HIA REF: [ ]

NAME: [Fionnuala McAndrew]

DATE: [22 April 2016]

THE INQUIRY INTO HISTORICAL INSTITUTIONAL ABUSE 1922 TO 1995

Witness Statement of Fionnuala McAndrew

I, Fionnuala McAndrew, will say as follows: -

1. I recently submitted a joint statement to the Inquiry in conjunction with my two HSCB / PHA colleagues, Mrs Mary Hinds Director of Nursing and Dr Carolyn Harper Director of Public Health Medicine in relation to Lissue Hospitals. I took up my current post, along with my colleagues, in April 2009 when there was the structural change from four Area Health & Social Care Boards to one Regional Health & Social Care Board.

2. I wish through this statement to provide an explanation of how I became involved in the Lissue review process and the steps I subsequently took. By April 2009, the Stinson Social Work review report had already been commissioned and received by the Board, the Devlin Nursing review report had been commissioned by the former Director of Nursing and an agreement in principle had been made, that a Medical review was required. This had not yet been formally commissioned and as I wanted to be sure that this was carried through, I undertook that task as part of my new role. We identified Dr Jacobs in his role as a Consultant Child and Adolescent Psychiatrist working for the South London and Maudsley NHS Foundation Trust. This eventually resulted in the Jacobs review report.

3. In relation to my subsequent involvement in the outworkings of the work done as outlined above, this has been highlighted to the Inquiry in a document known as Folio 21 see LIS **LIS-10763 to LIS-10784** . This incorporates the

subsequent explanation which I provided to the Regional Board in 2011, based on the Stinson, Devlin and Jacobs reviews along with an explanation of the parallel work being done in Belfast Trust as a Retrospective Audit see **LIS-10738 to LIS-10762**. This same set of information was subsequently also sent to Mrs Maura Briscoe in the DHSSPS as I was required to update the Department on these matters.

4. In this information that I was providing to the Board / Department, I was referring to references from the Stinson, Devlin and Jacobs Review reports. I would wish to confirm the terms and parameters of this series of reviews. These are also referred to in the Minutes of a series of meetings from September 2008 to March 2009 involving Board and Trust staff. In one of these meetings on 15 January 2009 [see **LIS-12037 to LIS-12039]** which was attended by the then Director and Deputy Director of Social Services, the Acting Director, Public Health Medicine and the Director of Nursing, The Minutes record that the Assistant Director Marion Reynolds was the lead on the Historic Review and that when the information has been gathered, that Nursing and Medical Colleagues should have the chance to consider this. It goes on to state that ' ' *Both Mrs Waddell* [Director Nursing] *and Dr Lyttle* [Acting Director of Public Health Medicine] *are to seek nursing and medical input to review the documentation with a view to determining whether there has been any breaches of professional codes of conduct that were extant at that time.'*

5. In relation to Historic Cases Review, Miss Reynolds commissioned a retired member of Social Work staff, Mr Robert Stinson to assist with this. This process is set out in the document referred to as Folio 6 and can be seen at **LIS-11100** and it's purpose is described as follows;

'To assist the EHSS Board in the examination of 30 Children's CAMHS [Child and Adolescent Mental Health] *and where available F&CC* [Family and Child Care] *files and named staff case files in relation to initial allegations of historic abuse in Lissue and Forster Green Hospitals as part of a scoping exercise designed to ascertain what, if any further action should be taken.'*

6. Thus this review / scoping exercise was very focused and limited in nature. This document goes to say under the heading of 'Methodology',

'A total of 30 CAMHS and where available their F&CC files will be examined to determine whether or not a fuller investigation is required. The following is the approach developed to select the files.

1) *Examine the 7 children's files associated with the* LS 69 *allegation.*[1]
2) *Examine the 3 children's files associated with the* LS 66 *allegation;*
3) *Take a random sample of files drawn from the admission reports to bring the numbers up to 30.*
   The first 2 aspects will include an examination of F&CC files which exist in respect of the children. In relation to the sample children's files an examination of F&CC files will only occur where suggestions exist of potentially abusive type behaviours.'

7. Thus I believe that the wording of the above and particularly of the last sentence reinforces that this was a very specific exercise. It was never envisaged to be a full review of Lissue, it's staff and methods. Rather it was a more limited and immediate exercise designed to try to ensure that there were no safeguarding issues for children being cared for in Lissue. By this I understood this to refer to whether there was the possibility that any member of staff thought to be a possible risk was still being employed in a caring role.

8. With regard to what has come to be known and referred as the "Stinson Report", I would like to make a comment on both the process and the nomenclature involved. In relation to the process Mr Stinson did not review full files. Rather, he read selected extracts from files provided after an initial sift by a former librarian who I understand had been employed on the basis of her skills to quickly read material and she was asked to identify any records of concern. In relation to the title of this report as EHSSB ' Independent Report Lissue and Forster Green Hospitals Historic Case Review', I believe

[1] *The HSCB believes that this was a typing error at that time and that the initials should have been* LS 69

that it was clearly understood by all at that time, that this was an independent review of extracts of files that the EHSSB commissioned and from which they would subsequently provide future recommendations. Thus, I feel that it may have been clearer if this report had been entitled, 'An EHSSB Report in respect of Lissue and Forster Green Hospitals incorporating an independent review of historic cases.'

9. As set out in paragraph 108 of the overview statement, there was also at this time a Belfast Trust Retrospective Child Protection and Safeguarding Audit on-going see **LIS-10738 to LIS-10762** . I referred both these processes to the Board in October 2010 and subsequently to the DHSSPS in my letter to Maura Briscoe.

10. As indicated above, Folio 21 set out for the Board, the issues which had arisen in respect of Lissue and Forster Green Hospitals - the processes that had been undertaken with regard to review along with the conclusions, by what at this stage was the legacy EHSSB. Thus, I drew from the Stinson, Devlin and Jacobs commentary. This was not based on any direct knowledge I had or any further review undertaken by me as I believed that I had no reason to do so. In the correspondence to the Board and also later to the DHSSPS, the limitations of these reviews were not highlighted and it may have been clearer had I done so.

11. The purpose of my letter to Ms Briscoe was to fulfil my reporting obligations to the DHSSPS in my role as Director of Social Work within the HSCB and in the context of the on-going monitoring and audit requested by the DHSSPS.

12. My comments were based on the limited sample examined which was concerned about any immediate on-going safeguarding issues as it's main focus. I therefore set out a summary of their findings. This was based on a very particular sample which, while it incorporated a small random sample, was also drawn from the cases where concerns /complaints were present. Therefore by it's very nature, this was never designed to be, nor ever could be seen from a methodological perspective, as an overall objective review to

assess work done and interventions undertaken in Lissue. Hence no Lissue staff were involved which clearly would have been the case if this had been a full review.

13. I used wording from the Stinson review to highlight the concerns about high levels of peer abuse, about a regime which was at times harsh and punitive and also about instances of staff care that gave rise for concern. I then referred to the Nursing Review which referred to examples of practice from the case notes which indicated a harsh and punitive regime which promoted authoritarian control of Nurses over children. This Devlin report also referred to little evidence of multi-disciplinary working. I would again wish to highlight that the Devlin review was done as a limited desk top exercise examining four files.

14. Finally I also incorporated conclusions from the Jacobs report which highlighted more information about peer abuse and which were subsequently forwarded to the PSNI who responded by saying that since no formal complaints were provided by the children involved that they would not be pursuing this. While the Jacobs report indicated that the services provided by the medical staff were good he stated that there were a range of factors that mitigated against providing appropriate and adequate care.

15. Thus I based my commentary on what was provided by these series of Reviews and believe that this was a fair summary of the conclusions reached in those reports at that time. I brought this to the attention firstly of the Board and subsequently to the DHSSPS. However I also acknowledged that the children admitted to Lissue and Forster Green had a range of challenging needs. I also acknowledged the changes that occurred over time noting that *'professional practice required today has changed significantly with more emphasis on support to practitioners through policies, procedures, guidance and appropriate training'*

16. Clearly and subsequent to all of this, the HSCB has undertaken a thorough analysis of other evidence and perspectives to the Inquiry provided to the HIA

Inquiry. Given that this has included much greater detail and insight, this inevitably provides an alternative perspective and one which can place all this in fuller context.

17. In relation to the 'harsh and punitive regime' commentary, this was a view offered some years later, on work undertaken within a different context and time. There have been comments about how techniques employed under the Behaviour Modification programme which, while accepted by some as effective and legitimate, would not be supported by all. Evidence of this was highlighted at paragraphs 128 and 129 of the Overview Statement, wherein reference is made to the Horizon documentary produced by the BBC. The documentary highlights that even parents who considered the methods to be brutal did also acknowledge that this had the positive effect of changing the negative behaviour.

18. While this is just one case, I am aware that there were similar thoughts and views expressed by others. It has been drawn to the Inquiry's attention that it is entirely possible that these techniques could have been viewed as harsh and some may have thought them punitive also when that was actually not the intent. Rather, the intent was to effect change to very entrenched and difficult behaviour.

19. Upon reflection now in relation to previous comments made about a harsh and punitive regime, a lack of multidisciplinary working, there being no protocols or procedures, a lack of appropriate care planning or planned responses to children engaged in sexualised behaviours and bullying and the environment within the unit presenting challenges for staff observing and managing the children, I would now wish to put those in the context of the limitations I have outlined above.

20. I am mindful that given the allegations made, there was a heightened alertness at that time to any staff behaviour that may have been seen as unacceptable. This could have resulted in criticism of staff and other

arrangements in Lissue which may not have been entirely warranted and may not be sustainable now in light of the fuller context provided to the Inquiry by the staff who were employed at that time in Lissue.

21. I would also acknowledge that there could be criticism of the review processes undertaken, but I am mindful that these were never intended to be a comprehensive review and assessment as already outlined above and thus cannot be viewed on that basis.

22. I am also mindful that hindsight brings a different perspective and thus believe that it is appropriate to consider the context of the time and the expressed purpose and limitations of those reviews.

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

Signed 

Dated 22 April 2016

For Noting

Health and Social Care Board

Report in respect of Historic Review of Children admitted to Lissue and Forster Green Hospitals

Introduction

This report sets out the findings of a review of the care and treatment of children admitted to Lissue and Forster Green Hospitals in the late 1980's.

The review was instigated by the legacy Eastern Health and Social Services Board following receipt of a Serious Adverse Incident report on 2 May 2008.

The report includes a summary of a parallel audit undertaken by the Belfast Health and Social Care Trust to ensure that current safeguarding arrangements within the regional inpatient child and adolescent facility are robust.

Background

Lissue and Forster Green Hospitals were directly managed services within the Eastern Health and Social Services Board with the establishment of Trusts in 1994. The hospitals provided inpatient care for children with a range of mental health difficulties including anorexia, depressive illness, suicidal and self harming behaviours and a range of conduct and behavioural problems.

The service was at that time Consultant led and two Consultant Psychiatrists provided support from the Child Psychiatry Unit based on the Royal Victoria Hospital site. Lissue Hospital ceased operation as a Child Psychiatry Unit in 1991.

Incident Report

An allegation was made by a previous resident at Lissue regarding her care and was notified to the EHSSB as a Serious Adverse Incident in May 2008. The Belfast Trust advised that it was undertaking an internal review in respect of allegations made about staff previously employed at Lissue and Forster Green Hospitals between 1986 and 1991. The allegations related to physical, mental and sexual abuse.

The DHSSPS was aware of 2 previous allegations made in 1993 and 1994 and in receipt of the SAI brought this to the attention of the Belfast Trust and EHSSB to assist with their investigations.

The EHSSB historic review of records sought to determine the nature and extent of any abusive behaviours at the units and was augmented by work lead by both Belfast and South Eastern Trust.

Methodology of the Review

The EHSSB commissioned an independent review of 34 records of children admitted to the units to identify any concerns. This was followed by two further independent reviews to look at clinical practice at the time. The EHSSB and Belfast Trust worked closely with PSNI who investigated the complaints and considered the findings of the reports as they identified any potential criminal activity.

Independent Review Reports

An initial report was provided by an Independent Social Work consultant following a review of 34 case files. The findings of this review indicated that there were matters of professional concern at both units. The review found high levels of peer abuse and a regime which was at times harsh and punitive. There were also instances of staff care that gave rise for concern.

Three allegations of abuse were made through PSNI of which two were investigated. One case was referred to the Public Prosecution Services and the Board is not yet aware of their decision.

A second review was undertaken by an Independent Nurse Consultant and the report was received in May 2009. This provided an overview of the standard of nursing care at Lissue and Forster Green based on the first independent review report and an examination of a further 4 case files.

The review found that there was a lack of appropriate care planning and planned responses to children and adolescents engaged in sexualised behaviours or bullying.

The lack of procedures and protocols aimed at promoting the safe management of relationships resulted in children and staff being placed in vulnerable situations.

Examples of practice from the case notes indicate a harsh and punitive regime which promoted authoritarian control of nurses over children.

There was little evidence of multi disciplinary working and the use of restraint was clearly referenced in case files.

The review drew attention to the conduct of a named member of staff which is addressed later in this report.

The third review was undertaken by an Independent Consultant in Child and Adolescent Psychiatry who works within the NHS in England. This report was received in February 2010 and provided a commentary on the initial review report and notes and records were made available including notes at ward rounds.

This report highlighted new information from the case notes in relation to abuse of children by other children. This new information was forwarded to PSNI who responded in September 2010 advising that their contact with the children identified has not resulted in a complaint and they did not intend to proceed in this matter.

This report concluded that the service provided by the medical staff was clinically good, however, there were a range of factors that mitigated against providing appropriate and adequate care to the children at that time.

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9th March 2011

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Dear Maura,

RE: RETROSPECTIVE SAMPLING

Please find attached a report into the review of a sample of cases of children who were admitted to Lissue and Foster Green Hospitals. You are aware from previous communications that the HSCB has liaised with the Belfast Trust and PSNI on these matters and PSNI has confirmed that no further action will be taken in relation to the allegations they have investigated.

The review reports have been shared with the Belfast Trust. there were 16 recommendations and 12 conclusions contained within the three professional review reports commissioned by the HSCB and there was some overlap in their findings. I have written to the Belfast Trust to require further reassurance in respect of three of these as follows:

Process for Monitoring Abscondings

The Trust should confirm that it has robust policies for monitoring and assessing abscondings from its current in patient facility and for independent de-briefing of young people on their return.

Use of Regional Restraint Guidelines

The Trust should confirm that its restraint policies and procedures are compliant with the DHSSPS Guidance on the use of Restraint and Seclusion (2005).

Care Plans

The Trust to confirm that young people's care plans are person centred.

All other recommendations have been either:

- Actioned by HSCB as a result of the review reports
- Actioned by Belfast Trust and contained within the action plan provided as a result of their retrospective sampling exercise. DHSSPS is in receipt of this report and action plan. the HSCB requested an update of progress on this action plan on 19 November 2010 and the Trust reported that all but one of the actions had been completed and the remainder was being progressed.
- Incorporated into policy and guidance issued since these events took place
- Reviewed within both the QNIC audits and the recent RQIA review of CAMHS, the latter incorporating child protection arrangements specifically.

In making their recommendations, all three reports highlight the need to consider the findings in the context of practice at the time and it is clear that some practices that were common place would not be tolerated today. It is also important to recognise that current inpatient and residential accommodation for children and young people is open to more external scrutiny than in the past. However, it is also clear that children accommodated within these hospitals were subjected to a harsh and punitive regime, and that staff were challenged by the complex needs of the children, a poor physical layout and at times inadequate staffing levels. Specific concerns were identified in relation to some individual staff members and I am satisfied that these have been appropriately addressed.

I would also like to confirm that the Health and Social Care Board was made aware of the findings of this exercise at the confidential Board meeting held on 25 November 2010.

Finally, I would like to apologise for the delay in finalising this report to you. As you are aware the work was commenced by the legacy EHSSB. The final review report relating to medical practice was commissioned by the new HSCB. On receipt this identified new concerns which were shared with PSNI, and there was an administrative delay in receiving their confirmation of no further action.

However, I hope that you will find that the EHSSB instituted a robust sampling exercise but if you have any further queries then please contact me.

Yours sincerely

Fionnuala McAndrew
Director of Social Care and Children

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