Northern Ireland
Assembly

COMMITTEE FOR
HEALTH, SOCIAL SERVICES AND
PUBLIC SAFETY

OFFICIAL REPORT
(Hansard)

Allegations of Abuse at Lissue and Forster Green Hospitals

26 October 2011

NORTHERN IRELAND ASSEMBLY

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Members present for all or part of the proceedings:
Ms Michelle Gildernew (Chairperson)
Mr Jim Wells (Deputy Chairperson)
Ms Paula Bradley
Mr Gordon Dunne
Mr Mark H Durkan
Mr Sam Gardiner
Ms Pam Lewis
Mr John McCallister
Mr Kieran McCarthy

Witnesses:

Mr Edwin Poots	)	The Minister of Health, Social Services and Public Safety
Ms Christine Jendoubi	)	
Dr Michael McBride	)	The Department of Health, Social Services and Public Safety
Dr Andrew McCormick	)	

The Chairperson:

Minister, we appreciate that you were asked only this morning to give us a heads-up on the issue reported in the media today about allegations of abuse at the former children's psychiatric hospitals at Forster Green Hospital and Lissue House. We invite you to make a short presentation on the issue.

Mr Poots (The Minister of Health, Social Services and Public Safety):

I would like to make a short statement about the story carried in 'The Irish News' this morning concerning allegations of abuse carried out in the 1980s and early 1990s at Lissue Hospital and Forster Green Hospital.

Let me say at the outset that I am appalled at the cases that were reported in 'The Irish News' today and how sorry I am for the children and young people who may have been subjected to abuse or mistreatment in those facilities. I reassure the Committee that times have changed, and that child protection and adult safeguarding have come a very long way in the past 20 years. Systems and safeguards that are in place in both health and social care and voluntary sector facilities today are much more robust than those in place in the 1980s and even in the 1990s. Staff vetting, the introduction of best-practice guidance, regular inspections by the Regulation and Quality Improvement Authority (RQIA) are all in place and, together, provide the level of safeguards necessary for the protection of vulnerable adults and children.

However, best care and practice today in no way absolves those who had a duty of care in the past. It has to be remembered that the matters reported today have been the subject of a number of rigorous investigations by the Health and Social Care Board, involving the police as required, at the time and since and are not news. Indeed, it was the former Eastern Health and Social Services Board that commissioned the Stinson and Devlin reports. The findings and recommendations of those reports were fully implemented by the relevant organisations at the time, and the issues raised in those reports are included in an ongoing review of past child protection practices undertaken by the Health and Social Care Board, the PSNI and my Department.

The review was instigated on foot of the investigation by the police into a complaint by a former patient at a learning disability hospital in 2006. As a result, it was considered prudent to conduct a sampling exercise in other learning disability and mental health facilities across the relevant period in order to provide reassurance that proper procedures were being followed and that abuse was not widespread. In 2007, my Department asked trusts to carry out a sampling exercise of case files to identify whether there had in the past been incidents of abuse or

mistreatment of vulnerable adults and children while in statutory mental health and learning disability facilities. The reports referred to in 'The Irish News' were supplied to the Department in March 2010 as part of that exercise. I mentioned that those reports were commissioned by the relevant health and social care board and trusts at that time, and their recommendations were fully accepted. I understand that the board developed an action plan to take forward the findings and recommendations of the reports. Work on my Department's sampling exercise, however, remains ongoing.

Initial findings have been shared with the PSNI. As a result of those initial findings, further and more detailed work is under way. Because that work may result in criminal proceedings, it is very difficult for me to add much more about the cases. However, I am happy to take questions and answer them if I can.

The Chairperson:

Thank you, Minister. It is interesting that you say that the report may lead to criminal proceedings, because I understood that this was a case that was nearly closed and that criminal proceedings would not be brought or that the evidence needed to do so was not there. I welcome that this is being looked at in a way that may lead to criminal proceedings. Do you know how many children went through Lissue and Forster Green?

Mr Poots:

I will bring in Andrew and Christine in a moment on that, but there have been discussions about potential criminal proceedings with the PSNI, and it will be for the PSNI to decide whether to request that the Public Prosecution Service instigate criminal proceedings. That decision is not in our hands. We have passed the information to the relevant authorities, and it is for them to decide.

The Chairperson:

But, on that point, the report was given to the PSNI a number of years ago and it was not actioned. It is good but interesting that they are reopening the case and looking at the potential for criminal proceedings.

Mr Poots:

My Department has gone through and considered a series of files, and has passed that information to the PSNI. Perhaps Andrew or Christine wish to give more detailed information on that, within the constraints in which we find ourselves.

Dr Andrew McCormick (Department of Health, Social Services and Public Safety):

As you said, this has been ongoing for several years. The PSNI has been fully involved from the outset. The Minister mentioned that the first case was in 2006. I met the police at that time and we have kept in close touch since. There was a stage at which it was judged that the case could be closed. As a result of our review of the retrospective sampling exercise, we re-engaged with the police. I met police in May of this year and drew those further conclusions to their attention. More recently, there has been further dialogue, which has led them to reconsider the matter. However, exactly where that goes depends on their judgement as to the details of the case. Obviously, we are not aware of and cannot comment on that detail.

It has been a matter of making sure that there is a proper and proportionate response. The first thing that was established was that there was no issue in respect of current practice. As soon as the matter came to light in 2006, the first question that we asked and were assured about was that present practice was OK. The question was then one of approach. To put it in context, we were looking at decades-old records, changed practice and at children and young people with a range of conditions. That is delicate and difficult territory. The process took a long time, but our assurance is that we will play our part in reviewing and investigating. Any follow-up of the nature of pursuing potential criminal cases is a matter for police.

I do not have details on the numbers, but this covered quite an extensive period, so they will be substantial. That is why our initial approach was to apply a sampling exercise. We did a 100% check at the learning disability hospital where the case first came to light. We then questioned whether there were similar issues elsewhere. So the approach was to do a sampling exercise and judge, on the basis of that sampling, whether further investigation was required. That is the sequence of the process that we went through.

The Chairperson:

Why was the report kept secret?

Dr McCormick:

This is ongoing work. It is a matter of managing the process sensibly and acting on and bringing attention to issues, which includes briefing Ministers, when there are conclusions. The process is ongoing. We have not reached a final position, either in our sector or that of the PSNI. It is ongoing business.

Ms Christine Jendoubi (Department of Health, Social Services and Public Safety):

The reports are on Lissue and Forster Green. Lissue closed in the early 1990s and its services were transferred to Forster Green, so it all relates to the same service. Those reports were carried out by the trust, on foot of a critical RQIA report on inpatient child and adolescent services. By the time we got the reports, they had been submitted to the two trusts and the board concerned. They had been fully investigated and an action plan was being developed to take forward the recommendations of the reports. The police were satisfied that no further investigations or prosecutions were going to come out of those two reports. However, the retrospective sampling exercise that we are currently undertaking covers all the learning disability and mental health hospitals over the same period, so we cannot exclude Lissue and Forster Green from that, even though a substantial piece of work has been done and closed off on those two hospitals.

The Chairperson:

Are any of the six nurses who were subject to allegations of abuse in today's newspaper still employed or were any referred to the Nursing and Midwifery Council?

Ms Jendoubi:

I am not aware whether they are still employed. I know that one was dismissed and one has retired. I am not sure about the other four, but they have been fully investigated as a result of the reports that have come out of Lissue and Forster Green.

The Chairperson:

The allegation was made in the newspaper that many of the recommendations of the 2008 report

have not been implemented. Have all the recommendations been actioned?

Ms Jendoubi:

Our advice is that all the recommendations were accepted and an action plan developed to address them all. I cannot give the Committee a categorical assurance about whether they are all complete at this stage because I do not know.

The Chairperson:

But that is over three years ago and we are talking about the most vulnerable children and adults in our society. An action plan in place is not the same as the recommendations being implemented.

Ms Jendoubi:

Bearing in mind that Lissue closed in the early 1990s, and Forster Green closed as far as taking children and adolescents are concerned in 2008 and was replaced by Beechcroft, any recommendations that would remain outstanding would be general ones that would apply across the system.

Dr McCormick:

Of course, the context is that we are now applying and ensuring the application of modern-day guidance and practice in relation to child protection and the protection of vulnerable adults. All that guidance and all that action, which has been very substantial across the health and social care sector and other sectors, is in place. It is not as if there was an identification of substantial vulnerabilities in relation to the present day. These are detailed recommendations emerging from investigation of the past.

It is, as you say, important that they are addressed and dealt with, but the assurance is that we are applying consistently, and checking on the application of, modern-day practice in relation to child protection. We have the regular reports by RQIA, which has been thorough and effective in ensuring that there is consistent scrutiny and review of that process across all trusts and all the relevant facilities. So I think that we can provide significant assurance and confidence. We will confirm later to the Committee, as soon as we can, matters in relation to any outstanding

recommendations. However, the general position has to be of strong confidence.

The Chairperson:

Bob Stinson's report was fairly damning with regard to the ability he had to scrutinise records. He said that no files or only partial files existed. I cannot remember his exact words but he basically said that files generally provided little detail on how risks were identified or how they were reported to social services and/or the police.

It worries me that the ethos then was not to keep records. However, to have records and for them not to be available to Bob Stinson is another thing. Was there a culture of not making those files available? That was not the first time that that has happened and it will hardly be the last. However, Bob Stinson obviously did not have all the information he needed in terms of dealing with the sample report.

Ms Jendoubi:

It is not that files were withheld from Mr Stinson; it is that files were incomplete. The records were not there because they were 20 years old, had been moved around the place, and were simply not available. When the trusts undertook the retrospective sampling exercise, they found the same gaps in records.

The Chairperson:

You might find some of them in Belvoir. I should not even joke about it, but the fact is that these are very serious files. Those children were vulnerable. They had mental health issues, Tourette's syndrome, eating disorders, and they were abused in the most horrific way. The article in today's newspaper may just be the tip of the iceberg, and I felt sick when I read it this morning. It is hard to imagine that it happened in my generation. We are talking about young people who are the same age as me, and they are probably still in the mental health system. What support has been put in place for those people?

Today's report could trigger a reaction from people in their 40s and 50s who had been in Lissue House or Forster Green, who have been suppressing memories. They may be dealing with their memories of that time with drugs or alcohol. This could open up a need, and I would like to

hear how you are trying to identify that. A couple of years ago, we met departmental officials in Donagh, and we asked about the need for counselling. We were told that the waiting list had been dealt with and was under control, but when we went back to the people providing the counselling, we were told that that was not the case. Therefore, is there a plan in place for dealing with people who come through and say that they were one of the people who had been abused and that they need help?

Ms Jendoubi:

If they do that, they are most likely to approach their GP and be referred to counselling, which is available through community counselling services and psychiatric nursing. We will just have to keep an eye on the volume and see that those services are able to cope, and, if necessary, reinforce them.

The Chairperson:

If this is a trigger for people who have been suppressing memories, they will need help straight away, but if they go on the merry-go-round, it could lead to further difficulties. It was bad enough for me reading that article this morning, but if you had been there and witnessed or been subjected to that abuse, you would obviously be in an awful state today after reading that information. I want to give other members a chance to speak.

Mr Wells:

This is aimed at Michael and Andrew: you may remember that, last spring, there was a whole series of revelations involving mostly the Belfast Trust, but also the Western Trust. At one of those sessions, I asked a very simple question: is there anything else out there that could cause severe embarrassment to your Department or a trust if it emerged? I remember very clearly, in the presence of Colm Donaghy, being told no: that it was all out there, and there were no more revelations to come. Within a week, we had the Royal Victoria Hospital school of dentistry revelation and the recall, followed in March by the scandalous situation at Belvoir Park Hospital in which X-rays were put up for sale, the ghoulish activity in the old hospital at Belvoir — and now this. I have to ask again: when I was told that there was nothing else out there, was that the case? Secondly, is there anything else out there that we should know about that the Department or the Belfast Trust is withholding from us?

Dr McCormick:

The fact of the matter is that the underlying issue of the concerns about abuse in learning disability and mental health facilities had been publicised. That was in the public domain from 2006 onwards. Therefore, it was not news in that sense. However, what was going on was proportionate and considered, and there was a follow-up investigation to assess what further action might be necessary. That is what we were doing, conscientiously and thoughtfully. At the time of your question to me in January or February, the new reports were not with us. They came to us in March, and we then considered what was the appropriate way to proceed at that time.

There was no holding back in any sense. The answer that I will give you now is the same as the one I gave you in the previous mandate: the way we work means that we do not chase every particular issue, but to seek assurance that we have clear guidance and that standards are being applied across all aspects of health and social care services. The Department's role is to ensure that there are good standards, clear guidance and effective staff in place to deliver, according to those principles and practices. There is a responsibility on everyone in the system to draw things to our attention in a proportionate and effective way. We have clear procedures for the escalation of issues when something comes to light. We have a very effective process for the handling of early alerts and serious adverse incidents. That is all being followed through. Major lessons have arisen as a result of the dental inquiry that will be brought forward in due course to ensure that processes and systems are right.

It is never possible for us to be aware or for us to inform the Minister or the Committee of each and every detail of everything that is currently under investigation. There is always bound to be a range of issues, given the complexity and scale of health and social care. We are asking people across the system to manage risks and difficult situations, often against significant resource and workload challenges. If we were to come to the Committee, either publicly or confidentially, to discuss every single issue of potential concern we would be here all day, every day. That is what we are asking the system to manage.

The system manages risk very effectively. The vast majority of issues are dealt with soundly and effectively. There is bound to be a number of issues that go wrong. Society in general, the

Department and those in the political and managerial realm and the media need to recognise that difficult issues are being managed day and daily. We need to support the people in the trusts and across the system who are doing their very best to manage those issues. They are conscientiously doing their best to handle those things. For the agenda to be set by the media is not a helpful way forward. We are not hiding anything; we are seeking to manage risk effectively.

The Chairperson:

It is not fair to say that we are reacting to the media. The fact is that a report that was written in 2008 or 2009 was put in a locked filing cabinet in the Department. That is what Jim is asking about. Are there any more of those reports that the Committee needs to know about? The media did not make this up. The story is based on a report that has been with the Department for some time.

Dr McCormick:

We were seeking to manage the process effectively and to act only when there was clear information to act on. We had completed one stage of that process. We had serious internal meetings at which I met all the chief professionals. We met the police to assess whether we had enough information to reach a conclusion. The view was that we did not, and that we needed to seek more information, meaning that a further process was required. All that is ongoing and responsible work to try to manage things and secure the careful scrutiny and oversight of a highly complex system.

It is not about hiding things. The report was not locked away; it was still under active consideration so that we could make sure that the action that we took would be proportionate. A lot of this is to do with time long past. The discussions that I had with the police on this issue go back to 2006. A big concern in that context was about the amount of resources that should be devoted to investigating the past when we have a responsibility as a health and social care system, and from the police point of view, to ensure effective protection for children and vulnerable adults in the present day. If we devoted all our resources to investigating the past, it would take away from the present.

We always seek to manage our responsibilities sensitively. I will not claim that we get it right

all the time. By definition, things have not worked as they should have, as has happened today, and I have to apologise for that. It was not through any deliberate withholding. It is always about trying to manage the process as effectively as we can.

Mr Wells:

I know that there are thousands of abuse incidents out there. I accept that you cannot report them all to the Committee or the Minister; that is entirely right. However, surely this incident, given the nature of this report and what we now know about it, must have sent alarm bells ringing. You should have realised that this is an issue that the Committee and the Minister should have been informed about. The question that I must ask is: when would we have known about this, had Seanin Graham from 'The Irish News' not obtained the final and complete version of a leaked report, and splashed it across the newspaper?

With hindsight, this falls into the same category as those incidents that involved the RVH school of dentistry, the radiotherapy unit at Altnagelvin Hospital and the check on the children's hospital. It is clear that these incidents are so obvious when they became public, and I would have thought that we should have been informed about this incident. Another option, which I have offered previously, would be for departmental officials to take the Chair, the Deputy Chair and the Clerk into a darkened room and tell them that they do not want a particular issue to be publicised, but that they need to be made aware of it. By doing that, any hint of a cover-up disappears without it getting out into the public and causing a lot of concern. However, that option has never been used.

Mr Poots:

I can understand where you are coming from, Jim, and I agree to a considerable extent with what you are saying. However, there is not a smidgen of cover-up in this case. The report came to the Department's attention in 2006 as the result of one person lodging a complaint. A cover-up would have involved trying to get that person to go away, but the opposite was done in this case. The Department — this was before my time — instigated a review of all of the files to look at the potential for other cases, and when the report was worked up in March of this year it went to the PSNI. Therefore, this is not a cover-up. The Department was actively seeking to ensure that those who may have committed some crime in the past — I would put it in those terms — were

identified. The report is with the police, and it is up to them to come to a decision.

We could have another discussion about how the Department should have handled this. I learned of it only today and, to be honest, that was not particularly satisfying. Nonetheless, there is no smidgen of evidence that we are discussing a cover-up here.

Madam Chair, my time is largely gone. I suggest that you may want to reconvene on this issue in a few days, and meet privately with Andrew, Christine and others on the team. You would probably have a more open meeting if that was the case. Would that be acceptable to you?

The Chairperson:
We will certainly think about that and discuss it after you leave Minister; we would want to look at where such a meeting would leave this Committee.

Will this report be shared with those who are conducting the OFMDFM inquiry into institutional child abuse?

Mr Poots:
Yes.

The Chairperson:
Does anyone have a burning question that they want to ask? I know that some members had indicated earlier that they wished to speak. Gordon, just a one sentence question please.

Mr Dunne:
I will do my best, Madam Chair. We are all shocked at what has come out today, and we have expressed our revulsion at it. We thought that we had moved on from all of this. We are all very much aware of the Bamford review and of all its outworkings that have yet to be implemented. This fully vindicates the Bamford review and what it proposed.

What assurances can you give to the public that there are no skeletons left in the cupboard, and that we have strongly moved on? I am new to the Committee, but I believe that a relatively

new system has been put in place by the RQIA. What strong and robust processes are in place, and what auditing procedures are in place to review those processes to bring forward improvements and continuous review? How the processes are managed is the most important thing, and that obviously did not happen in the past. What assurances can you give us that those processes are in place and that the system is working and robust?

Dr McCormick:

There are very extensive guidance on and standards for child protection and the protection of vulnerable adults. There are also clear governance responsibilities in all the organisations in the health and social care sector for the application of those principles. Regular reviews are also conducted by each organisation, and there is scope for a programme of reviews by the RQIA. That has happened in the past, and there has been a series of reports on different aspects of those functions in the past number of years.

Part of my way of working is that I keep an eye on issues by working with RQIA and with the wider team to ensure that, where there is any hint of difficulty, we investigate and review as quickly as possible. It is never possible to give an assurance that everything is perfect — and it would be wrong to do so — but we have comprehensive, proportionate approaches to managing all the risks to ensure high professional standards and good governance in all the organisations. Therefore, the Committee can be assured that this is well governed —

Mr Dunne:

That the risks are managed?

Dr McCormick:

The risks are managed. Everyone knows that one of my catchphrases is: zero tolerance of unmanaged risk. We cannot eliminate risk; it depends on human behaviour. However, we need to be grateful for the many human beings who take responsibility; nevertheless, they are human beings, and a proportion of them will do wrong things at times. We have to be supportive, and when things go wrong we must apply a proportionate response to ensure that the right professional regulations are followed and that employers handle matters properly and effectively. I assure the Committee that those measures are effective and that we manage risks well.

The Chairperson:

Thank you very much. We will come back to you. I know that you had only a few hours' notice. I presume from what you said, Minister, that you got as much of a surprise as we did when you read the paper this morning. We will consider your offer and come back to you on it. In the meantime, thank you. We would like to be kept updated, although if there is a criminal investigation, we accept that there might be difficulties. Nevertheless, it would be good to see how this develops.

Mr Poots:

It would certainly be easier in the context of a closed meeting. I assume that members would maintain confidentiality. If we are to have a strong relationship with as much information as possible passing to and fro, that would have to be the case.

The Chairperson:

We will discuss the matter after you leave. Thanks very much.