Northern Ireland
Assembly

COMMITTEE FOR HEALTH, SOCIAL SERVICES AND PUBLIC SAFETY

OFFICIAL REPORT (Hansard)

Lissue House and Forster Green Hospital: Alleged Patient Abuse

18 January 2012

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 Michaela Boyle
Ms Paula Bradley
Mr Mickey Brady
Mr Gordon Dunne
Mr Mark H Durkan
Ms Pam Lewis
Mr John McCallister
Mr Kieran McCarthy

Witnesses:

Mr Edwin Poots	)	The Minister of Health, Social Services and Public Safety
Mr Sean Holland	)	Department of Health, Social Services and Public Safety
Ms Christine Jendoubi	)	

The Chairperson:

I welcome the Minister and his team, Christine Jendoubi and Sean Holland. It is good to see you again.

When we last discussed this matter in Committee, it was within hours of the news breaking,

and there was not a lot of time to digest what is in the report. Hopefully, by now, there will be answers to some of the questions that we asked on 26 October 2011. I understand that you will give a short presentation, Minister. After that, I will open the floor to questions. You are all very welcome.

Mr Poots (The Minister of Health, Social Services and Public Safety):
Thank you, Madam Chairperson. I am grateful for the opportunity to provide further information to members of the Committee on allegations of abuse at Lissue House and Forster Green Hospital and on the ongoing investigation into the allegations.

Members will recall that I briefed the Committee on 26 October, and I subsequently made a statement to the Assembly on 7 November about the allegations of abuse and the investigations that ensued and those that were ongoing. I do not propose to take up Committee members' time by rehearsing what is already on public record. The Committee will have received my briefing paper, which I hope answered the specific questions that members raised. I will take the next few minutes to comment on the context in which the alleged abuse took place and how it is being investigated.

First, however, I would like to put on record that there has been absolutely no attempt to cover up these matters or to hide them from the public or the police. All agencies involved in investigating the allegations of abuse, including the police, did so in partnership and with a determination to get to the bottom of the allegations and follow due process.

As I said in my statement in November, these matters have been under investigation since 2005, following a complaint of abuse at Muckamore Abbey Hospital. That complaint was fully and robustly investigated in a process that involved the police from the outset. It involved professionally monitored interviews with patients and the scrutiny of almost 300 files of patients who had been in Muckamore Abbey. It was the investigation of alleged abuse at Muckamore Abbey, which was largely into the abuse of patients by other patients, that led the Department to undertake a further exercise to see whether there was any evidence of abuse in other mental health and learning disability hospitals. That is why the retrospective sampling exercise was instigated. That was an example of staff taking an extremely proactive approach rather than simply being content to investigate individual complaints.

The investigations have been lengthy and complex because, as you will appreciate, we are dealing with people who were then children and adults with a learning disability or a mental health problem. In many instances, we are talking about individuals who are actively mentally ill: some of them have communication difficulties and some have intellectual impairment. It is often difficult to establish clear facts from such patients, especially when the events occurred 20 or 30 years ago.

As you are aware, the Public Prosecution Service (PPS) announced in April last year that there would be no prosecutions arising from the Muckamore Abbey investigations. Having reviewed the Stinson and Jacobs reports, the police also confirmed, after investigation, that they will be taking no further action on the basis of those reports unless further evidence comes to light. When a child makes an allegation of abuse, the child must be listened to, and the allegation must be fully investigated. However, although it is important to uphold the rights of the child, we are still tied down with the rights of others, and we have to ensure that due process is followed in any disciplinary or criminal proceedings. That having been said, let me assure you that any new information that is brought forward, be it from staff, individuals who were former patients or any other sources, will be thoroughly investigated. We have long-established protocols with the police for that purpose, and those are in operation today.

It is clear from all the reports, including those from the retrospective sampling exercise, that the regime across all the mental health and learning disability hospitals in the 1970s, 1980s and even 1990s was, by the standards of today, often harsh. Lissue House and Forster Green Hospital were certainly no exceptions. In that regard, they were no different from mental health and learning disability hospitals elsewhere in the British Isles and probably further afield at the time. Indeed, it could be said that many settings in which children were cared for, including schools, during those decades could also have been considered to be harsh and punitive by today's standards. It therefore would be wrong to judge them by the standards of today. However, that is not to exonerate them in any sense or to belittle the negative experiences that children endured or the lasting impact that those experiences have had on many of their lives, even to the present day. That is why the wider retrospective sampling exercise carried out by the health and social care trusts has been ongoing. Where there has been any indication of abuse, the material has been shared with the police. I wish to make it clear to members that that preceded recent media coverage and has not been a response to it. At this point, it is worth stating for the record that, on the basis of the information gathered to date, neither social services nor the police has been able

to verify conclusively any instance of abuse to the standards required for either disciplinary or criminal proceedings.

In summary, I want to assure members again that I am satisfied that any allegations of abuse uncovered by any of the exercises were taken seriously, and where there was the possibility of abuse having taken place in other settings, patient files were examined to see whether it had taken place. It is important that we understand how children and young people were treated in the past. That is why I have given my full support to the establishment of a historical institutional child abuse inquiry by the Executive. It is particularly important that, if children and young people were the victims of abuse, those matters be fully investigated. That is what any victim is owed. It is also essential to ensure that we manage potential risks to children and young people today, and that has to be my main focus. That is why, over the past five years, the Regulation and Quality Improvement Authority (RQIA), at the direction of my Department, has on two separate occasions independently reviewed the current systems and processes that safeguard children and vulnerable adults to ensure that every possible effort has been made to prevent abuse from occurring. That provides independent assurance that our systems today are robust and that the safety and dignity of children and vulnerable adults is paramount.

As I said, the Department, the Health and Social Care Board (HSCB), the health and social care (HSC) trusts and other relevant HSC bodies will co-operate fully with the historical abuse inquiry, which is being set up by the Office of the First Minister and deputy First Minister (OFMDFM). Officials will be liaising closely to avoid duplication between their work and ours. I take this opportunity now to encourage any individual who has been abused to raise concerns or complaints to the inquiry, the Department, the HSCB or, indeed, the police, as appropriate.

The Committee is aware that OFMDFM had put together a preliminary list of 23 institutions that might be addressed by the inquiry team. The list was drawn up before the terms of reference for the OFMDFM inquiry were finalised and was simply an attempt to scope the extent of the inquiry. It was never intended to be a definitive list. These were institutions that had been mentioned by victims and survivors of institutional abuse at public meetings that OFMDFM had arranged. As no one at those meetings had mentioned Lissue House or Forster Green Hospital, they were not included in OFMDFM's preliminary list. It would be a misconception if anyone were to believe that the appearance of a named institution on a list would mean that that institution would be included in the scope of the inquiry, or, indeed, that the absence of a named

institution would mean that it would not be included.

It is extremely regrettable that the issue came to my attention and that of the public in the way in which it did. It is equally regrettable that the information was presented in such a way to denigrate the work of HSC staff, who were working hard to uncover and pursue incidents of abuse with the police.

Recently, there has been a lot of talk about hounding the whistle-blower. Whistle-blowing is where an individual discloses, in the public interest, information that has been or might be covered up. There are clear guidelines, procedures and protections for those who are concerned that that might be the case. I do not believe that this story is about whistle-blowing, as I am not aware of any individuals who sought to raise the issue in an HSC organisation or with a regulator and who were ignored. It is actually a story about officials making every effort to uncover the truth about allegations of abuse.

Confidential information relating to staff and patients that was obtained as part of the investigations appears to have been removed from HSC files. It is for that reason that the HSCB has commissioned, through the Cabinet Office, investigators to examine the unauthorised removal of documents. That confidential information was given to and used by the media. Members must be aware that, in some cases, that was information about individuals against whom no allegations have ever been made. Those former members of staff who worked at Lissue House and Forster Green Hospital without blemish today feel sullied by the inaccurate implications drawn from that material to create headlines.

I believe that leaks of confidential and personal information are contrary to the rights of individuals and prejudicial to the conduct of good government in general. I will support the board in taking whatever action it feels necessary against any staff found to be in breach of their duty to their clients, colleagues and employers. I will not support any action against individuals who genuinely bring a matter of public concern to the attention of appropriate bodies.

Thank you for giving me the time thus far. I am happy to take questions.

The Chairperson:

Thank you, Minister. I agree with the first part of the last point that you made about members of

staff being made to feel sullied in order to make headlines. I think that, had there been a robust attempt to find out who was guilty of abuse of children, it would have ensured that the people who were not guilty were not tarred with the same brush. I am concerned about members of staff who were not party to some of the things that went on at Lissue House and Forster Green Hospital yet feel sullied, but I think the way in which to deal with that is to ensure that the people who contributed to what went on be dealt with appropriately.

I also take exception to the idea of making headlines. My understanding, and you can correct me if I am wrong, is that those documents had been signed off on, basically so that they could be put into storage, and that they were regarded almost as having "case closed" stamped on them. If there were issues there that had not been dealt with properly, and those files were being put away for ever, I believe that the person who forwarded the information did so in the public interest and not to make headlines. I reiterate my support for the person who made those files available. Clearly, there were issues arising from the Stinson report that I believe should have been dealt with in a more appropriate fashion. The right thing was done.

If I might ask you, Minister, who sanctioned the Cabinet Office leaks inquiry? I have a lot of questions on the back of the previous evidence session and your statement today, but I would be interested to know whether you were made aware of the inquiry in advance and whether you signed off on that decision, or it was taken by somebody else.

Mr Poots:

No, I was aware of it. From the point of view of good governance, it is not appropriate for people, particularly civil servants who are subject to the Official Secrets Act, to put matters into the public domain that contain personal details about individuals. This is not an inquiry in which the files are closed; this inquiry is live. So, the suggestion that the person felt aggrieved that the files were closed is wrong. If the individual did feel aggrieved, what steps did he or she take to bring it to the attention of senior personnel or, indeed, to my attention? I encourage whistle-blowing. Whistle-blowing occurs when people know that there is wrongdoing and bring it to the attention of senior people in the organisation. If that is ignored, they can take it to ministerial level, and, if that is ignored, there are other means of proceeding. Whistle-blowing is not the leaking of information to a newspaper, particularly information that contains personal data.

The Chairperson:

I do not want to move the discussion in another direction, and the whole area of whistle-blowing deserves a detailed examination. I am hearing from people who work in the health service, who are worried about their jobs, and who have gone through the channels you suggested. They have spoken to their line managers and have been treated badly as a result, and they do not feel that the culture there enables them to whistle-blow.

As regards the robust decision that you said that you were a party to and sanctioned; you were with us on the Wednesday of the week in which the Compton review was launched, yet within hours of leaving the Committee, letters went out to more than 200 members of staff. I understand that there was no engagement with the trade unions that represent these people and no consultation with, for example, the Royal College of Nursing. That, in itself, is a worrying development.

The tenacity used to find out who passed on the document should have been applied to finding either the perpetrators of abuse at Lissue House or the children who were in the state's care and who are now spread around the globe. In my opinion, there is a duty of care to those people. How much of an attempt was made to contact the 2,000-odd children who went through Lissue, 1,400 as inpatients and around 500 as day patients, to ask them whether, based on media reports, there were issues that they wanted to talk about? Was any attempt made to find out about the well-being of those people or to tell them where help would be available? Was any attempt made to let them know that, if they had a story to tell, the inquiry being carried out by OFMDFM is the vehicle by which to do that? Was any attempt made to provide information on how to contact the inquiry?

It seems to me that the 2,000 people who may have been affected were very much down the priority list compared to the 200-odd people who got the questionnaires to identify where the document came from. With the greatest respect, Minister, I see the Department of Health, Social Services and Public Safety's duty of care as being to the people who went into a state-run institution and were abused in it and not being in a cover-your-back exercise to find out where the document came from. The culture of whistle-blowing is not there. It was not there before Christmas, and it is a lot worse now. If you expect people to come forward with information that will help you to do a good job, they are far less likely to do so now than they were before Christmas.

Mr Poots:

I strongly refute the remarks on the tenacity involved in identifying the people who were engaged in abuse compared with that used in identifying the whistle-blowers; or, to use better terminology, those engaged in leaking. Thus far, around £6,500 has been spent on identifying the leak. Thus far, on the work relating to the abuse of children and vulnerable adults, we have reviewed 1,300 files from Muckamore, Lissue and Forster Green. That has engaged senior personnel, and it involves at least one to two days work on each file for our senior personnel alone. That was further reviewed by Stinson, Jacobs and so forth. So, senior staff have expended thousands of days looking at those files. We have spent millions of pounds seeking to get to the nub of this problem. No one can make the case convincingly that we have not been tenacious in seeking and uncovering the truth on this issue.

Many of us feel aggrieved that no one has been disciplined or brought to court about this issue. However, we live in a society with human rights laws, and those are applied. People in this part of the world are innocent until proven guilty, and that creates a significant problem because the burden of proof is on the state. That burden of proof must be demonstrated by the removal of all reasonable doubt. We have not been in a position to safely take someone to court and prove beyond all reasonable doubt that they have been engaged in abuse. I deeply regret that and very much wish that those people had been in court and that strong action had been taken against them, but that is not a position that we have been able to adopt, given the legislation within which we live.

The Chairperson:

I do not understand. I know that conflicting reports came back from the PSNI within a short time, around how it was dealing with this case. With the greatest respect, from the paper that you provided to the Committee and the rigour applied in looking at the Muckamore situation, I suggest that we are not comparing like with like.

As you said, the Muckamore situation primarily involved patients with other patients. Although there was some of that at Lissue House, much there was about abuse by staff. You cannot equate the two. Lissue House staff had a duty of care to children and young people. We appreciate that the papers were made available to us. They make absolutely harrowing read. I do not know how other members feel, but I was shaken by what I read. The documents were

redacted; there were no names in the papers that we got. However, if that was on the public record when Stinson reported, I cannot imagine why no convictions followed.

More worrying is the fact that that information was never passed on to, for example, the Nursing and Midwifery Council. There were no disciplinary issues around that report. The report, of which we have the redacted copy, named people who are known to you as not being the kind of people that you would want looking after your children, yet they are free to go wherever they like. They can work in the private sector, with voluntary groups, with vulnerable children or adults. None of this will appear on an Access NI form. I could not sleep in my bed at night knowing that people with serious questions to answer about their conduct and behaviour, and who should be looking at a custodial sentence, are able, down the road, to work with children and vulnerable adults. How can that be?

Mr Poots:

When it comes to prosecution, you are looking to the wrong people. Our task has been to collate the information and seek to identify evidence. Considerable effort has been made to do that. All of that evidence has been passed to the police. There are protocols for doing that and those have been followed. The police are subject to the decision by the PPS on whether to take such cases forward. All of this has been passed to those authorities. You expressed your strong feelings that people should have gone to court; but, if there are questions to be asked on that front, they are not to be asked of us, per se, because we did everything to facilitate the organisations responsible for carrying out such prosecutions — the police and the PPS. Nothing has been held back from them in that respect.

The Chairperson:

The responsibility is with the employer. If I had worked for the Department of Health as a nurse in one of these institutions and left with a 10-, 15- or 20-year record, that information would go nowhere if the employer had not dealt with outstanding issues before I left.

Mr Poots:

The responsibility for the duty of care certainly lies with the employer. All of this information has been passed to the police, has followed due process and has gone through all of the protocols that existed.

With regard to Access NI, the police have the information. If they wish to apply that to Access NI, that is a matter for the Department of Justice; it is not something over which we have control. I am saying clearly that this Department has presented to the relevant authorities all of the information of which it is aware in which vulnerable people were put at risk by individuals. It is for those authorities to make the decisions that you are pressing for, which would involve prosecution.

The Chairperson:

Had people been dealt with while they worked for you, it would be a matter of record, and the situation in which, for a period of years, they were free to do what they liked, where they liked and with whomever they liked would not have resulted.

Mr Poots:

People were interviewed about these issues and were strongly defended by their unions. I want to put it on the record that they were strongly defended by their unions. Their innocence was strongly defended by their unions. We have questioned people in a forum that had the potential to lead to disciplinary proceedings. Again, the issue is the evidence of proof burden that exists, which needs to be fairly robust. We cannot take disciplinary proceedings against someone without the appropriate evidence to carry it through. My understanding is that there was not enough evidence for disciplinary action or for prosecution. Again, I find both of those facts regrettable.

The Chairperson:

Why was there not enough evidence? Were people protecting others? I am trying hard not to use words that exacerbate the situation, but I cannot, for the life of me, understand how there cannot be evidence, having read the papers, to prosecute people who have very clearly breached any kind of trust. This is not something that happened in the dim and distant past; it happened in our lifetime. Some of the things mentioned in the Stinson report happened in the 1990s. Surely, things were robust enough then to identify that what was happening was wrong and was not the way to look after vulnerable children.

I am keen to know how many interviews the Cabinet Office people carried out. You said the inquiry cost in the region of £6,500. How many people were interviewed on the back of that inquiry?

Mr Poots:

I do not know; it has not concluded.

The Chairperson:

I would appreciate more information when the inquiry concludes.

Stinson said something at the beginning of his report about statutory duty and record storage. I think that he went on to say that records were inaccurate and incomplete. Will you clarify for the Committee the statutory duty for record storage of these kinds of files?

Mr Sean Holland (Department of Health, Social Services and Public Safety):

The comments that you refer to in the Stinson report made reference to his inability to access some files. All hospital files relating to children who were cared for in Forster Green and Lissue were available to Bob Stinson. However, there were family and childcare fieldwork files that he was not always able to access. Not all of the children had such files, but some did. In the report, he refers to a statutory duty to hold those files for 75 years and implies that there was a breach of that duty because they were not always available; in actual fact, that duty came into force only under the Children (Northern Ireland) Order 1995. So, in many instances, the files that he was seeking preceded the making of that legislation. Prior to that date, the protocols in place for the storage of files were local arrangements and varied. In many instances, the trusts did not store files for 75 years, so they were not necessarily available.

With reference to the current situation; under the Children Order, there is now a legislative requirement for the files of any child who has been in care to be held for 75 years, as Bob Stinson referenced. In addition to that, we now have a region-wide, health and social care-wide, policy in relation to the retention of records called Good Management Good Records. We can certainly furnish you with the details of that. It has very detailed prescriptions about the kind of file that needs to be retained and for what period.

The Chairperson:

Bob Stinson did his report in January 2009. If the 75-year rule did not pertain to some files, what was thought to be good practice? Was it to keep them for 20 years, 30 years — what? Where were the files stored? What happened to them when they no longer had to be stored? Where did

they go?

Mr Holland:

My understanding is that the practice varied from one trust to another and that after a certain period of time, which also varied between the different trusts, those files were destroyed.

The Chairperson:

Were they burnt, incinerated, shredded: do you know how they were destroyed?

Mr Holland:

I do not have any information as to the exact method of destruction.

The Chairperson:

Bob Stinson also pointed to the fact that the person who wrote up the report on the day often did not identify themselves and that there were instances in which two members of staff were maybe discussed without being named. The record keeping was absolutely horrendous. He even found evidence that information about some children, who were very vulnerable and damaged, did not seem to have been shared with social services and that an interagency approach had not been taken.

It is unthinkable that all of that happened in the past few decades, and yet we are not at a point at which the people who carried it out can be dealt with appropriately. The people who were not party to it have not been asked about what they can tell us. In October, we asked this question: was any attempt made to identify other members of staff in order to give them the opportunity to tell their story and to identify people? Was an attempt made to supplement the information that you already had with people's memories in order to try to get to the bottom of this? I do not believe that enough was done. The robustness with which you went after the whistle-blower should have been applied to the people who perpetrated terrible things on vulnerable children. As I say, many other members want to get it in. This is probably the hardest piece of work that we have had to deal with in the short life of this Committee. I feel very sad that we are in the position that we are in today.

Mr McCarthy:

I, too, share the disgust expressed by the Chairperson. This is horrendous reading. It is a

shocking report, and everybody acknowledges that. The victims were innocent young people. Words cannot express my feelings about what happened in those institutions at that time under the authority of the Health Department. There were six nurses involved. The last time you were here, Ms Jendoubi, we asked you about where those people were and what had happened to them. You said that two were accountable but that four were gone. Have you tried to trace those four? I know that the 'The Irish News' was able to trace one person. Have the others been traced and asked about what happened on those occasions? Certainly, if 'The Irish News' can find out where these people are, I imagine that the Department would be able to find them.

Maura Devlin's report in 2009 referred to a member of staff who was then working at a campus unit in the Belfast trust. It suggested that further investigation was warranted. Is that a separate case from that of the six nurses, and if so, what was the follow-up procedure?

Finally, point 4 of your briefing report indicates that a strategic management group decided to investigate "only the most serious offences." Surely it is well known that all forms of ill-treatment, and certainly the abuse of youngsters, have lasting effects on children and young people when they become adults. Who decides what is "serious" and "most serious", and what was done about it? That is the strategic management group on page 2 of your briefing.

Finally, will that group encourage former patients to come forward? Will it facilitate former patients to obtain appropriate support including psychotherapy if required?

Mr Holland:

I will begin, and I am sure that my answer will be supplemented by information from my colleague Christine Jendoubi.

The media reported the number as being six nurses, and I can only speculate as to which six nurses they are referring to. However, my speculation is that those are the six members of staff that were referenced in a specific complaint that Bob Stinson referred to in his report. The report overall considers the actions of, I think, more than 30 staff, so the number six really only relates to one particular complaint. It is important to be clear that the statement made by the witness did not make allegations against all six nurses. Some of them were stated as having worked in the facility at the time, so it would be wrong to suggest that some of them had a complaint made against them: they did not. As for their location, I am not sure to whom the media are referring

when referring to six nurses. I think that my colleague will have some details as to where we believe each of the six people Bob Stinson referred to are currently.

You mentioned the strategic management group making a decision about investigating the most serious offences. First, it may be helpful to talk about that strategic management group. To come back to the point made by the Chair about these events being in our lifetime, I think it is important to recognise that there have been huge changes in how we go about trying to protect children and vulnerable adults in that period. If I can be frank, when I started practise, the situation was considerably less robust than it is now. There has been progress. I can look back over this period and say that things were not done very well, and that I think we have had a continuous process of improving how we protect children and vulnerable adults.

One part of that improvement is that we now have very formal agreements between the PSNI and social services about how we go about investigating suspected and alleged cases of child abuse involving children and vulnerable adults. The protocol that governs the joint investigation of suspected or alleged abuse of children includes the provision for the establishment of a strategic management group, where it is felt such a group is required, to co-ordinate an investigation. It is led by senior people from the PSNI and the relevant health and social care trust, and their decisions are operational.

In saying that we should focus on the most serious offences, it is worth bearing in mind that our attitudes towards children have changed considerably. The Stinson report includes some very distressing details. Equally distressing is that, unfortunately, a lot of what it describes reflects how children were treated 20, 30 or 40 years ago in any setting in which they were cared for. For example, physical violence against children by adults was common in schools. I am sure that some Committee members experienced that, and I certainly did. There were situations in my school days that would be considered very serious today and would be prosecuted, but which, after a period of time, would not have been likely to result in a prosecution. The group took an operational decision about what to focus on. I do not second-guess its decisions, but those would have been made by a senior police officer and senior members of the health and social care trust in accordance with an established protocol.

The Chairperson:

I am trying hard not to dominate the meeting. I do not buy that. Pages 30 and 31 of the Stinson

report refer to child BB, who was a 13-year-old girl when she was admitted to Lissue in 1979 and was a day patient between 1980 and 1981. The account in the report of what happened to her was not acceptable ever. Yes, we all got a slap at school, but this is not the same thing. These are serious allegations of child abuse by someone who could be described as a paedophile, who worked for the Department of Health, Social Services and Public Safety, and who has left your employ with not one single blot on their record.

Mr Holland:

The Stinson report covers a spectrum of practices —

The Chairperson:

It does, and I am pointing out one example.

Mr Holland:

You have picked up on what, for me, is the most distressing example, and I suspect that that will be the case for anyone who reads the report. It is an allegation of abuse that was made, and I will not discuss the particular details of why there might be difficulties with investigating that allegation. What I will say is that it was investigated by the police, and I know that they pursued those matters vigorously. There has been outstanding co-operation between the police and health and social care on all aspects of the investigation. Sometimes allegations are made, and most serious efforts are made to investigate them; but, if they cannot be proven and corroborated, they remain allegations.

The Chairperson:

On that particular allegation, Jacobs talks about a clinical psychologist who was in to exonerate, if you like, some of the people who may not have been involved directly but who may have known and been in a position to report some of these things. He vindicated that and said that the fact that child BB was on medication would probably stand up. How can you say that there has been good co-operation and that this has been robustly investigated if that person is still able to do those things now?

Mr Holland:

Chair, you are asking me to speculate as to how the case may or may not be proven. You are taking me into the territory of criminal investigation, which is not my area of professional

expertise. A crime can be very robustly investigated and not proven, and that can either be because the crime did not take place or because insufficient evidence is available to prove that it took place. Those are the only conclusions that I can draw from this, but I have no reason to believe that it was not a robust investigation. As I said, and as the Minister referred to earlier, criminal investigation is beyond our area of responsibility.

The Chairperson:

I am sorry for butting in, Kieran. Have your questions been answered?

Mr McCarthy:

The talk of serious and most serious cases worries me, because, in my opinion, all cases should be investigated. I do not know who decides which should be investigated and which should be forgotten about. The Maura Devlin report stated that further investigation was warranted. Was that a separate case, and, if so, what was the procedure that was followed?

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

If the reference in the Devlin report is the one to which I think you are referring, Mr McCarthy, that was the same person.

Mr McCarthy:

It was one of the six? OK. That answers that. Maura Devlin's report certainly said that further investigation was warranted. Was that further investigation carried out?

Ms Jendoubi:

Do you have a page reference?

Mr McCarthy:

It was one of her recommendations.

Ms Jendoubi:

In that case, yes, it was carried out. It is on page 9; it is one of the recommendations. Yes, further investigation was carried out.

Mr McCarthy:

What was the outcome? Do we know?

Ms Jendoubi:

We can speculate, because it is about nurse X of newspaper fame.

Mr McCarthy:

That does not register with me. What do you mean by "of newspaper fame"?

Ms Jendoubi:

It is nurse X on whom 'The Irish News' reported.

The Chairperson:

The recommendation was that there should be a further in-depth review of nurse X's professional conduct with a view to appropriate referral to the Nursing and Midwifery Council (NMC). Has that been done?

Ms Jendoubi:

My understanding is that it has been done. Nurse X has been thoroughly investigated by the Belfast Health and Social Care Trust, the HSCB and the police.

Mr McCarthy:

And everything is fine?

Ms Jendoubi:

There was not enough evidence to bring him to prosecution or to conduct disciplinary procedures to a conclusion. That having been said, he is no longer on the NMC register, and there is a flag on the register that will alert the authorities should he apply to get back on it.

Mr McCarthy:

What if he were to go somewhere else? To some other trust or to a country other than Ireland, for instance. Could he carry on with the same conduct?

Ms Jendoubi:

We cannot control that.

Mr Poots:

He is no longer a registered nurse. He would have to be registered to practise as a nurse in any other jurisdiction, and the NMC has a warning flag against him.

Mr McCarthy:

Would that prohibit him from doing so?

Mr Poots:

It is not what you would desire, but it would stop him practising as a nurse, in this jurisdiction or another.

The Chairperson:

However, he could work as an auxiliary. He does not have to be a nurse, but he could still work with vulnerable adults and children.

Mr Poots:

For those appointments, you have to go through Access NI procedures. The police are aware of all the details. It is outside our remit, but it is up to the Department of Justice, through Access NI, to act on that.

Mr McCarthy:

I asked whether the strategic management group (SMG) will facilitate former patients if they need appropriate psychotherapy treatment.

Ms Jendoubi:

Yes.

Mr Holland:

That is not the role of the SMG, but health and social care will certainly facilitate provision of any services that a survivor of abuse requires. That is also an issue that OFMDFM is concerned with, in the light of the forthcoming historical abuse inquiry. That Department is exploring ways

of putting in place appropriate advocacy and support services for any adults who now come forward about their childhood experiences.

We already have some arrangements in place. For example, the Health and Social Care Board funds an excellent organisation, Nexus, which provides support to survivors of sexual abuse. We also fund a 24-hour telephone helpline called Lifeline, which can support people who are distressed as a result of previous experiences. Of course, the full range of existing services is available to those people. GPs, mental health services and social workers are assisting people every day to cope with various experiences that they have had throughout their life. That is available to all victims.

Mr McCarthy:

That is encouraging.

The Chairperson:

That question was not answered earlier. No attempt was made to identify the 2,000-odd people who came through Lissue House to find out now whether they need any further help or support. They had to go seeking it.

We have talked about this before, Sean. We had a brilliant presentation from Nexus when we visited Altnagelvin Hospital. Nexus is funded by different trusts, and its funding is piecemeal. In fact, Fermanagh District Council also provides funding because of issues in that council area, and that is to be commended. However, Nexus is not in receipt of mainstream funding. It has to go looking for and chasing after funding, and it has significant waiting lists. If somebody read this story in the paper and went to Nexus, the chances are that the person would be told that there is a three-month, six-month or eight-month waiting list. That is not good enough either.

Mr Holland:

I will come back on that point. My understanding, and it may be helpful if we provide you with a detailed written piece on Nexus, is that the difficulties that it has experienced with waiting times in the west relate in part to the difficulty in its being able to obtain counsellors. I have had discussions, with the Minister's support, with the Health and Social Care Board throughout this period that have been along the lines of saying that, if it needs additional resource to respond to an increase in people approaching Nexus following this story becoming public, we will provide

that resource. There has been no sign of its services being overwhelmed by people coming forward to date, but if that situation changes, we will certainly treat the attempt to ensure the availability of services as a priority.

Mr Wells:

Sean, I agree with what you said about looking at the report through the prism of present day standards. As happened you, things happened to me 40 years ago at school that, if they were to happen now, the perpetrators would be in prison. That physical violence happened to males and females, and it was seen as the norm. If you misbehaved, you got a kicking from the teacher, and no matter how violent it was, it was acceptable.

Of course, we have moved on, and standards are much higher. Equally, sadly, some of what we are seeing is being seen through the prism of present-day standards, and it is all utterly unacceptable.

I want to explore the point about there not being sufficient evidence for prosecution. I presume that part of the problem here is that the person making the allegations would have to go to court, give evidence and be cross-examined. I imagine that there would be enormous difficulties around people in that form of care being seen as a credible witness, even though they could be telling the absolute truth and be certain of their facts. Some QC on the other side would simply tear them to ribbons. When the phrase "insufficient evidence" is used, it does not necessarily mean that there is not a lot of information about the allegation; alternatively, it can mean that the evidence is insufficient in that it would never stand up in court. Is that what we are dealing with? Rather than the issue being about the hearsay evidence, is the problem not the fact that you know and the police know that it could never get past the first day of a court hearing?

Mr Holland:

You raise a number of good points, Deputy Chairperson. Certainly, the ability of someone with a serious mental illness will present challenges in securing any prosecution. Some of those children were very seriously mentally ill at the time, and, unfortunately, some of them are quite seriously mentally ill as adults. Equally, relying on the evidence of someone with a significant cognitive impairment will also present challenges.

What has changed in the period is how these services are managed. Two things have changed

quite significantly. First, the standards of practice have changed an awful lot. Much of the behaviour that we rightly consider to be abusive now just does not happen. People understand that it is unacceptable. There are clear standards, and people have been trained more appropriately. Services are also designed in such a way so as to reduce the opportunities for abuse to occur.

Secondly, one thing that Bob Stinson commented on was the unsuitability of the physical environment of the building that was being used in those days. Nowadays, and Christine can verify this, when we are building a facility, one of the things that we will look at is how the built environment can support good care, including making sure that there are not built-in vulnerabilities, where people could be abused away from supervision.

Those two things have changed significantly. As regards the particular detail of any prosecution, as I say, I am not a criminal investigative officer, so I cannot make an evaluated judgement. Broadly speaking, those points are relevant to why prosecutions probably have not been successful.

Ms Jendoubi:

It is also the case, however, that the police found, in a number of instances, that the people whom they pursued to see whether they wanted to make a complaint were not interested in doing so. They wanted to put the unpleasant, difficult experiences of 30 years ago behind them and move on, so they were not prepared to make a complaint.

Mr Wells:

Let us look to the present. It is quite clear that things happened that, again, may have been acceptable 40 years ago. For instance, older children being involved in the care of younger children is an obvious risk area, and the fact that the shower door must always be left open for supervision, even when female patients are showering and male staff are on duty. The evidence is that that was done to prevent self-harm. However, that sort of practice, even if it is entirely innocent, clearly creates all sorts of opportunities for something rather untoward to happen. Has all of that been completely erased from the system? Are there no risk areas now?

Mr Holland:

The Chairperson and you, Deputy Chairperson, will be aware that, on a number of occasions

during previous appearances before the Committee, I have been wary about saying anything absolutely on the protection of children and vulnerable adults. We cannot give absolute guarantees, but I think that what we can say is that there are now standards that would preclude that kind of practice.

I think that our understanding of risks and threats have moved on. On the practice of engaging older children in the care of younger children, I can understand how, at the time, people may have done that naively. One of the things that has changed in the intervening period is that we have become increasingly aware of peer abuse — children on children. We have not stopped in the development of our understanding and knowledge. I suspect that, in 10 years or 15 years, people will look back at some of our current practices and say that we were incredibly naive not to appreciate the full risks presented by, for example, the internet. There are new types of abuse emerging now among children and young people involving the internet. Our knowledge changes over time. Again, when I started out in practice, I certainly did not appreciate that. In my mind, abusers were always adults on children. It rarely occurred to me that females could be perpetrators of sexual abuse or that children could be abusers of other children. Our knowledge has moved on, and we now understand that that was a risky and inappropriate practice.

Mr Wells:

Finally, as a result of the media coverage of these incidents, has new information come forward? Have people who stayed in Lissue House and other institutions come forward to provide further information, which, had it been known, would have assisted any of the inquiries?

Mr Holland:

We are still involved in a joint investigative process with the PSNI. That goes beyond Lissue House and Forster Green. It is not confined to children but also looks at material relating to vulnerable adults. I do not want to comment in any detail on what is an ongoing operation for fear of compromising any prospect that it has of bringing people to justice, identifying risks or disciplining people.

My understanding is that, since the story broke in 'The Irish News', some people have come forward to Nexus and said that they were doing so as a result of experiences connected to Lissue House and Forster Green. I think that approximately seven people are involved. The police are saying that they have dealt with approximately nine or 10 new lines of enquiry. However, I have

to say that there may be overlap among those people. I know of one person included in that number who had come forward previously. It may be the case that some others had also come forward previously and that there have been investigations into the material that they supplied to health and social care and the PSNI.

Mr Dunne:

We support the Chairperson's comments about our abhorrence and shock at the report's findings and the detail in it. I think that what has come out is really appalling.

I want to make a couple of points. The Minister has given a categoric assurance that there has been and will be no attempt to cover up the matter. That is good, and we welcome that. Have the management teams at both hospitals been interviewed about what went on, and, if so, did any significant findings arise? Obviously, they have a responsibility, and they are accountable for what went on in their establishments.

Are the cases still open? You have probably clarified that with Jim. You have taken the matter so far, and it has been admitted that it will be very difficult to proceed. However, if further evidence were to be presented, and that may well be the case, will that be followed up on, perhaps to prosecution?

Mr Poots:

I will deal with the second question and Sean will deal with the first one.

I strongly encourage anyone, be it former staff at Lissue House, friends or relatives of anyone who was a patient there or, indeed, individuals who were patients there, to bring to us any evidence that will add to the inquiry. It will be treated seriously and will be used. As I indicated, the police have said that, they currently cannot prosecute, but if more evidence were to come forward, they would consider it. We have a desire to prosecute, so if there is further evidence that will assist our inquiry and could lead to prosecutions, we ask that people present it.

Mr Holland:

My understanding is that some members of hospital management were interviewed during the process. However, rather than run the risk of misspeaking, I will follow that query up with a written response that will give you a definite answer and will reinforce what the Minister has

said.

I also have to make it clear that the police are in no way showing any reluctance or hesitation to pursue cases. Before Christmas, along with the permanent secretary, I met the Chief Constable to discuss those matters. We had a further meeting on 28 December and another as recently as last Friday with senior police officers to talk about how best to respond to any new information and ensure that it is rigorously pursued.

Mr Dunne:

Good. Thank you. As Jim said, we are all keen to ensure that there is no reoccurrence of those events. I understand that rigorous processes are in place that are managed by the RQIA. I am from an engineering background, and I was involved with quality assurance. The bottom line was that, when issues were found, it was a learning process. Processes were put in place to ensure that there was no reoccurrence.

Can you assure the public today that what happened cannot happen again and that the proper processes are in place? The buildings are important, but they are just part of it. If the processes are there and are monitored, audited, reviewed and managed, those events should not happen again. Can you also assure us that the processes are adequately resourced and managed?

Mr Poots:

Legislation has changed considerably, and, as a result, practices have changed. Record-keeping, and other staff members' record-keeping of behaviours, and so forth, has changed dramatically and considerably over time. What is in place now should, in theory, ensure that these things do not happen.

However, I have to add a caveat: paedophiles are particularly wicked people, but are very devious and clever about what they do. Many good institutions and organisations have been infiltrated by paedophiles. People who have brought others in, in good faith, have been badly let down as a consequence of bad judgments in allowing people to engage in organisations, whether it be churches, scouting organisations or whatever. Such people have entered the health system, as has been evidenced. There will always be a challenge in keeping them out. They often prey on vulnerable women with young children, and their real interest is not in the woman but in her children. However, that does not become evident until later. They prey on their nephews, nieces,

and so forth. That is the nature of paedophilia.

At this stage, we have done as much as we can to meet best practice standards. If new standards come out, we will be quick to adopt them. If people have ideas or suggestions as to how we can improve things, we will seek to improve them, but, as standards go, ours are as good as is currently possible. We can only hope that, as a result of introducing those standards, things that happened in the 1970s, 1980s and 1990s should not happen today.

Ms Boyle:

I share the Committee and the Chairperson's concerns. Jim has already asked my question. The report makes disturbing reading, and this is probably one of the hardest Committee meetings that I have attended since our tenure began in May.

The report talks about the perpetrators — there is obviously more than one — responsible for abusing those vulnerable young children, but the state also neglected its duty of care by allowing what happened to all those people to happen. Hospital management and staff have a responsibility in all of this. One of the things that sticks in my mind is that these were vulnerable young children. In particular, the stories of young girls who were going through puberty reveal that the people whose job it was to educate them about hygiene and health were instead taunting and abusing them. That struck me when I read the reports.

We talked a lot about the word "robust". As we meet here today, are robust meetings still going on with the PSNI and the Department or has all of the information now just gone to the PPS, and the Department no longer has a role to play? Where does that sit with the ongoing process?

Mr Holland:

I must make it clear that this goes beyond Lissue House and Forster Green. The Muckamore Abbey situation and the Lissue and Forster Green situations started with single complaints. Far from trying to cover up those complaints, we have seen a continued effort by people to find more and more information by looking at files and by doing full or percentage samples of files across a range of facilities. That process is ongoing. We have undertaken a retrospective sampling exercise of adult and children mental health facilities across Northern Ireland. The historical abuse inquiry will focus on children, but we are looking at both.

That exercise has generated material that may indicate the need for further investigation. Therefore, a strategic management group has been established between the police and social services. The group does not include the Department, which is not an operational agency, but the Health and Social Care Board and the PSNI are enjoined in a strategic management group established under paragraph 6.24 of the 'Protocol for Joint Investigation by Social Workers and Police Officers of Alleged and Suspected Cases of Child Abuse — Northern Ireland'. That is ongoing, it is live, and matters are currently under investigation.

Ms P Bradley:

Like everyone else around the table, I read with total shock and disbelief that this was allowed to happen.

You spoke about how times have changed and that, years ago, things were handled differently. There are a few weaknesses in that, because children 20 years ago are no different from children now or children 40 years ago. Jim brought up the issue of older children looking after younger children. All of us, no matter whether we have a difficulty in life or not, go through certain emotions and feelings during puberty and express those emotions one way or another. Those older children should not have been left in charge of younger children.

The argument is very weak and just does not wash. Those children are no different from children now who have a sexual awakening and become sexually aware. They were left to their own devices to do whatever they wanted with younger children in those homes. It is extremely sad, and it was no different then from how it is now. All teenagers are the same.

Mr Holland:

It was wrong, it was insensitive, it was risky and it was inappropriate.

Ms Jendoubi:

It was also common in schools.

Ms P Bradley:

It is very sad that the teenagers who were perhaps the perpetrators were also vulnerable. Their vulnerabilities were left. There are such gaps and loopholes.

Mr Holland:

It is particularly tragic, given that some of the children and young people who were cared for in Lissue House were there because they were having difficulties emerging from trauma that they had experienced elsewhere in their life.

Ms P Bradley:

That trauma was not dealt with. It was allowed to manifest itself and become worse. It is extremely sad.

Mr McCarthy:

Has anyone been held accountable for what happened there? In the Assembly this week, we heard about Helm Housing, the housing association, being in trouble. At least the people who were responsible got out. They were accountable for what happened at Helm. Have we anyone in the Department who is accountable for what happened here?

Mr Holland:

I do not think that there is anyone in the Department who was in employment at the time, and there was certainly not anyone who was in a position of responsibility for overseeing those services in the period that Bob Stinson covers.

A direct answer to your question is that, as far as I know, no one has been sacked over this.

Mr Poots:

Close to a generation has now passed, so many people who worked in the facility have moved on or retired and some have passed away. That complicates the matter further, Mr McCarthy.

Mr Brady:

I have a couple of comments and perhaps a question to Christine. In my generation, teachers were quite violent, but there is a big difference between getting hit and sexual abuse, which is what we are talking about. I follow Paula's argument that it was wrong then, was always wrong and always will be wrong. The fact that physical violence took place in schools 40 years ago does not necessarily have any bearing on what happened in some of these very disturbing cases. When you made the comment about what happened in schools, Christine, were you talking about

bullying or sexual abuse?

Ms Jendoubi:

I was talking about the practice of older children being made responsible for looking after younger children. Prefects did that all the time.

Mr Brady:

Perhaps it depended on the school. That was not that big a feature in the schools that I went to.

Mr Poots:

Sadly, sexual abuse took place by older pupils of younger pupils, and some of those have been publicly recorded. That has done huge damage.

Mr Brady:

I wanted that clarified.

When reading these really appalling and disturbing cases, it is hard to imagine abuse taking place in those institutions in isolation: that one member of staff perpetrated the abuse without other members of staff knowing about it. That is disturbing and does not seem to have been brought out enough. It is hard to believe that one or two individuals were serial offenders and that other members of staff, or even management, were immune to it or simply did not know about it.

To be perfectly honest, I find that hard to believe. It seems to me that people were complicit in the perpetration and in the cover-up. I use such words advisedly, but it seems to me that that must have happened. As a student, I worked at the huge Middlefield Hospital just outside Birmingham, which dealt with vulnerable adults and young people with learning disabilities. I did a summer job there for about two months, and I cannot imagine such abuse happening without other members off staff being aware of it. It seems difficult to believe that that is possible. Did complicity undoubtedly happen? Has that been investigated to any degree?

Ms Jendoubi:

I am sure that what you say is right, Mr Brady. If this kind of abuse happened, it seems inconceivable that other people on the staff at the time were not aware of it. Unfortunately, we in

the Department have not seen the detail of how those cases were investigated at the time by the employers, but I am sure that that figured as part of the investigation.

Mr Holland:

May I add that when I talked earlier, I in no way equated the violence that people experienced in schools with sexual abuse, although extreme violence and sexual abuse has happened in schools, and I mean extreme violence — as bad as anything contained in the report. As regards general awareness, Bob Stinson talked about a harsh and punitive regime, and I think that all staff would have been aware of that kind of behaviour. They would have been aware that physical chastisement was being used and that there was a bullying attitude. I am sure that that was common knowledge among all staff. However, my experience of predatory sexual abusers is that they go to great lengths and are often extremely skilled at concealing their activities. Almost a defining characteristic of sexual abuse tends to be that it happens in secret, and people can be very talented at making sure that their abuse stays secret. So, I do not know whether you can necessarily assume that, if that took place — and there is no definitive proof of it — it would have been, necessarily, widespread knowledge among a staff group.

Mr Brady:

Obviously, some members of staff were the perpetrators, but the majority, hopefully, were not. However, in many ways the latter are as much to blame, if they were aware and did not do anything about it. There is no difference between that fact 40 or 50 years ago and now. Wrong is wrong, and if you are aware of something such as that it should be reported and dealt with quickly. I do not want to labour the point, but, on reading these reports, it seems to me that there was complicity: it would be impossible in many ways not to think so.

Mr Poots:

It, perhaps, would not have been as blatantly obvious to other members of staff that people were engaged in abuse because of the practices that were acceptable then. Some were deemed to be normal practice. My wife told me about some of her experiences in Downshire Hospital when she was training to be a nurse. In one sense those things did not amount to abuse, but extreme physical restraint was used to deal with people who were clearly very disturbed. When one becomes involved in a mental health or learning disability facility, difficult practices are engaged in, when a degree of restraint is needed on occasions and where assurance is needed that people's cleanliness is being maintained. We have much better standards now than was the case all those

years ago. Sadly, the practices allowed then would have created the opportunity for those with abusive intent to engage in it.

Mr Brady:

I take your point. I think that in many cases staff were dealing with difficult patients. However, there is a difference between the restraint needed due to a condition and sexual abuse, which is a completely different issue.

Mr Poots:

There is no disagreement on that. I find all of this particularly difficult because I have been in the Muckamore institution thousands of times in my life. Over that period, I have got to know many of the people. Some wear helmets and pads on parts of their bodies to protect themselves. One thing about them and about most people who live in those facilities is that, although they are never going to be doctors, lawyers or anything like that, they can give unconditional love. That is one thing about people in the learning disabled community. If someone treats them right, and shows them proper and appropriate care, they will return unconditional love. I find it horrifying that youngsters, particularly teenage youngsters, have been potentially subjected to some form of sexual abuse even though they are the most vulnerable in our society.

Let me make it absolutely clear to the Committee that this happened during a period of direct rule, and the investigation took place under a previous Minister. I would not be standing with the Department's officials if I thought that they had been engaging in some sort of cover-up or shoddy practice. There may be things that might have been done slightly differently, but there has been a huge effort made to identify whether wrongdoing has taken place and, if so, who engaged in it. It is hugely regrettable to everyone that that has not led to disciplinary proceedings or prosecutions. However, that has not been because of a lack of will, or because someone has been engaging in cover-up or anything else.

We wanted to get to the truth of this and to get justice for the individuals involved. If we have failed, it has not been because of lack of effort, it has been because of circumstances beyond our control.

Mr McCallister:

I apologise for missing the earlier part of the proceedings; I had a meeting in Dundonald House

that I could not reschedule.

I do not disagree with you, Minister. This is appalling. I agree with your comment that it is disturbing that this has happened. Have you put measures in place that will constantly review the position and make the necessary changes? As standards change or evolve, we must ensure that all those things are in place. We do not want to be visiting this matter again in 10 years from now, or whenever. We want to ensure that we constantly monitor our facilities to ensure that standards are maintained and that the appalling abuse that you referred to cannot happen again.

Bearing in mind what Sean said; in practice, people can be very talented at getting around the system. Such people must be identified, weeded out and not allowed to be near children. That is easier said than done, given the experience that Sean relayed to the Committee about how devious people can be with regard to getting through the system.

Mr Poots:

The RQIA is in place now, and its role is investigative. There are a couple of aspects to that. When the RQIA sees general shortcomings, it should draw them to our attention so that we can make new legislation and rules; but where it sees shortcomings in a particular facility, it is up to the RQIA to ensure that those shortcomings no longer exist, which may lead to the closure of that particular facility. The RQIA has a huge responsibility to ensure that we provide the appropriate care to vulnerable people, whether they are children, adults or the elderly.

Ms Jendoubi:

I will add a few words of detail. The RQIA has been involved in this process since 2006, when the investigation into Muckamore brought to light the indications that the abuse was more than just an isolated incident and that we might have a wider problem. It was asked to conduct a review of the safeguarding of children and vulnerable adults in mental health and learning disability hospitals. The RQIA did so and produced a report in 2008. It made a number of recommendations about user involvement; recruitment, supervision and management of staff; appropriate policies and procedures; training of staff and volunteers; children and young people being in adult wards; and the existence and implementation of adult protection guidance. The RQIA report was circulated to the trusts, who were asked to produce action plans in response to it, and they did so. The RQIA was asked to go back and assure the Department that the trusts' action plans for implementing the recommendations were appropriate. The RQIA did that and

confirmed that the trusts' action plans were appropriate.

The RQIA has since produced a report, in February 2011, on children and adolescent mental health services, which reported on improvements at a number of levels. It is particularly gratifying that that report included the significant degree of satisfaction of children and young people and their families with the child and adolescent mental health services (CAMHS) that they have received. It also drew attention to the important development of the purpose-built inpatient facility in Beechcroft and the fact that that has increased capacity for young people requiring admission. As of last Friday, we have a total of four young people awaiting non-urgent admission to Beechcroft and no urgent cases awaiting admission; so, that has improved inpatient facilities enormously.

There are obviously things that still require to be done. The trusts are addressing the recommendations made in the CAMHS report. It is a constant programme of review and review and review and inspection and review. That has been ongoing, and it will continue to be ongoing.

Mr McCallister:

Is Beechcroft full, or close to full, at the moment?

Ms Jendoubi:

Yes.

Mr McCallister:

Are we hitting the right levels of CAMHS funding?

Ms Jendoubi:

CAMHS has traditionally been underfunded given the developments and improvements that we would like to make. It is a function of the overall budget that there are areas in which we just do not have as much money as we would like to have. CAMHS is one area that we would want to focus on if additional money became available from any source.

Mr McCallister:

At the minute, do we have any children in adult units across —

The Chairperson:

John, you are straying off.

Mr McCallister:

I accept that I am straying off slightly, but it is only because Christine introduced the subject.

The Chairperson:

To be fair to the team, they are not here to talk about this issue. Today's discussion has gone on for a considerable length of time. It is not that this issue is not important, but perhaps we can ascertain the facts in another evidence session. I want to be fair to the people who have given us quite a bit of time today.

Mr Holland:

I would hate it if anyone thought that we had avoided answering that question. The truth is that, unfortunately, there are children being cared for in adult facilities. We are working to a situation where we would love to eliminate that number. There are now protocols in place when children are in adult facilities. There are arrangements that have to be put into operation to make sure that those children are as safe as they can be. It is a deficit in our service, and I feel obliged to answer that question.

Mr Poots:

The private sector has indicated a desire to build a CAMHS unit, and there have been discussions with the HSC. The level of support for the services required, if they proceed with it, has been quite positive.

The Chairperson:

I want to ask one or two more questions, Minister, if you do not mind. Where are the children's files that are subject to the 75-year rule?

Ms Jendoubi:

The hospital files are all together in secure storage in Belfast. The family files are in the trusts in the areas in which the families live. The files not still in use are in secure storage, and the ones that are not there will have been destroyed.

The Chairperson:

Are you confident that the secure storage is secure?

Ms Jendoubi:

Without going to each trust, naming the individual patients in Lissue and Forster Green over the period of the Stinson report, and asking the them to seek out the files and provide an assurance on each of those almost 2,000 files, which we have not done, I could not put my hand on my heart and say that every single file is available, is even in existence, or is appropriately stored.

The Chairperson:

Do you mean the hospital files?

Ms Jendoubi:

No, I mean the family and childcare files. The hospital files are all there. Mr Stinson got all the hospital files that he asked for in connection with the review, because they were all in one place; they were the medical files. Mr Stinson wanted to see the social work files for some of the patients, if the trusts had them. Not every family has a social work file. He wanted to check whether, when a child was discharged from Lissue and went home, the social workers noted anything in their files about that child's time in the facility — whether they had said anything or passed any remarks about their treatment there. In some cases, he did not get the files; they were not provided to him. In other cases, when he did get them, the files were incomplete. As Sean explained earlier, there were no regional protocols in place in those days for retaining social work files.

The Chairperson:

You said that the hospital files are in secure storage in Belfast. Can you be more specific?

Ms Jendoubi:

No. We put that question to the Belfast Trust. The response was that the hospital files are all in secure storage.

The Chairperson:

Do you not think that it would be useful to know the whereabouts of those files and to double check that that is the case so that those files cannot be accessed by anyone?

Ms Jendoubi:

The trust has given us an assurance that the files were available to the Stinson review. If anyone wants to see them, the trust will make them available, but they are currently being held securely.

Mr Holland:

I will add to that answer in relation to recording. Not only has practice changed in the period of that storage of files, but the standard and the expectations of what would be recorded on files has changed dramatically over the period. Many years ago, it would have been acceptable for very brief notes to have constituted a file record. If you were to look at a file today, the expectation is that it is much more structured and that certain pieces of information are systematically recorded. That practice has changed an awful lot over the period.

The Chairperson:

Sean, you were asked earlier about the interviews, how many people had been interviewed and how many checks had been done on members of staff. As an anecdotal example, in the early 1980s I broke my arm and went to a hospital in Armagh to have an X-ray and a cast put on. I needed to take off my school shirt, but before I did so, the nurse who was looking after me asked me whether I had anything on underneath. The reason that she checked was because there was a man in the vicinity of A&E whom I had noticed, even at the age of 11 or 12, was a wee bit pervy and there for a wee duke. It is not funny. She asked if I had something under my school shirt, before she allowed me to take it off because she was aware that he was unsavoury and did not want him to be there looking at a child. I thought nothing of it at the time, but I have thought back to it a few times since. She was a person who had her suspicions about a fellow she was working with.

I believe that there are people who worked in Lissue House who, given the right culture or atmosphere, would be happy to share some of their experiences with you. I am disappointed to find out that you, Minister, sanctioned the investigation and the bringing in of the Cabinet Office to hold a leak enquiry. Did you ask John Compton how he tried to find the people who, perhaps, could provide the information in a non-judgemental environment? Perhaps they could be asked whether they had suspicions about any people they had worked with. The nurse in Armagh was able to make sure that I had something else on before I took off my school shirt. People worked with people. I take what you say about people being devious, but we all have eyes, ears and instincts. Some people who worked there probably feel that they are all being tarred with the one

brush, and they, perhaps, would be prepared to make information available to you.

I would have much preferred to hear today that you went back to the people who worked there at the time and asked them whether they would share their experiences with us, or that you had tried to find the 2,000 people. After all, there are files and hospital numbers, so they could be tracked down. You could have asked: "How are you now? Do you need anything?"

Having read some of the stuff in the Stinson report, I know that some things might have been buried at the back of a person's mind, and might only have manifested themselves when the individual, perhaps, gave birth. It is only then that someone might think, "How was I put in a position in which I suffered as I did in that place? How did that happen to me?" Maybe it is only when you become a parent that the trauma of what you experienced kicks in properly.

I would have preferred to hear you say that you would try to find the children who were affected by this and who are now adults. I would have liked to have heard that you tried to find the people who could shed some light and who would welcome the opportunity to get things off their chests. Instead, we are hearing that the really robust exercise carried out was to try and find the person who leaked the paper. We are not blaming anyone who came here to talk to us today; I accept you were not there and were not part of it. However, you could be part of the solution. You could be part of putting it right, Minister. More needs to be done to put it right. Although things may have changed in the past 20 or 30 years, there are still people in society who are a danger to our children and it is incumbent on all of us to know who they are.

At the beginning of the meeting, you were very robust in saying that there was no cover-up. However, if you look back to the PSNI's first statement on 27 October and at the things we have learned since, you will see that not enough was done to find the people who perpetuated the abuse, whether physical, sexual or emotional, on children and vulnerable adults. Not enough was done to find them and deal with them in a proper manner. This issue leaves me with a very heavy heart. More could be done. Minister, I ask you to make it your business to do more to find the people who were involved in this.

Mr Poots:

Again, I make an appeal to anyone who has information to bring it to us. The individuals named were not the only individuals who were interviewed. Other members of staff were interviewed,

so a course of work has taken place in that respect. If a member of staff who has not been interviewed and has information, or has been interviewed but has additional information that has come to mind, I ask them to please come and give us that information. We want that information; we very much desire it and we will pursue it. If there is an issue about individuals not being able to make a compelling case within a court system, perhaps members of staff might be better capable of doing that and might have a greater opportunity of achieving success in court. We would very much love to have our day and engage in prosecution if it were available to us. At this moment in time, it is not.

The Chairperson:

How do those people do that? Do they skulk about the filling station hoping to bump into you? You sanctioned the issuing of 200 questionnaires. I think that you need to sanction 200 letters being sent to the people who worked in Lissue, asking them to come forward and giving them the relevant numbers to contact you on. Unless you do that, you will never get to the bottom of this. The same robustness should be applied to ascertaining the truth in all of this.

As I said earlier, the culture does not exist for someone to come to any of the three of you or to other people at senior level in the Department because of fear. I am picking that up from hospitals across the board. There is a culture of fear. Nobody wants to put their hands up and say that things are being done that might cause a premature death or lead to someone not getting the treatment that they deserve. People are afraid to come forward. I am saying this in the best interests of our healthcare workers who are petrified of putting their hands up and saying that all is not as it should be. I am just giving you a warning that people are too afraid to come forward and speak. The actions that were taken in the week before Christmas have fed into that fear. There needs to be a serious culture change in the Department or you will never get to the bottom of problems. Things are going to happen that you will not be able to stand over, Minister. That situation could be avoided.

Mr Poots:

Many staff report issues of concern. In fact, they have a duty of care to do so, which means that they should report issues of concern to those above them; their line managers and so forth. If the problem is with the line manager, it is up to the person to report the problem to line manager's line manager. I can only make it absolutely clear that I encourage that type of activity, because it helps us to drive out poor practice.

Of course, there will always be people who engage in poor practice; you will not get an organisation of 70,000 people in which everybody performs to their absolute optimum at all times. So, I strongly encourage members of staff in DHSSPS to bring wrongdoing that comes to their attention to the attention of those to whom they are responsible. If those people do not take it seriously, they should take it up another level, and another level if that is required. We need to get to the truth of these things. We will not get to the truth by leaking information; we will get to the truth by whistle-blowing. I support whistle-blowing, and I am opposed to leaking.

The Chairperson:

To finish on a lighter note, I want to ask about the children's hospital in Belfast. I am thinking of women who have potentially gone through Lissue. You were asked a question about perinatal beds in the Chamber on Tuesday. Women and children need to be prioritised in your work, and I would very much appreciate your taking a personal interest in the children's hospital in Belfast, with a view to moving swiftly on that project, which has been on the table for a long time.

Mr Poots:

I visited the children's hospital several months ago. I have to say that its condition is very poor. It is an old building, and there have been quite a lot of bits added to it. The old building has weathered considerably better than many of the extensions that have been added to it, which are in a very poor condition. I have established a health infrastructure board, comprising five people from the Department with the support of the SIB. It is currently looking at our capital programme. My predecessor announced the capital programme in March or April 2011. I have a problem with some of it, in that it identified projects that would start. For example, one project is scheduled to start in 2015; it will cost £60 million, but £2 million has been identified for it in 2015. So a lot of it runs into the next financial term.

I believe that I am in a slightly better financial position in that Osborne announced that approximately £130 million will be coming back to Northern Ireland. We need to establish how much of that will be coming to the Department of Health. We also need to know what is happening in relation to the A5; what money will be used to complete whatever element of that is to take place and what will be surrendered. We will make a bid for some of what is surrendered. That still will not cover our financial need for capital infrastructure, so I will look at other means. Potentially, we may have a build-and-leaseback of properties, and some of that may involve

public finance initiatives (PFI).

However, I am determined to look at how we can considerably extend the building projects — the capital projects — identified by the previous Minister. Among the large developments, the new regional women's and children's hospital is my first priority. Obviously, we have agreed to the Omagh project but, beyond that, the children's hospital is my first priority. The Altnagelvin project is also agreed. I also want to do a series of primary care clinics which can help us implement the Compton report by taking more care into the community with the lesser requirement on our hospitals.

The Chairperson:

I attended an event for the children's hospital when my nine-year-old was weeks old. The issue has been on the table for a long, long time, Minister. This is a personal thing. I am very anxious to see it advanced as expeditiously as possible and in a way that does not involve a big PFI commitment from taxpayers in the future.

I am going to enable the Minister to go. I thank all of you. It is almost 4.00 pm. It was a very long session and a very tough one. Thanks, Sean, Christine and Edwin for your attendance. I suspect that this is a session that none of us will ever be able to get out of our minds. If there are further developments, the Committee would appreciate being fully apprised of them. We will see how things develop if there are convictions. We cannot get involved in matters that are sub judice, but we want to be kept apprised of any issues relating to this matter over the following weeks and months.