STRATEGIC MANAGEMENT GROUP:

REVIEW OF RETROSPECTIVE SAMPLING EXERCISE IN MENTAL HEALTH AND LEARNING DISABILITY HOSPITALS

FINAL REPORT

DECEMBER 2013

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1. BACKGROUND

A retrospective review of patient case files within Muckamore Abbey Hospital was completed between 2005 and 2009 by the Eastern Health and Social Services Board (EHSSB) and North and West Belfast Health and Social Services Trust. Following this the Department of Health Social Services and Public Safety (DHSSPS) instigated a retrospective sampling exercise in June 2007 across all 5 Health and Social Services Trusts to identify if there were concerns, significant prevalence or similar findings within any other mental health or learning disability inpatient hospital.

The DHSSPS required the retrospective sampling exercise to focus on those people most at risk especially minors (children under the age of 18 years) admitted to mental health and learning disability hospitals over a twenty year period between 1985 and 2005. A 10% sample of relevant files was agreed.

The retrospective sampling exercise encompassed long stay wards in adult mental health hospitals, learning disability hospitals (excluding Muckamore Abbey –ospital which had already been reviewed) and regional child and adolescent inpatient mental health services (which included a specific investigation of Lissue and Forster Green Hospitals commissioned by the EHSSB and latterly the Health and Social Care Board (HSCB) as a result of a complaint detailing serious allegations made when the above exercise was being planned).

Each Trust was asked to follow the methodology applied in the Muckamore Abbey Review which characterised the incidents as follows:

- Category 1: Sexualised behaviour between adult and minor
- Category 1a: Sexualised behaviour between minor and minor
- Category 2: Sexualised behaviour between adult and adult (non-consenting)
- Category 3: Sexualised behaviour between adult and adult (consent unclear)
- Category 4: Sexualised behaviour (consenting)
- Category 5: Suspected sexualised activity (general details unknown)
- Category 6: Physical abuse involving actual bodily harm and above
- Category 7: Sexualised behaviour query significance
- Category 8: Issues noted and dealt with thoroughly using recognised procedures

Between April 2008 and August 2009 eight reports were submitted to the DHSSPS covering ten sites. In late 2011 these reports and other reporting documents (thirteen in total) were handed over by the DHSSPS to the PSNI for further investigation under Operation Danzin.

The PSNI analysis noted that in some of the reported incidents no further police action was required. Other incidents required more detailed information to enable the PSNI to determine what further action, if any, was required.

It was also evident from the PSNI analytical review that the scale and scope of the sampling had been interpreted by Trusts in different ways. This resulted in significant inconsistencies and variances in both methodology and sampling applied within the commissioned reports.

The DHSSPS subsequently requested that the HSCB and PSNI review the retrospective sampling process. The purpose of this review was to provide assurance to the DHSSPS that, where incidents of abuse were noted in the retrospective sampling exercise reports, these had been appropriately identified and dealt with.

After a series of discussions with the DHSSPS, HSCB and PSNI it was agreed to set up a Strategic Management Group (SMG) in accordance with the Protocol for Joint Investigation of Alleged and Suspected Cases of Child Abuse in Northern Ireland (2004), Although established under the provisions of the Protocol in relation to children, in this case the remit of the SMG was extended to include vulnerable adults.

2. STRATEGIC MANAGEMENT GROUP

The SMG was chaired by Fionnuala McAndrew, Director of Social Care and Children, HSCB and Brian Hanna, Detective Superintendent, Serious Crime Branch, PSNI.

The terms of reference for the SMG are included in Appendix 1

A list of members of the SMG is contained in Appendix 2.

The SMG met for the first time on 25 April 2012, and met on a total of 5 occasions. A calendar of meetings is attached in Appendix 3.

The SMG ensured the active cooperation and coordination of all relevant agencies, agreed a joint communication plan (See Appendix 4) and a Human Resources flowchart (See Appendix 5) to assist in the review process. At each meeting of the SMG progress was reviewed. It was agreed that at the conclusion of the SMG process a report would be submitted which addresses the key issues that emerged from the review of the retrospective sampling exercise.

The SMG set up two subgroups to progress the work, one in relation to adult services and the other in relation to children's services.

Each sub-group met on a number of occasions and the terms of reference of each sub-group are contained in Appendix 6 (Adults) and Appendix 7 (Children's).

Health and Social Care Trusts identified senior members of staff to participate in both the Children's and Adults' Sub-groups. They completed audit documentation in relation to either the Children's or Adults Sub-groups on behalf of the Trust and also acted as key liaison individuals in reviewing the information presented within each of the Trust reports.

The PSNI identified a Detective Inspector who participated in both the Children's and Adults Sub-groups and provided advice and guidance in relation to the potential for criminal proceedings in specific cases.

Given the complexity and number of facilities which were subject to the review, members of both the SMG and the relevant sub-groups signed a "Declaration of Interest" indicating whether or not they had managerial or any other type of involvement with the various facilities during the time period under investigation.

A copy of the Declaration of Interest pro forma is included at Appendix 8.

3. HISTORICAL INSTITUTIONAL ABUSE INQUIRY

On 31 May 2012 the First Minister and Deputy First Minister announced an Inquiry into historical institutional abuse in Northern Ireland. The Northern Ireland Executive Inquiry and Investigation into –istorical Institutional Abuse Inquiry (HIAI) will examine if there were systematic failings by institutions or the state in their duties towards those children in their care between the years 1922 – 1995.

The Inquiry and Investigation will take the form of

- An Acknowledgement Forum;
- A Research and Investigative Team; and
- An Inquiry and Investigation Panel with a statutory power which will submit a Report to the First Minister and the Deputy First Minister.

A number of cases of interest to the –IAI have already been referred to PSNI for investigation.

As the –IAI has indicated that Lissue and Foster Green will be included in its consideration it is anticipated that the SMG report will be made available to the HIAI to assist where possible.

4. METHODOLOGY:

Given the complexity of the previous exercise and the apparent inconsistencies which had been identified by both the DHSSPS and the PSNI, it was agreed that, in order to provide a more consistent analysis of the exercise, the SMG would develop audit templates to quality assure and analyse the available information.

Audit Template 1 was applied across all the original retrospective sampling exercise reports to ensure that any childcare or adult safeguarding concerns have been identified and addressed, either within Trusts policies and procedures and/or Protocols for Joint Investigation processes with the PSNI.

The template considered the following:

1. Has the Trust complied with the initiating request from D–SSPSNI to undertake a retrospective sampling exercise? If not, what gaps have been identified and what steps is the Trust taking to address these gaps?

2. Have individuals identified as victims been referred to the PSNI for further investigation?

3. Have members of staff in any of the institutions about whom concerns have been expressed been subject to police referral and/or referral to the relevant regulatory and/or professional bodies? If so, when and who took lead responsibility for progressing the concerns within the Trusts?

4. Where investigations were completed at the time of the original allegations, was reference made to the relevant policy and procedures as they pertained at that time and were the investigations carried out in line with the legislation, policy and best practice in place at that time?

5. Were appropriate safeguarding arrangements in place in each of the institutions at the time?

6. What actions, if any, has the Trust set in place following the retrospective sampling exercise and how are these being progressed?

A copy of Audit Template 1 is included in Appendix 9.

The SMG also developed **Audit Template 2** which was designed to capture key information across all Trusts and asked:

- Are the terms of reference included in the report?
- Does the report address the timescale 1985-2005?
- Does the report confirm the 10% sample was reviewed?
- How many files were reviewed in total?

- Does the report address children's files?
- Are specific incidents referred to which identify the victims as adults?
- Is an action plan referenced in the report?
- If yes is it available?
- Are any actions outstanding?
- Does the report fully address the terms of reference?

Each Trust was required to complete this audit template in order to provide a consistent analysis across the five Trust areas in relation to the reports that have been produced. A copy of Audit Template 2 is included in Appendix 10.

Finally, the SMG developed **Audit Template 3** in order to capture specific details on individual cases. A copy of Audit Template 3 is included in Appendix 11.

5. ANALYSIS - ADULT SUB-GROUP

Following the establishment of the SMG, the Adult Sub-group met on 7 occasions. In addition, 2 joint meetings were held with the Children's Sub-group.

5.1 Terms of Reference:

The Sub-group has addressed the Terms of Reference agreed by SMG, that is, to:

- Quality assure the retrospective review process and reports in relation to adults;
- Ensure any issues or concerns in relation to individual adults have been actioned appropriately;
- Ensure that any criminal concerns or issues have been referred to PSNI; and
- Ensure that any –uman Resources and regulatory issues have been taken forward by the appropriate Trust or employer.

5.2 Cases involving children:

The initial review of the reports of retrospective sampling exercise indicated that a number of cases involving children had been reported on by adult services. These cases were extracted from the Adult Sub-group return and referred to the Children's Sub-group for their consideration.

5.3 Western HSCT

The retrospective sampling exercise identified 10 incidents where an in-patient or visitor to the hospital may have been subjected to abuse. 1 incident where the victims were noted as being under the age of 18 was passed to the Children's Sub-group for their consideration. Of the adult patients, 6 were identified as female, with gender unspecified for the remainder. All 9 incidents involving adults were described as being of a sexual nature, ranging from alleged indecent exposure to rape.

- 3 incidents occurred in Mourne House (a unit for people with learning disabilities) and involved the same alleged perpetrator ;
- 3 incidents involved patients in the Tyrone and Fermanagh –ospital. One of these patients made 2 allegations of abuse;
- 2 incidents were reported from Gransha –ospital; and
- 1 incident did not indicate which facility was involved.

In all 9 cases, these matters were referred to the PSNI at the time of the original retrospective sampling exercise. 7 were subsequently noted as requiring no further police action, and 2 required further police consideration.

All but one case was closed following review by the PSNI. This case required police investigation but, following careful consideration the victim was assessed as being unfit to engage in any criminal or other investigative process. The case has now been closed by the PSNI.

No members of staff were named as either alleged perpetrators or victims in any of these allegations.

SMG can, therefore, be satisfied that in relation to the retrospective sampling exercise in the Western Trust:

- any issues or concerns identified in relation to individual adults have been actioned appropriately; either
  - At the time of the original incident;
  - As a result of the retrospective sampling exercises; or
  - As a result of the SMG review process
- any criminal concerns or issues identified were referred to PSNI; and
- no Human Resources or regulatory body issues were identified

5.4 South Eastern HSCT

The methodology adopted by the South Eastern Trust at the time of the retrospective sampling exercise identified a total of 45 incidents for consideration. 39 of these involved patients identified as female, 4 were male, and the patient's gender was unspecified in 2 cases. 1 incident involving a child was referred to the Children's Sub-group for their consideration.

All incidents were categorised as of a sexual nature, ranging from allegations of common assault and indecent exposure to gross indecency. All incidents were reported from the Downshire Hospital.

- 39 of the total of 45 incidents involved 10 alleged perpetrators. Of these, 3 were involved in 2 separate incidents; 3 individuals were involved in 3 separate incidents; 1 was involved in 4 incidents; 1 was involved in 5 incidents; 1 was involved in 6 alleged incidents and 1 was involved in a total of 9 incidents;
- 6 patients alleged that they had been subjected to unwanted sexual advances on more than 1 occasion, ranging from 2 to 8 incidents;
- 1 incident involved the alleged rape of a 76 year old woman. This was reported to the police at the time, and was subject to an initial police investigation. Unfortunately however, due to the circumstances of the offence and the frailty of the victim, it was not possible to pursue a criminal investigation any further;

- Records indicated that on 7 occasions, staff members were subjected to alleged sexual assaults by patients.

No members of staff were named as alleged perpetrators in any of these incidents.

Following the SMG review, a total of 38 incidents, including those incidents where staff may have been subjected to assault, were passed to the PSNI for review. On review of the full papers, all but 5 of these were closed.

Of these 5, which were deemed to require police investigation, 3 have been closed as, following careful consideration, the victims have been assessed as being unfit to engage in any criminal or investigative process. The other 2 relate to cases where the victims are staff members rather than patients and identification details are required to progress the matters any further.

The Trust states that no specific Down Lisburn Trust policies covering the early period of the original retrospective sampling exercise were found, with the earliest extant policies dating from 2002.

Reference was also made by the Trust review team to Eastern Health and Social Services Board policies that were extant in the mid years of the audit, i.e. E–SSB Guidance on Abuse of Vulnerable Adults (1996 and 1997).

SMG can, therefore, be satisfied that in relation to the retrospective sampling exercise in the South Eastern Trust:

- any issues or concerns identified in relation to individual adults have been actioned appropriately; either
  - At the time of the original incident;
  - As a result of the retrospective sampling exercises; or
  - As a result of the SMG review process
- any criminal concerns or issues identified have been referred to PSNI; and
- no Human Resources or regulatory body issues were identified

5.5 Northern HSCT

Due to problems with the original methodology, the Northern Trust took the decision to review all available patients notes considered as part of the retrospective sampling exercise, with the exception of one young person where the Trust could not identify the original incident. This re-audit identified 10 incidents involving adults which required further consideration. 1 of these patients was identified as male. All incidents were categorised as of a sexual nature and were reported from Holywell Hospital.

- An additional incident was identified which involved a 17 year old. To date the Trust has not been able to trace the identity of this young person. Nevertheless, this was referred to the Children's Sub-group for their consideration.
- In 3 of these incidents it is alleged that a member of Trust staff was involved.
- In 1 incident the staff member was named. Trust records show that this incident was investigated on the ward at the time, in that the patient was interviewed by a Consultant Psychiatrist and a Senior Nurse. No contact was made with the PSNI, and the allegation was withdrawn by the patient on the same day. The Trust review team has not been able to find any record either of the allegation or any subsequent investigation.
  The member of staff named was not subject to any internal disciplinary processes, and remained in employment. The staff member resigned from the Trust to work for another provider, but was re-employed by the Trust shortly afterwards. He has since worked in a variety of roles within the Trust, including the provision of community-based care. This matter has now been investigated by the PSNI and the Trust under the Protocol for the Joint Investigation of Cases of Alleged and Suspected Cases of the Abuse of Vulnerable Adults (2009) and the relevant Human Resources procedures. Both investigations have now concluded and no further action will be taken.

The PSNI reviewed a total of 7 incidents. Upon full review, only one case required police investigation. This has now been investigated by the police and has been closed.

SMG can, therefore, be satisfied that in relation to the retrospective sampling exercise in the Northern Trust:

- any issues or concerns identified in relation to individual adults have been actioned appropriately; either
  - At the time of the original incident;
  - As a result of the retrospective sampling exercises; or
  - As a result of the SMG review process
- any criminal concerns or issues identified have been referred to PSNI; and
- any –uman Resources and regulatory issues identified have been taken forward by the Trust.

5.6 Belfast HSCT

The retrospective sampling exercise identified a total of 8 incidents for further consideration, all of which were reported from Knockbracken Healthcare Park. Of these, 5 were categorised as physical, 2 of a sexual nature and 1 case of theft. 6 patients were female.

It was noted that 6 incidents appeared to involve 5 children under the age of 18 years. All of these were referred to the Children's Sub-group for consideration.

One allegation of physical assault was reported to the PSNI and investigated at the time of the incident.

The retrospective sampling exercise also identified one incident which involved the suspected theft of a patient's handbag. Records indicate that this was not referred to the PSNI but was dealt with within the hospital. The PSNI have indicated that no further action is required in relation to this matter.

No members of staff were named or identified as alleged perpetrators in any of these incidents.

SMG can, therefore, be satisfied that in relation to the retrospective sampling exercise in the Belfast Trust:

- any issues or concerns identified in relation to individual adults have been actioned appropriately; either
  - At the time of the original incident;
  - As a result of the retrospective sampling exercises; or
  - As a result of the SMG review process
- any criminal concerns or issues identified have been referred to PSNI; and
- no Human resources or regulatory issues were identified.

5.7 Southern HSCT

The retrospective sampling exercise in relation to adult patients identified a total of **14** incidents for further consideration. 13 of these were drawn from wards in Longstone Hospital (a facility for people with learning disabilities) and 1 was from St Luke's Hospital. 10 cases were categorised as being of a sexual nature, 1 of a physical nature and 3 were uncategorised. 8 cases involved male patients, 2 involved females and in 4 cases the gender of the patient was not specified.

- One incident of physical assault involved a member of staff. The matter was referred to the police. The staff member was subsequently dismissed and was later convicted of assault occasioning actual bodily harm. The individual had been employed as a Nursing Assistant and so was not a member of any regulatory or professional body.
- 1 female patient alleged she had been abused on more than 1 occasion. Insufficient detail is available within the records to clarify if either of these incidents constituted a crime
- 1 male patient alleged he had been abused on 2 occasions. One incident involved an allegation of physical assault resulted in a prosecution and conviction of a staff member. The records do not contain sufficient detail of the second incident to assess if a possible crime may have been committed.

- The retrospective analysis indicates that 3 cases were subject to Strategy Discussions under the Protocol for the Joint Investigation of Alleged and Suspected Cases of Abuse of Vulnerable Adults. However, the outcome of those discussions is not recorded in the hospital notes.

Two incidents remain outstanding, none of which involved members of Trust staff as either alleged perpetrator or victim. In both cases, the alleged abuse occurred within the patients' homes prior to their admission to hospital and, as such, fall outside the remit of the retrospective sampling exercise. However, the Trust and the PSNI continue to work together to investigate these incidents and this work is almost complete.

The Trust notes that the original retrospective sampling report did not make any comment on whether the practice noted was in accordance with policy or best practice guidance at the time.

SMG can, therefore, be satisfied that in relation to the retrospective sampling exercise in the Southern Trust:

- any issues or concerns identified in relation to individual adults have been actioned appropriately; either
  - At the time of the original incident ;
  - As a result of the retrospective sampling exercises; or
  - As a result of the SMG review process
- any criminal concerns or issues identified have been referred to PSNI; and
- any Human Resources and regulatory issues identified have been taken forward by the Trust.

6. ANALYSIS: CHILDREN'S SUB-GROUP

Children identified through information contained within the relevant reports were subject to discussion within the Children's Sub-group and information forwarded to PSNI for their consideration. While the PSNI will report on their deliberations in a separate section of the report (See Chapter 7), it is clear that a number of cases should have been reported to PSNI either at the time of the incident or during the retrospective sampling exercise.

6.1 Western HSC Trust

Only one incident in the Western Trust was reviewed in the retrospective sampling exercise. The incident involved an adult male patient from Tyrone and Fermanagh Hospital in 1989 and involved 2 child victims. The incident was not referred to police but was referred during the retrospective review. The victims were not known to social services and were not referred for social work intervention at the time. The Protocol for Joint investigation only came into place in 1991 and was therefore not relevant. There will be no further investigation as the victims' identities are not known and cannot now be confirmed.

SMG can, therefore, be satisfied that in relation to the retrospective sampling exercise in the Western Trust:

- any issues or concerns identified in relation to individual children have been actioned appropriately; either
  - At the time of the original incident;
  - As a result of the retrospective sampling exercises; or
  - As a result of the SMG review process
- any criminal concerns or issues identified have been referred to PSNI; and
- no –uman Resources or regulatory issues were identified.

6.2 South Eastern HSC Trust

One incident was reviewed under the retrospective sampling exercise which involved sexualised behaviour between an adult patient and a minor. It was reported at the time and police were involved. The alleged offender self-referred to police and subsequently signed the Sex Offenders Register in 1999. The offender was a patient in Downshire Hospital. There is no further follow up required.

SMG can, therefore, be satisfied that in relation to the retrospective sampling exercise in the South Eastern Trust:

- any issues or concerns identified in relation to individual children have been actioned appropriately; either
  - At the time of the original incident;

  - As a result of the retrospective sampling exercises; or
  - As a result of the SMG review process
- any criminal concerns or issues identified have been referred to PSNI; and
- no Human Resources or regulatory issues were identified.

6.3 Northern HSC Trust

One incident was reviewed under the retrospective sampling exercise. The incident involved a 17 year old female patient in –olywell –ospital and involved sexualised behaviour between an adult and a minor. The Trust is unable to identify the original case file so little information is available about the case, and no further information is available that could assist in identifying the case.

In these circumstances therefore, SMG cannot be completely satisfied that in relation to the retrospective sampling exercise in the Northern Trust:

- any issues or concerns identified in relation to individual children have been actioned appropriately; either
  - At the time of the original incident;
  - As a result of the retrospective sampling exercises; or
  - As a result of the SMG review process
- any criminal concerns or issues identified have been referred to PSNI; and
- any Human Resources and regulatory issues identified have been taken forward by the Trust.

6.4 Belfast HSC Trust

At the time of the original retrospective sampling exercise, Belfast Trust reviewed 30 sample incidents, 10 from Lissue Hospital, 10 from Forster Green –ospital and 10 from the Young People's Centre. The audit was undertaken by 2 senior staff from outside the Child and Adolescent Mental Health Service (CAMHS). The audit did not include the 8 point classification used by the Muckamore Audit Team and it remains unclear why this classification was not used.

6.4.1 *Lissue Hospital*

The review of 10 cases within Lissue did not present with any new concerns. A number of former patients have, however, already made contact with the PSNI in relation to historical allegations of abuse. These are being investigated by the PSNI and sit outside the SMG process.

6.4.2 *Young People's Centre*

As part of the retrospective sampling exercise the Trust reviewed facility files but did not review fieldwork or other files. 10 cases were reviewed, none of which identified issues of concern from within the facility. 7 of the cases referenced contextual

issues that involved allegations of abuse prior to admission to the Unit. Whilst outside the scope of the SMG these incidents are being reviewed by Trust staff to ensure that any allegations of abuse have been appropriately identified and responded to within agreed protocol and procedures. This includes further discussions with the PSNI to determine if these cases should be referred to the Public Prosecution Service. –SCB will seek assurance from the Trust that this has been completed.

6.4.3 *Forster Green Hospital*

Examination of the files from Forster Green revealed that in all but one case,

concerns were in respect of overall family functioning or allegations of mistreatment within the wider family circle. One file referenced a young person's allegation of sexual mistreatment by a "doctor"- with another young person in the Forster Green site. This allegation was reviewed by the Children's Sub-group.
The Belfast Trust confirmed that this

incident was investigated following the original retrospective sampling exercise. The incident was referred to both the PSNI and the General Medical Council, the professional and regulatory body for doctors. The matter has now been fully addressed and no further action is required.

6.4.4 *Knockbracken Healthcare Park*

As a result of the SMG process, the Belfast Trust identified a further 6 cases in the Knockbracken facility where children and young people may have been involved in incidents which required further investigation. These cases were referred to the PSNI for consideration, and the police concluded that there are no outstanding policing issues and no further police involvement is required. However, it should be noted that while limited information was available to the original retrospective review exercise, the original case papers in relation to these cases were destroyed in line with the procedures and timescales set out in Good Management Good Records (DHSSPS 2011) and so were not available for further inspection and analysis. As a result, additional details of the incidents are unknown and cannot be progressed by any police investigation.

SMG can, therefore, be satisfied that in relation to the retrospective sampling exercise in the Belfast Trust:

- any issues or concerns identified in relation to individual children have been actioned appropriately; either
  - At the time of the original incident; or
  - As a result of the retrospective sampling exercises;
  - As a result of the SMG review process
- any criminal concerns or issues identified have been referred to PSNI; and

- any Human Resources and regulatory issues identified have been taken forward by the Trust.

6.5 Southern HSC Trust

There were 19 incidents identified within the Southern HSCT area involving 10 victims. Two victims were involved in two separate incidents, one was involved in three incidents, and one was involved in 5 separate incidents. 6 of the alleged perpetrators' identities are not known and 13 of the alleged perpetrators are recorded as patients.

- One incident from 1997 involved a staff member. The records indicate that the staff member allegedly discussed pornographic material with a 16 year old (male) patient. This case is being reviewed by police and Trust personnel. The staff member is no longer employed by the Trust. In reviewing the files in relation to this case, the police identified a further allegation by the victim of rape when he was aged 5 and living in a Children's Home This had not been previously reported to Police but is now subject to further investigation by police and Trust personnel. This part of the investigation is not part of the SMG process.

- One alleged perpetrator is involved in two incidents; another is involved in 4 incidents.

- One alleged perpetrator offender is deceased and one victim is believed to be deceased.

- The police are actively reviewing Trust files to further investigate 15 of the incidents to determine if they can be cross referenced and additional information obtained.

- 6 incidents are recorded as category 1 with a further 2 considered as category 1. There are 5 deemed as category 5 with a further 1 considered as category 5. There is one case noted as category 7 and a further case assessed as possibly category 8. There are 3 incidents where it is not recorded.

In a number of the noted incidents the information available to the retrospective sampling exercise was limited. As a consequence, the Trust set up a process to review information contained in other files not considered by the retrospective sampling exercise, such as field work files to determine if further investigations or actions may be required.

Following full review of the available information by the PSNI, 4 cases were identified as requiring police investigation. These 4 cases all involve the same victim. 2 of the cases require additional information from the Trust to enable the PSNI to determine if

any further investigations are required. The remaining 2 have been referred to local PSNI for investigation.

SMG can, therefore, be satisfied that in relation to the retrospective sampling exercise in the Southern Trust:

- any issues or concerns identified in relation to individual children have been actioned appropriately; either
  - At the time of the original incidents a result of the retrospective sampling exercises; or
  - As a result of the SMG review process
- any criminal concerns or issues identified have been referred to PSNI; and
- any Human Resources and regulatory issues identified have been taken forward by the Trust.

7. PSNI ANALYSIS FROM AUDIT RETURNS

The PSNI provided the following report for the SMG:

7.1 Adult Sub-Group

Police were handed documents relating to the Belfast and Western Health & Social Care Trusts on 16th November 2012 during a meeting with Ms Joyce McKee, Regional Adult Safeguarding Officer, Health and Social Care Board. The remainder of the Trusts then submitted reports via email following internal audits.

7.1.1. Belfast Health & Social Care Trust

Belfast Health & Social Care Trust referred 8 cases as part of their audit.

Of these 8 cases 2 (one relating to a physical assault and the other to a theft) were reviewed and no police investigation was required.

The remaining 6 cases all involved a child victim and, as such, were referred to the Children's Sub-group for comment.

7.1.2. Western Health & Social Care Trust

Western Health & Social Care Trust referred 10 cases as part of their audit.

Of these 10 cases only 1 was reported to Police at the time however there were a further 7 cases which contain reference to having been reported to Police at a later date as part of a retrospective review and Police recommended no further action at that stage.

In the remaining 2 cases one case was closed during review. One case was identified as requiring police investigation. However, the victim had been assessed as unfit to engage in any investigation and therefore the case has been closed.

There is 1 case reported by Western Health & Social Care Trust which has been duplicated on the Child return – this case is one of those which were retrospectively reviewed by Police and no further action was recommended.

7.1.3. Southern Health & Social Care Trust

Southern Health & Social Care Trust referred 14 cases as part of their audit.

Of these 14 cases there were 3 cases which had previously been reported to Police and therefore no further report is required.

Following an initial review 8 cases have been identified as requiring further information. Full papers are awaited so that decision can be made as to whether a police investigation is required.

There are also 4 cases included in Southern Health & Social Care Trust's Child Return which involve an adult injured party but where the suspect in the case is a minor. These four cases require further information in order that Police can make a formal decision whether to investigate the matter or not.

7.1.4. South-Eastern Health & Social Care Trust

South-Eastern Health & Social Care Trust referred 45 cases as part of their audit.

Of these 45 cases there were 2 cases which were reported to Police at the time of the alleged offence and therefore no further report is required.

Following an initial review, 38 cases were identified as requiring further information. Papers in these cases have now been reviewed and 5 were identified as requiring police investigation.

Of these 5 cases, 3 have been closed as the victims have been assessed as unfit to engage in any investigative process. The remaining 2 cases involve members of staff as victims rather than patients. Identification and contact details are required to progress these details.

There is one duplication of a case with the Child return. However this was one of the cases which were reported to Police at the time of the alleged offence and therefore no further report is required.

7.1.5. Northern Health & Social Care Trust –

Northern Health & Social Care Trust referred 11 cases as part of their audit.

Of these 11 cases there were 4 cases which were reported to Police at the time of the alleged offence and therefore no further report is required.

There are a remaining 7 cases where further information was required in order that Police could make a formal decision whether to investigate the matter or not. Following this review only one case required police investigation. This was passed to the relevant department and an investigation was initiated. This has now concluded and no further action is required.

7.2 Children Sub-Group

7.2.1 Belfast Health & Social Care Trust

Belfast Health & Social Care Trust referred 6 cases as part of their audit. All of these 6 cases had previously been raised under the Adult SMG return.

Of these 6 cases there was only 1 case reported to Police at the time of the alleged offence and therefore no further action is required.

Papers for the remaining 5 cases have been destroyed and therefore none of these matters could be fully progressed or reviewed. A specific query was raised by Belfast Health & Social Care Trust in relation to a complaint against a doctor attached to Forster Green In-Patient Unit in 1993. A report was prepared as the case had come to light following an audit of files in October/November 2009. The report has been reviewed and no further action is required.

A further 7 cases have been referred from the Young People's Centre. These relate to matters occurring outside of a care environment but which had been reported or disclosed whilst the victims were in care. These cases all require police investigation. However, current contact details need to be confirmed before this matter can be progressed.

7.2.2. Western Health & Social Care Trust

Western Health & Social Care Trust referred 1 case as part of their audit. This case had already been highlighted as part of the Adult return and, whilst the matter was not reported to Police at the time of the alleged offence, the papers comment that the case was the subject of a retrospective review and was discussed with Police at that time and no further action was recommended.

7.2.3. Southern Health & Social Care Trust

Southern Health & Social Care Trust referred 19 incidents as part of their audit. One of these cases has already been highlighted within the Adult return.

Of these 19 incidents there were 3 cases which were reported to Police at the time of the alleged offence and therefore no further report is required (although it is believed one of these may be a duplication).

There are 4 cases included in the return which involve an adult injured party but where the suspect in the case is a minor.

All the referred cases have been reviewed and a police investigation is required in relation to 4 cases. These 4 cases all involve the same victim. 2 of the cases have been referred to the relevant department for investigation and the matters are on-going. The remaining 2 cases await information from the Trust in order to progress.

7.2.4. South-Eastern Health & Social Care Trust

South-Eastern Health & Social Care Trust referred 1 case as part of their audit. This case had already been highlighted as part of the Adult return. The case had previously been reported to Police and therefore no further report is required.

7.2.5. Northern Health & Social Care Trust

No papers were received from Northern Health & Social Care Trust as part of the Child return. However one case was identified within the Adult return involving a

female aged 17 at the time of the alleged offence. This case could not be progressed as no papers were available and therefore no review can be carried out.

7.2.6. Current Investigations

As of 1 January 2013, there are a further 69 cases which have been reported directly to the police or have been referred by the Historical Institutional Abuse Inquiry. All of these cases involve injured parties who were children at the time of the alleged offence(s). The date range of these complaints is far wider than that of the SMG audit, with complaints ranging from 1953 to 2007.

Police decisions on these matters will take into account the evidence and documentation available at this time; the injured party and the time of the alleged offence. There will also be consultation with the Public Prosecution Service and, prior to recommending any prosecution, consideration will be given as to whether it is in the public interest to pursue some of the alleged cases.

8. CHANGES IN POLICY AND PROCEDURES:

The agreed time period for review was a twenty year period between 1985 and 2005. However, some of the incidents considered in the retrospective sampling exercise occurred as far back as 1971, with others having taken place as recently as 2004.

Over that period there have been significant changes in clinical practice as well as legislation, policy and procedures on how to respond to and investigate allegations of abuse.

There has also been recognition that effective treatment and care for people with mental health problems or learning disabilities can be provided in community settings or in smaller group living arrangements. As a result, fewer people are living in or being admitted to mental health and learning disability in-patient facilities.

These and other developments such as improvements in professional and in-service training have contributed to a positive change in the culture of mental health and learning disability in-patient facilities since the 1970s. Both processes and practice across a range of settings and professional groups have been significantly enhanced so as to afford greater protection to children and vulnerable adults. These developments include but are not restricted to:

- The United Nations Convention on the Rights of the Child 1989
- The Children (Northern Ireland) Order 1995, supplementary legislation and associated volumes of guidance
- Revision of D–SSPS Children 'Sharing to Safeguard (Revised HSCC 3/96
- The Human Rights Act 1998
- Co-operating to Safeguard Children (DHSSPS 2003) (currently being revised)
- Protocol for Joint Investigation of Alleged and Suspected Cases of Abuse of Children (2004)
- The Bichard Inquiry Report 2004
- Equal Lives (2005)
- Strategic Framework for Adult Mental Health Services (2005)
- UN Convention on the Rights of People with Disabilities (2006)
- SSI Overview Report 'Our Children and Young People - Our Shared Responsibility' (Dec. 2006) ("SSI Overview Report 2006")
- Safeguarding Vulnerable Adults: Regional Adult Protection Policy and Procedural Guidance (2006)
- Criminal Justice (Northern Ireland) Order 2008 and Guidance on Public Protection Arrangements Northern Ireland (NIO) 2008
- Independent Review Report on Agency Involvement with Mr Arthur McElhill, Ms Lorraine McGovern and their Children - Henry Toner QC (June 2008)
- The Sexual Offences (NI) Order 2008
- Understanding the Needs of Children in Northern Ireland (UNOCINI) D–SSPS 2008

- The Protection of Children in England - A Progress Report - Lord Laming (March 2009)
- Protocol for Joint Investigation of Alleged and Suspected Cases of Abuse of Vulnerable Adults (2009)
- Adult Safeguarding in Northern Ireland: Regional and Local Partnership Arrangements (2010)
- Manual of Practice: Public Protection Arrangements in Northern Ireland (December 2010)
- Reporting and Follow up of Serious Adverse Incidents (HSCB 2010)
- Achieving Best Evidence Guidance on interviewing victims and witnesses, the use of special measures, and the provision of the pre-trial therapy (2011)
- Justice Act (Northern Ireland) 2011
- Records Management: Good Management Good Records (DHSSPS 2011)
- Safeguarding Board for Northern Ireland - Policy Framework Safeguarding Board (Northern Ireland) Act 2011
- RQIA Review of the Effectiveness of the Safeguarding Arrangements in place for Children and Vulnerable Adults in Mental Health and Learning Disability Hospitals in Northern Ireland (2012)

In addition, Trust governance and information management systems now record incidents involving individual service users or staff members and ensure that these are escalated to the appropriate senior managers for action.

9. RECORDS MANAGEMENT

In 2011 the DHSSPS published "Good Records Good Management" as a guide to the required standards of practice in the management of records.

This guidance provides a framework for consistent and effective records management based on advice and publications from the Ministry of Justice and the Public Records Office of Northern Ireland. In establishing this guidance the DHSSPS took account of current practice followed by a wide range of organisations in both the public and private sectors, recommendations emanating from reviews, guidance from professional organisations and bodies, and importantly what the law requires.

"Good Records Good Management" applies to both adult and children's services and to all services, whether delivered in the community or in a hospital, and includes guidance on the retention and destruction of records.

Some of the records from the period of the original retrospective sampling exercise have been destroyed by Trusts in keeping with this guidance. This is particularly relevant in the Northern and South Eastern Trusts.

It also became evident through the work of the SMG that while each service area and specialism maintains its own record of contact with individual service users, these are not routinely cross-referenced. As a result, it is clear that each Trust considered only records from within mental health and learning disability facilities and did not examine individual service user's community-based records. For example, hospital staff were not always aware that a safeguarding investigation was underway in the community, and community staff were not always aware that an allegation of abuse had been made by a hospital in-patient.

Reference has already been made to the lack of formal Terms of Reference for the original retrospective sampling exercise. The SMG acknowledges that, given the time scale for reporting on the original retrospective sampling exercise, it would simply not have been possible for audit teams to examine all records for each individual, even if this had formed part of the original Terms of Reference.

The amount of time that has elapsed and the absence of a central repository of Trust internal operational policies have meant that it has not been possible for the SMG to examine some issues in any detail. For example, issues of ethnicity, race and diversity were not routinely recorded in the 1970's and 80's. It has not, therefore, been possible for the SMG to comment on these areas.

10. SUMMARY OF FINDINGS:

The PSNI and the Adult and Children's Sub-groups reviewed the available information against the Terms of Reference set for the SMG using specially designed audit templates to analyse the information. In relation to each of the Terms of Reference, the Sub-groups would make the following comments:

- Quality assure the retrospective review process and reports in relation to adults

The methodological challenges with the retrospective sampling exercise have already been noted elsewhere and include:

- Inconsistent application of time frames;
- Inconsistent sampling including numbers of cases and records considered;
- Variation in recording of the audit findings; and
- Variation in the analysis of the findings.

A further variation has arisen in relation to the quality assurance of the original sampling exercise and the assessment of whether the actions taken at the time of the original incident were in accordance with best practice. This has varied from a reliance on the knowledge and integrity of the original auditors, through to a complete re-audit of patient files.

The Sub-groups were unable to identify all the policies, procedures, protocols and good practice guidance that regulated practice during the time period considered by the retrospective sampling exercise. A limited list has been compiled, but it is believed to be incomplete. It is therefore difficult to assess whether practice as noted in the contemporaneous notes available to the retrospective sampling exercise, was always in accordance with the policies, procedures and best practice guidance of the time.

- Ensure any issues or concerns in relation to individuals have been actioned appropriately

All issues which have been identified in relation to individuals have been actioned, either:

- At the time of the original incident;
- As a result of the retrospective sampling exercises; or
- As a result of the SMG review process.

These actions included a review by PSNI of any incidents where it is alleged or suspected that a criminal offence may have taken place although a small number of inquiries are continuing. Where appropriate, referral to the relevant Trust Human Resources process or regulatory body.

- Ensure that any criminal concerns or issues have been referred to PSNI

It is clear from the retrospective sampling exercise reports that a number of incidents involving individuals should have been passed to the PSNI for further investigation at the time the incident occurred. Where it has been possible to identify either the victim or the alleged perpetrator, this has now been done. All completed audit templates have been shared with PSNI.

However the PSNI have identified the following challenges in relation to any investigations:

- The criminal law has changed since the timeframe covered by the original sampling exercise and some offences have been de-criminalised;
- Trusts have not been able to identify either the alleged victim or the alleged perpetrators in some cases;
- Due to the lengthy period of time that has elapsed since the alleged incidents took place, it may not be possible to establish if the threshold for criminal activity has been reached;
- A number of the incidents are now statute barred;
- Some of the relevant patient records will have been destroyed in accordance with Records Management: Good Management Good Records (D–SSPS 2011).

- Ensure that any –uman Resources and regulatory issues have been taken forward by the appropriate Trust or employer

Adult Sub-group:

A total of 4 incidents within the Adult Sub- group (1 from the Southern Trust and 3 from the Northern Trust) have been identified where it is alleged that abuse took place and where the alleged perpetrator was a member of Trust staff. These instances of alleged abuse were all identified in patient records at the time of the alleged incident and were highlighted by the retrospective sampling exercise.

In one of these incidents, the staff member concerned was subject to both criminal and employer investigations and was dismissed from Trust employment on conviction.

In one incident, the Trust has determined there are no grounds to take forward an internal disciplinary procedure or for referral to a professional or regulatory body.

However, in 2 incidents (from the Northern Trust), it has not been possible either to identify the alleged perpetrators or victims, or to determine if the conduct warranted referral to a professional or regulatory body. Consequently it has not been possible

for the Trust to take forward any HR or regulatory matters in relation to these individual members of staff.

Children's Sub-group:

A total of 4 incidents within the Children's Sub-group have been identified where it is alleged that abuse took place and where the alleged perpetrator was a member of Trust staff or other statutory organisation.

3 of these were from the Belfast Trust. In one case a referral was made to the relevant regulatory body and Trust HR procedures were implemented. This case is now concluded with no further action required. In two other incidents the allegations were investigated and no further action is required.

1incident from the Southern Trust involved a member of staff who is no longer employed by the Trust.

11. Learning and Next Steps:

The SMG has identified a number of areas of learning through the course of this review.

1) It was difficult to reconcile the processes and methodologies used by the different Trusts in the original retrospective sampling exercise. In any future reviews the following should be considered in order to ensure consistency of reporting:
   - agreed, clear Terms of Reference from the start which set out the required reporting timescales should be available;
   - the establishment of a Monitoring Group (including representation from the PSNI) to oversee the review process and agree the final Report ; and
   - the methodology along with any appropriate audit tools should be based on the Terms of Reference and should be available from the beginning of any investigation.

   The procedures for the establishment of a Strategic Management Group set out in the Protocol for Joint Investigation of Alleged and Suspected Cases of Child Abuse (2004) were particularly helpful for this review, and could be used as a model for any future reviews of this kind.

2) The SMG only considered the findings of the original retrospective sampling exercise which in turn reflected on practice between 1985 and 2005. While there has been significant progress in safeguarding arrangements, processes and practice in the interim period, there is a need for constant vigilance to ensure that the systems in place to protect vulnerable children and adults are as robust as possible. The SMG is aware that the Regulation and Quality Improvement Authority (RQIA) has recently completed an inspection on this theme. The SMG recognises that the HSCB and PHA have a responsibility to ensure that the recommendations contained in the RQIA report "Safeguarding of Children and Vulnerable Adults in Mental Health and Learning Disability Hospitals in Northern Ireland – Overview Report (2013)" are fully implemented. The HSCB and PHA have established a formal reporting process on the implementation of these recommendations, which includes individual reports from and meetings with Trusts, plus a schedule of reports to the DHSSPS.

3) It was apparent that information relating to allegations of abuse during an admission to an in-patient facility was noted on facility files, but it was not clear if these were subject to proper process, including referral to the PSNI under the Joint Protocol arrangements. Nor was it clear from the records that clinical teams in in-patient facilities were always aware of new or continuing safeguarding investigations in community settings. It is important that in all cases other relevant

Trust records, including fieldwork files, Looked After Children records and community services files are cross-referenced so that all relevant information be considered to ensure a more consistent and holistic assessment of a safeguarding concern.

4) The original retrospective sampling exercise considered only 10% of files from the period 1985 to 2005. The SMG recognises that there may be incidents falling outside the audit period or sample size where former patients of mental health or learning disability facilities believe that they were subjected to inappropriate or abusive behaviours during their stay in hospital. The SMG would encourage any former or current patient who feels that they are in this position to contact the PSNI, HSCB or relevant HSC Trust who may then need to consider what actions, if any, may be required. To promote a culture of openness and transparency, it would be necessary to establish a point of contact for individuals and their families or carers who may wish to raise concerns and to have them addressed on an individual level. The promotion of the HIAI will also afford further opportunity for individuals to come forward if they consider that the care afforded to them when in an institution was of an abusive nature and they wish this to be explored further.

5) Throughout this review it has been difficult to access internal legacy Trust and Board policies and procedures which applied at different times throughout the sampling period. A central archive would allow any future inquiry or investigation to access the relevant policies and procedures quickly and easily. This in turn would allow for a clearer and quicker determination as to whether best practice and policy guidance was adhered to at the time. The HSCB will discuss this with the DHSSPS to consider the value of creating such a regional archive

12. CONCLUSIONS:

The Strategic Management Group (SMG) was set up to take forward a specific piece of work, that is, to consider issues arising out of the retrospective sampling report carried out by the 5 Health and Social Care Trusts and to provide assurance to the DHSSPS that, where incidents of alleged abuse were noted in the retrospective sampling reports, these have been appropriately identified and dealt with.

The retrospective sampling exercise encompassed long stay wards in adult mental health hospitals, learning disability hospitals (excluding Muckamore Abbey Hospital) and regional child and adolescent inpatient mental health services and covered the period 1985 - 2005.

To progress this work, the SMG set up two sub-groups, one in relation to adult services and one in relation to children's services. A number of audit tools were devised and applied to the retrospective sampling exercise reports provided by each Health and Social Care Trust. This work is now complete.

The findings from the audit process were analysed by both sub-groups and shared with colleagues in the PSNI. A total of 77 incidents were referred to the PSNI for consideration and comment. Two incidents led to referral to an appropriate regulatory and/or professional body.

In addition, Belfast and Southern Trusts are reviewing additional files that were not part of the original retrospective sampling exercise, to provide assurances that any contextual issues or concerns have been appropriately followed up.

The SMG is able to provide assurance to the DHSSPS that, with one exception in the NHSCT, where incidents of alleged abuse were noted in the retrospective sampling reports, that

- Any issues or concerns in relation to individuals have been actioned appropriately; either
  - At the time of the original incident;
  - As a result of the retrospective sampling exercise; or
  - As a result of the SMG review process
- Any criminal concerns or issues have been referred to PSNI; and
- Any Human Resources and regulatory issues have been taken forward by the appropriate Trust or employer.

APPENDIX 1 – SMG TERMS OF REFERENCE

STRATEGIC MANAGEMENT GROUP

TERMS OF REFERENCE

Introduction

The Department of Health, Social Services and Public Safety (DHSSPS) have engaged in a series of discussions with the Health and Social Care Board (HSCB) to set up a Strategic Management Group (SMG) in accordance with the Protocol for Joint Investigation of Alleged and Suspected Cases of Child Abuse in Northern Ireland (2004) (the Protocol).

Although established under the provisions of the Protocol in relation to children, in this case its remit will be extended to include vulnerable adults.

The SMG will conduct a Review of the work undertaken by the 5 Health and Social Care Trusts (HSCTs) which sampled case records of patients in Mental Health and Learning Disability hospitals in the period 1985 to 2005. The purpose of this limited retrospective sampling exercise was to provide assurance to the DHSSPS that. Where incidents of abuse had occurred in the past, these had been appropriately identified and dealt with.

The Review will also include consideration of the conclusions of investigations relating to Lissue and Forster Green –ospitals.

The Regulation and Quality Improvement Agency (RQIA) have been commissioned by the DHSSPS to review the effectiveness of the current safeguarding arrangements for children and vulnerable adults within Mental Health and Learning Disability –ospitals in the Trusts. The SMG will therefore not address current safeguarding arrangements. The SMG will liaise closely with RQIA to address any potential safeguarding issues which may emerge during the course of its review and

to follow up issues identified in the Overview Report prepared by RQIA at the conclusion of its process.

Definition of Abuse:

The SMG will use the definition of organised abuse contained in the Protocol, and extend the definition to both children and vulnerable adults.

The Protocol defines organised abuse in three main settings, families, communities and institutions. Section 6.3 of the Protocol refers to institutions where an adult or adults, employed in the public, private or public sector, abuses the children he or she works with. Section 6.8 of the Protocol states that:

"Institutional abuse is abuse by adults working in a position of trust, either in an employed or voluntary capacity, in an organisation or association that has responsibility for or provides activities for children. The organisation or association acts as the organisational base bringing adults and children together which provides the opportunity for exploitation by abusers. Institutional abuse often involves abuse of many children over a long period of time".

Membership:

The SMG will be Co-Chaired by the Police Service of Northern Ireland (PSNI) and Health and Social Care Board (HSCB).

Membership will include:-

Fionnuala McAndrew –SCB	Aidan Murray –SCB
Tony Rodgers –SCB	Philip Moore –SCB
Paula Smyth BSO	Alphy Maginnis BSO
Donald Glass PSNI	Paul Darragh PHA
Lesley Walker BHSCT	Marie Roulston N–SCT
Oscar Donnelly N–SCT	Trevor Millar WHSCT
Brice McMurray SHSCT	Michael Hoy SEHSCT

Mary Hinds PHA	Marian Hall HSCB
Brian Hanna PSNI	Kieran Downey WHSCT
Paul Morgan SHSCT	Ian Sutherland SE–SCT
Francis Rice S–SCT	Brendan Whittle SE–SCT

In addition the SMG will extend an invitation to one or more recognised experts from outside Northern Ireland who can also act as independent persons to provide professional oversight and ensure greater transparency during the review.

Functions of the Strategic Management Group

The SMG will fulfil the following functions: -

- Develop policy relating to the Review;
- Establish the principles of the conduct of the Review
- Address the issue of resourcing of the Review which will fall into two categories:-
  - Logistical resources - transport, accommodation, staff cover, etc; and
  - Staff resources –which includes administration support
- Act on a consultative basis to professionals involved in the audit of the retrospective sampling exercise
- Ensure co-ordination between the key agencies, which have an interest in the progress of the Review
- Provide regular updates to the DHSSPS on the progression of the Review
- Draw up a communication strategy.

The SMG will **not** be responsible for any –uman Resource issues that may be identified within any of the institutions involved but will refer these directly to Senior Management in the respective Trusts for consideration and action as appropriate. It will be a matter for Senior Management in those agencies to actively consider referral to regulatory bodies and/or the professional associations of any staff identified during the course of the review about which concerns have been

expressed either in relation to their professional conduct and or ongoing criminal investigations.

Process

The SMG will meet within agreed timescales and as often as deemed necessary to discuss the progress of the Review and will take forward the following: -

a) Consideration of the retrospective sampling exercise undertaken by all five HSC Trusts and identify any particular gaps/issues which may require a further review of particular cases by developing and applying an audit tool.
   The audit template will consider the following:
   1. Have Trusts complied with the initiating request from DHSSPS to undertake a retrospective sampling exercise? If not, what gaps have been identified and what steps is the Trust taking to address these gaps?
   2. Have individuals identified as victims been referred to the PSNI for further investigation?
   3. Have members of staff in any of the institutions about whom concerns have been expressed been subject to police referral and/or referral to the relevant regulatory and/or professional bodies? If so when and who took lead responsibility for progressing the concerns within the Trusts?
   4. Were investigations completed at the time allegations were made with reference to policy and procedures as they pertained at the time and were they in line with extant legislation, policy and best practice at the time?
   5. Were safeguarding arrangements appropriate in each of the institutions at the time?
   6. What actions if any have Trusts set in place following the retrospective sampling exercise and how are these being progressed?
b) The information technology and administrative support in order to take forward the investigation; and
c) Identify any specialist advice which is required such as legal, medical, psychiatric, cultural or special needs;

Children and adults who may require support and who are identified through the process of this review will be offered support and/ or counseling by an appropriate

organization. Any children or adults named by others, regardless of whether they have made statements or not, who may require individual help will be offered support or advice as appropriate. Individuals, both victims and alleged perpetrators, may also be referred to PSNI who will be responsible for undertaking any criminal investigations

It is recognised that the Review cuts across a number of Trust and PSNI boundaries and the following key points will be considered at all times.

- The continuing safety of children and vulnerable adults;
- Appropriate sharing of information; and
- Lack of contamination of evidence.

The SMG will ensure that lines of communication are well established between the Review Work Groups and the Trusts that have carried out the retrospective sampling exercise and which have responsibility for Lissue and Forster Green –ospitals.

At each meeting the SMG will:

- Review progress
- Review all aspects of the strategy
- Provide advice on the appropriate strategic direction;
- Ensure the continuing active co-operation of all relevant agencies;
- Agree a joint approach to media interest; and
- Produce an accurate record of all meetings held.

In particular, the SMG will consider the following:

- The aims of the investigation: -
  - Protection of Children and vulnerable adults
  - Identification of possible criminal offences
  - Evidence gathering; and
  - Consideration of other possible victims.
- The context of the investigation: -
  - The culture of the institutions
  - Ethnicity, race and diversity issues

- Consideration of resource implications;
- Possible community interest and reaction;
- Media/union/professional association interest; and
- Public profile/status of alleged abuser(s) or victim(s).

- Handling Information: -
  - Arrangements for handling information obtained in the Review
  - Managing confidentiality; and
  - The need to make other organizations aware of abuse allegations concerning their staff in order that they can take steps necessary for child or vulnerable adult protection within their respective organizations and otherHuman Resource considerations where appropriate.

Work Groups

Two work groups will be established to consider issues relevant to adult and children's services arising from the retrospective sampling exercise and the Lissue and Forster Green –ospital reports, and will make comment on the quality and appropriateness of Trust responses.

Welfare Principle

As with all investigations of abuse of children or vulnerable adults, care must be taken to ensure that the welfare of the child and vulnerable adult remains paramount. Whilst the gathering of criminal evidence is important, it must not be to the detriment of any child or vulnerable adult's welfare. Although investigations to establish the standard of evidence for criminal proceedings are important, the need to protect the child or vulnerable adult, which requires a lesser standard of proof, should not be delayed. Individual/group support to children, vulnerable adults and their families as appropriate should always be considered.

The SMG recognises that whilst some children may have been subjected to abuse or inappropriate treatment, they are now adults and may not wish to have or require ongoing social work involvement. All cases in which abuse is suspected will be referred to PSNI for criminal investigation.

Conclusion

At the conclusion of the Review the SMG will meet to discuss the salient features of the Review and make recommendations for improvements either in policy or in practice. Recommendations should be communicated to the Chair of the Regional Child Protection Committee (RCPC) or Safeguarding Board for Northern Ireland (SBNI) (if established), the Chair of the Northern Ireland Adult Safeguarding Partnership and the PSNI for further consideration and any necessary action.

A written report will also be sent by the SMG to the DHSSPS to inform future strategic and policy developments.

APPENDIX 2 –SMG MEMBERSHIP:

Fionnuala McAndrew, –SCB Co-Chair
Brian Hanna, PSNI, Co-Chair
Tony Rodgers, HSCB
Paula Smyth, BSO
Donald Glass, PSNI
Lesley Walker, BHSCT (subsequently replaced by Cecil Worthington)
Oscar Donnelly, NHSCT
Bryce McMurray, SHSCT
Aiden Murray, HSCB
Phillip Moore, HSCB
Alphy Maginness, BSO (Legal Department)
Paul Darragh, PHA
Cecil Worthington, NHSCT (subsequently replaced by Marie Roulston)
Trevor Millar, WHSCT
Michael Hoy, SEHSCT
Mary Hinds, PHA
Paul Morgan, SHSCT
Francis Rice, SHSCT (subsequently replaced by Miceal Crilly)
Marian Hall, HSCB
John Doherty, WHSCT (Later replaced by Kieran Downey)
Ian Sutherland, SEHSCT
Don Bradley, SEHSCT

In attendance:

Martin Quinn, HSCB
Joyce McKee, HSCB

APPENDIX 3 – SMG CALENDAR OF MEETINGS:

The SMG met on the following occasions:

- Wednesday 25 April 2012
- Friday 21 September 2012
- Friday 23 November 2012
- Thursday 24 January 2013
- Thursday 21 March 2013

ADULT SUB-GROUP: MEETING DATES

- 9 July 2012
- 14 September 2012
- 9 November 2012
- 7 December 2012
- January 2013
- 1 February 2013
- 29 March 2013

CHILDREN'S SUB-GROUP: MEETING DATES

- 22 August 2012
- 25 September 2012
- 26 October 2012
- 27 November 2012
- 19 December 2012
- 22 January 2013

- 21 February 2013
- 25 March 2013

ADULT AND CHILDREN'S SUB-GROUPS: JOINT MEETING DATES

- 12 October 2012
- 19 December 2012

APPENDIX 4 – COMMUNICATIONS PLAN

Strategic Management Group – Communications Plan

Introduction

The Department of Health, Social Services and Public Safety (DHSSPS) have engaged in a series of discussions with the Health and Social Care Board (HSCB) to set up a Strategic Management Group (SMG) in accordance with the Protocol for Joint Investigation of Alleged and Suspected Cases of Child Abuse in Northern Ireland (2004) (the Protocol).

Although established under the provisions of the Protocol in relation to children, in this case its remit will be extended to include vulnerable adults.

There is intense public concern surrounding the issue of organised and institutional abuse. It is essential that there is an effective communications strategy in place which ensures that information is released into the public domain in a timely, balanced, victim centred and appropriate way.

This will require a co-ordinated approach with all relevant organisations including the SCB, Police Service of Northern Ireland (PSNI) and HSC Trusts.

The historical abuse inquiry due to commence in the Autumn and other associated pieces of work may have an impact on this plan, so there will also need to be a close link with OFMDFM, DOJ and DHSSPSNI in relation to a co-ordinated communications approach.

It is important that the communications plan remains fluid and is developed as the work of the Strategic Management Group (SMG) progresses.

The purpose of this brief plan is to provide a very broad template from which to start the communication process; a list of the key stakeholders; communications options and a list of the key information needed in due course.

Objectives

The communications plan aims to:

- Support the overall aims and objectives of the Strategic Management Group

- Provide a co-ordinated communications approach with key partners.

- Ensure that no information is released into the public domain that will compromise or prejudice enquiries.

- Ensure that as far as possible all communications are sensitive to the needs of victims and where appropriate ensure that victims are briefed on any statements being issued into the public domain.

- Provide wider public reassurance that all appropriate steps are being taken by the SMG, within their remit, to effectively address issues relating to children and adults.

- To build confidence in the Strategic Management Group which will be essential for ensuring the review and any investigations are as effective as possible.

- To monitor all media and social media coverage and stakeholder statements, and effectively address any concerns at an early stage; providing necessary information and reassurance; and where the criticism is unfair, inaccurate and unfounded to robustly rebut it.

Partners and Stakeholders

Below is a list of key partners and stakeholders – the list is not exhaustive and can be added to as the work of the SMG progresses.

Key partners

- Health and Social Care Board
- Police Service of Northern Ireland

- HSC Trusts
- DHSSPSNI
- Dept of Justice
- Office of First and Deputy First Minister
- Regulation and Quality Improvement Authority
- Safeguarding Board Northern Ireland
- Public Health Agency

Key Stakeholders

- Victims
- Victim Groups
- Staff
- General public
- Local politicians
- Health Committee
- Justice Committee
- Local and national media
- NI Social Care Council
- Religious organisations
- Statutory organisations
- Charity organisations
- Regional Voluntary and Community Organisations
- Independent Contractors
- Trade Unions
- Care Providers
- BMA

- RCN

Key Communications channels

It is essential that there is effective communication both internally and externally to ensure that staff, stakeholders, and the public are kept fully informed as appropriate.

Whilst not exhaustive communications options include:

Internal

- Intranet
- Email
- Staff Publications
- Face to face briefings

External

- Media Briefings
- Press releases
- Interviews/feature articles
- Lines against enquiry
- E-briefings for stakeholders
- Updates on websites
- Briefings for Health and Justice Committees
- Assembly written and oral statements
- Letters to the editor

Key Communication Principles:

- The PSNI have primacy over all communications in relation to specific investigations. This is essential in ensuring that nothing is issued that could potentially jeopardise an investigation.

- Each organisation should identify a senior representative to approve media statements and lead on interviews as required.

- It is essential that all media enquiries, interview bids and any responses are shared amongst all relevant partner organisations.

Action Points

In order to ensure that we have an effective communications plan in place the following information will be required from the SMG as and when available:

- As appropriate and following close liaison with PSNI, details of alleged offences under investigation, including any protection issues.

- Where appropriate a brief on safeguarding and investigative steps taken at the time the offences occurred.

- Where appropriate a brief on safeguarding arrangements in place now to minimise the risk of this occurring again. There will also be a need to explain how these arrangements compare to protocols and polices in place at the time of any alleged abuse.

- As appropriate and following close liaison with PSNI, details of any progress in the investigation, arrests, charges, court appearances.

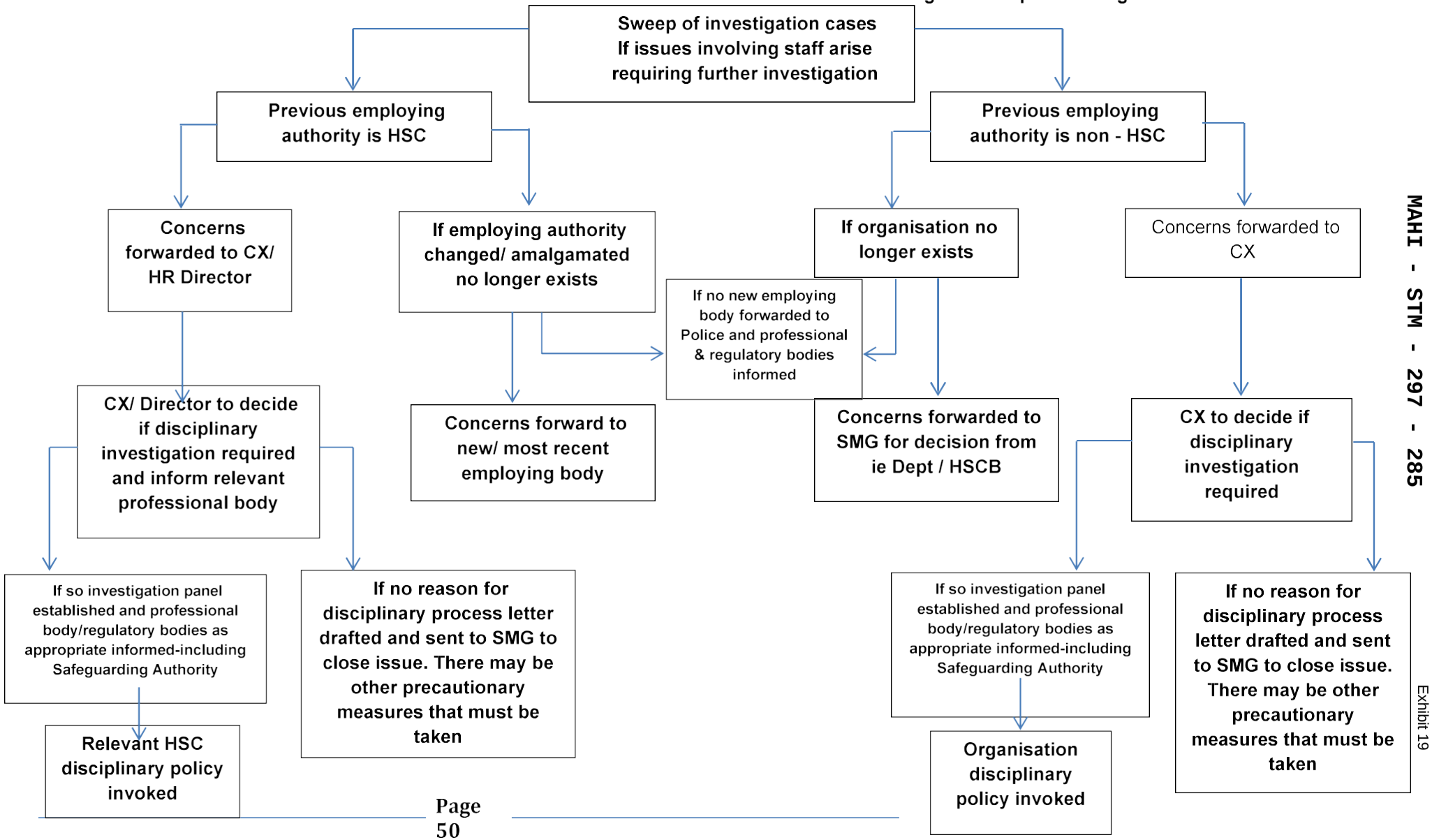
Next steps

SMG to advise on timings for communications activity. At this stage a detailed timetable of communications activity will need to be developed and agreed by all the relevant partner organisations.

APPENDIX 5 – HR PROTOCOL

HR Protocol for Non – Criminal Actions

This Protocol is established for non -criminal issues for all HSC staff discovered during the sweep of investigation cases.



APPENDIX 6 – ADULT SUB-GROUP TERMS OF REFERENCE

STRATEGIC MANAGEMENT GROUP

ADULT SUB- GROUP TERMS OF REFERENCE

Background:

- The Department of Health Social Services and Public Safety (DHSSPS) is engaged in on-going discussions with the Health and Social Care Board (HSCB) in relation to the establishment of a Strategic Management Group (SMG) in accordance with the Protocol for Joint Investigation of Alleged and Suspected Cases of Child Abuse in Northern Ireland.
- Although established under the provisions of the Protocol in relation to children, in this instance the SMG's remit extends to consideration of how to proceed with regard to any concerns that may arise in relation to the historic care of vulnerable adults emerging from the recent retrospective sampling work undertaken by each of the 5 Health and Social Care Trusts (HSCT).
- In order to ensure optimal co-ordination at a regional level, Social Services input is from the HSCB and the Police Service for Northern Ireland (PSNI) involvement is provided at a Detective Superintendent level.
- The SMG has established two sub-groups to take forward the work in relation to adults and children. The Sub-groups are chaired by the HSCB Adult Safeguarding Officer and Children's Safeguarding Officer respectively.

Purpose of Adult Sub-group:

The purpose of the Adult Sub-group is to:

- Quality assure the retrospective review processes and reports in relation to adults;
- Ensure any issues or concerns in relation to individual adults have been actioned appropriately;
- Ensure that any criminal concerns or issues have been referred to the PSNI; and

- Ensure that any Human Resources and professional regulatory issues have been taken forward by the appropriate Trust or employer

Regulation and Quality Improvement Agency:

- The Regulation and Quality Improvement Agency (RQIA) have been commissioned by the DHSSPS to carry out a review of the effectiveness of current safeguarding arrangements within Mental Health and Learning Disability Hospitals in the five HSCTs.
- This review will become the baseline to assure HSCB of the effectiveness of current safeguarding arrangements in these facilities, and formal discussions with RQIA are required to clarify this process.

Reporting Arrangements:

The Chair of the Adult Sub-group will report directly to the SMG on the sub-group's deliberations on an on-going basis and will, at a minimum, provide written reports to each SMG meeting.

The Chair of the Adult Sub-group will also contribute to the final report which will be submitted by the SMG to the DHSSPS, PSNI, SBNI and NIASP.

Membership of the Adult Sub-group:

J McKee (HSCB) Chair	
T Millar (WHSCT)	M Ó Maoláin (SHCT)
J Veitch (BHSCT)	T Fleming (NHSCT)
M Mannion (BHSCT)	M Mitchell (BHSCT)
D Bradley (SEHSCT)	D/I Stephen Wilson PSNI

APPENDIX 7 – CHILDREN'S SUB-GROUP TERMS OF REFERENCE

STRATEGIC MANAGEMENT GROUP

CHILDREN'S SUB- GROUP TERMS OF REFERENCE

Background:

- The Department of Health Social Services and Public Safety (DHSSPS) is engaged in on-going discussions with the Health and Social Care Board (HSCB) in relation to the establishment of a Strategic Management Group (SMG) in accordance with the Protocol for Joint Investigation of Alleged and Suspected Cases of Child Abuse in Northern Ireland.
- Although established under the provisions of the Protocol in relation to children, in this instance the SMG's remit extends to consideration of how to proceed with regard to any concerns that may arise in relation to the historic care of vulnerable adults emerging from the recent retrospective sampling work undertaken by each of the 5 Health and Social Care Trusts (HSCT).
- In order to ensure optimal co-ordination at a regional level, Social Services input is from the HSCB and the Police Service for Northern Ireland (PSNI) involvement is provided at a Detective Superintendent level.
- The SMG is the appropriate vehicle to co-ordinate (a response to)(joint investigations of)any cases of a child protection nature which may emerge from the forthcoming Historical Abuse Inquiry to be set up by the Office of the First and Deputy First Minister.
- The SMG has established two sub-groups to take forward the work in relation to adults and children. The Sub-groups are chaired by the HSCB Adult Safeguarding Officer and Children's Safeguarding Officer respectively.

Purpose of Children's Sub-group:

The purpose of the Children's Sub-group is to:

- Quality assure the retrospective review processes and reports in relation to children;

- Ensure any issues or concerns in relation to individual children have been actioned appropriately;
- Ensure that any criminal concerns or issues have been referred to the PSNI; and
- Ensure that any Human Resources issues have been taken forward by the appropriate Trust or employer

Regulation and Quality Improvement Agency:

- The Regulation and Quality Improvement Agency (RQIA) have been commissioned by the DHSSPS to carry out a review of the effectiveness of current safeguarding arrangements within Mental Health and Learning Disability Hospitals in the five HSCTs.
- This review will become the baseline to assure HSCB of the effectiveness of current safeguarding arrangements in these facilities, and formal discussions with RQIA are required to clarify this process.

Reporting Arrangements:

- The Chair of the Children's Sub-group will report directly to the SMG on the sub-group's deliberations on an on-going basis and will, at a minimum, provide written reports to each SMG meeting.
- The Chair of the Children's Sub-group will also contribute to the final report which will be submitted by the SMG to the DHSSPS, PSNI, SBNI and NIASP.

APPENDIX 8 – DECLARATION OF INTERESTS PRO FORMA

SMG DECLARATION AND REGISTER OF INTERESTS

QUESTIONNAIRE

Name: _____

Have you had direct professional responsibility (as a practitioner or manager) in any of the following facilities?

	Yes / No	If "Yes" please give dates:
Lissue Hospital		
Forster Green Hospital		
Young People's Centre		
Stradreagh Hospital		
Tyrone and Fermanagh Hospital		
Gransha Hospital		
Knockbracken / Purdysburn Hospital		
Longstone Hospital		
St Luke's Hospital		
Holywell Hospital		
Downshire Hospital		

Have you any connections* with any of the following facilities?

	Yes / No	If "Yes" please give dates:
Lissue Hospital		
Forster Green Hospital		
Young People's Centre		
Stradreagh Hospital		
Tyrone and Fermanagh		

Hospital		
Gransha Hospital		
Knockbracken / Purdysburn Hospital		
Longstone Hospital		
St Luke's Hospital		
Holywell Hospital		
Downshire Hospital		

*The DHSSPS has no firm definition of "connection"; however it states that you should declare any relationship which could be deemed to influence your views on any matter which may be discussed by the SMG.

Signed: _____ **Date: _____**

Title: ____ **Organisation: _____**

APPENDIX 9 – AUDIT TEMPLATE 1

Strategic Management Group (SMG) Audit Template

1. Background

A retrospective review of patient files within Muckamore Abbey was completed by the Eastern Health and Social Services Board between2005 and 2009 following a patient complaint.

This led to the Department of Health and Social Services and Public Safety (DHSSPS) instigating a retrospective sampling exercise across all five Health and Social Care Trusts (HSCTs) to identify if there were concerns or significant prevalence of similar findings within any other mental health or learning disability in-patient hospitals within Northern Ireland.

It was agreed in June 2007 that the sampling exercise should focus on those most at risk, especially minors/children admitted to mental health and learning disability hospitals over a 20 year period 1985-2005. A 10% sampling of relevant files was agreed. Each –SCT was asked to follow the methodology applied in the Muckamore Abbey review which categorised the incidents as follows: -

Category 1 -	Sexualised behaviour between Adult/Minor
Category 1 (A) -	Sexualised behaviour between Minor/Minor
Category 2 -	Sexualised behaviour between Adult/Adult (Non-Consenting)
Category 3 -	Sexualised behaviour between Adult/Adult (Consent unclear)
Category 4 -	Sexualised behaviour (Consenting)
Category 5 -	Suspected sexualised activity (General details unknown)
Category 6 -	Physical abuse involving actual bodily harm and above
Category 7 -	Sexualised behaviour – query significance

Category 8 - Issues noted – dealt with thoroughly using recognised procedures

Between April 2008 and August 2009, 8 reports were submitted covering 10 sites. In late 2011 these reports and other reporting documents, 13 in total, were handed over to the PSNI for further investigation.

It was evident from the analytical review of the available information that the scale and scope of the sampling had been interpreted by –SCTs in different ways and this resulted in significant inconsistencies and variances in both methodology and sampling applied within the commissioned reports.

2. Terms of Reference

Fionnuala McAndrew, Director of Social Care, Health and Social Care Board requested a template be developed for the Senior Management Group (SMG) to address the following key areas:-

- What was the expectation at the time of responding to the described scenarios?
- What legislation policy and practice guidance was in place?
- Were the responses in line with expectations of best practice at the time?
- Was there appropriate liaison with police and child or adult protection services?
- Are there any situations that require further investigation by the PSNI?

The PSNI carried out an investigative analysis report to determine if additional information was required for the PSNI to carry out its investigation and noted the following gaps in the submitted reports:

TRUST/HOSPITIAL	DATES 1985-2005		SIZE / %	CHILDREN	ADULTS		INCIDENT DETAILS
EASTERN – Lissue, Foster Green	1970-1979 1990-1999	NOT CLEAR	NOT CLEAR	YES	NO	NO	YES

WESTERN – Stradreagh	YES	YES	10%	YES	YES	YES	YES
WESTERN – Tyrone & Fermanagh, Gransha	YES	YES	37%	NO	YES	YES	YES
BELFAST - Knockbracken	1970-1986	NO	20% + 6	YES	YES	NO	YES
SOUTHERN – Longstone	YES	NOT CLEAR	25% + 10	YES	NO	NO	NO
SOUTHERN - St Luke's, Craigavon	YES	NOT CLEAR	25%	YES	NO	NO	LIMITED
Holywell	YES	NOT CLEAR	10%	NOT CLEAR	NOT CLEAR	YES	LIMITED
SOUTH EASTERN – Downshire	YES	YES	10%	NO	YES	YES	LIMITED

The PSNI report made the following comments: -

1. It is not possible to put a figure on the number of incidents reported on. This is due to some of the –SCTs reporting a number of incidents and others stating the number of patients affected.
2. It is not always clear where the patients involved are adults or children this means that the assessment of incident if criminal is difficult.
3. The lack of incident detail in some reports has made it difficult to make basic assessments of what has happened, when and where it happened and who was involved.
4. Information including patient names (whether perpetrator or victim), dates of birth, date of incident or whether the incident was reported to the police is not always recorded.
5. It has not been possible to complete the network analysis or analyse whether problems exist in particular wards or under certain staff members.

6. The main focus of many of the reports is on the process and policies that were in place at the time of the incidents and whether these were adhered to. They appear to overlook the vulnerable victims and perpetrators in some cases failed to emphasise the incidents where the police should have been involved and fully investigate why they were not.
7. In some of the reports it has been stated the police have advised on the findings of the report and are of the opinion that nothing further can be done.
8. There is no further information on who was consulted and whether these incidents were formally cleared.
9. Minutes of the reports assume a level of knowledge of the remit and the layout of the institution.

The police go on to identify information which is required in order to progress the analysis. The police indicate that much of the information required would have been captured at the time of completion of the individual reports and may still be readily available if the research has been retained.

Audit Template

TRUST:	**HOSPITAL SITE:**
REFERENCES: (Source Material, attached copies if possible)	
INCIDENT DATE:	**INCIDENT LOCATION:**
VICTIM:	**ALLEGED PERPETRATOR :**
Name or Unique Reference	Name or Unique Reference
Gender: MALE/FEMALE	Gender: MALE/FEMALE
DOB or Age:	DOB or Age:
Status (e.g. Inpatient, Outpatient, Staff, Other)	Status (e.g. Inpatient, Outpatient, Staff, Other)
RELEVANT LEGISLATION, POLICY AND PRACTICE GUIDANCE AT THE TIME:	
WERE THE RESPONES IN LINE WITH EXPECTATIONS OF BEST PRACTICE AT THAT TIME?	
CATEGORY	**Tick which is appropriate**

1. Sexualised behaviour between Adult/Minor	
1A. Sexualised behaviour between Minor/Minor	
2. Sexualised behaviour between Adult/Adult (Non-Consenting)	
3. Sexualised behaviour between Adult/Adult (Consent unclear)	
4. Sexualised behaviour (Consenting)	
5. Suspected sexualised activity (General details unknown)	
6. Physical abuse involving actual bodily harm and above	
7. Sexualised behaviour – query significance	
8. Issues noted – dealt with thoroughly using recognised procedures	
POLICE INVOLVEMENT	
Reported to Police	YES/NO
Police Advice	YES/NO
Further Details (e.g. Outcomes if known, Police Contact)	YES/NO
SOCIAL SERVICES INVOLVEMENT:	
Reported to Social Services	YES/NO
Social Services Advice	YES/NO
Further Details (eg Outcomes if known, referral to counselling, support services etc)	YES/NO

FORM COMPLETED BY:	
Name:	Job Title:
Signature:	Date:

APPENDIX 10 – AUDIT TEMPLATE 2

Strategic Management Group Audit Template 2

Name of Report	
Trust Name	
Signed off by	

Are the Terms of Reference included in the report?	☐	☐
Does the report address the timescale 1985 – 2005? If not what dates are covered?	☐	☐
Does the report confirm that a 10% sample was reviewed?	☐	☐
How many files were reviewed in total?	☐	
Does the report address children's files?	☐	☐
Are specific incidents referred to which identify either victims or adults? If yes can you complete template 2 for each case/file.	☐	☐
Is an Action Plan referenced in the report? If yes, is it available?	☐ ☐	☐ ☐
Are any actions outstanding? (Please attach a copy of Trust Action Plan)	☐	☐
Does the report fully address the Terms of Reference?	☐	☐
Comments		

APPENDIX 11 – AUDIT TEMPLATE 3

Strategic Management Group (SMG)

Monitoring Template – Audit Template 3

PSNI [i]					Social Services [ii]				
Initials or Identifying Reference	Nature of Alleged Offence	Statement of Complaint Yes/No	Investigating Officer	Update	Referred to Trust Yes/No *(if No enter N/A below)*		Lead Officer	Update	Criminal /
						Date of Referral			

APPENDIX 12 - SUB-GROUP MEMBERSHIP

Membership of the Adult Sub-group:

J McKee (HSCB) Chair	
T Millar (WHSCT)	M Ó Maoláin (SHCT)
M Mitchell (BHSCT)	T Fleming (NHSCT)
M Mannion (BHSCT)	D/I S Wilson (PSNI)
B Rhodes (SEHSCT)	

Membership of the Children's Sub-group:

M Quinn (HSCB) Chair	M Logan (S–SCT)
T Cassidy (WHSCT)	J Fenton (N–SCT)
T McAllister (B–SCT)	D/I S Wilson (PSNI)
A Garland (SE–SCT)	U Turbett (PHA)