewhere and to seek assurance that appropriate procedures were now in place to prevent such abuse, and any incidents identified had been properly and effectively dealt with[30].

4.2. This process resulted in the Stinson Review followed by the Devlin and Jacobs Reviews, each focusing on different aspects of practice within Lissue. The DHSSPS did not challenge the views of the EHSSB in relation to the report on Lissue and Forster Green. Rather, as it had general concerns that the exercises carried out by the Trusts were not consistent and having determined that further assurance was required about the rigour of the exercises, the DHSSPS set up a Strategic Management Group, the "SMG".

4.3. The SMG was established in March 2012. Its key findings are set out at paragraph 22.11 of Dr Harrison's statement[31]. Importantly it provided assurance to the DHSSPS that any issues or concerns in relation to individuals who could be identified through the files had been actioned appropriately, either at the time of the original incident, as a result of the retrospective sampling exercise, or as a result of the SMG review process. It further provided assurance any criminal concerns or issues had been referred to PSNI and any Human

[30] Statement of Dr Harrison LIS-804.
[31] LIS-805.

Resources and regulatory issues had been taken forward by the appropriate Trust or employer.

4.4. Dr Harrison noted in her evidence to the Inquiry that the current childcare landscape, both in terms of children's homes and hospital facilities is very different to that experienced before the *"very comprehensive social and clinical care governance framework"* was introduced in the 1990s[32].

[32] Day 200 Page 22.

## 5. Conclusion.

5.1. The Inquiry has now heard the evidence in relation to this module. The DoH has not sought to directly challenge any complainant in relation to abuse. The DoH regrets any abuse that did occur and condemns both the perpetrators and any others who by act or omission allowed abuse to take place.

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

Dated this 13th day of May 2016.

Andrew McGuinness
Bar Library