RQIA Independent Review of The McDermott Brothers' Case

November 2010

Contents

		Page
	Glossary of Terms	**i**
	Acknowledgement	**ii**
1.0	**Foreword and Executive Summary**	**1**
2.0	**The Regulation and Quality Improvement Authority**	**7**
3.0	**Terms of Reference**	**8**
4.0	**Methodology**	**9**
5.0	**Context**	**10**
6.0	**Description of Chronology of Events - McDermott Case**	**12**
7.0	**Findings**	**28**
7.1	Child Protection	29
7.2	Contribution to Public Protection Arrangements	33
7.3	Provision of Care and Treatment to the McDermott Brothers	36
7.4	Roles in Relation to Survivors of Sexual Abuse	41
7.5	Responsibilities in Relation to the Criminal Justice System	45
7.6	Responsibilities in Relation to Supervision and Treatment Orders (STOs)	50
7.7	Governance, including Coordination and Communication	55
8.0	**Conclusions and Recommendations**	**59**
9.0	**Appendix**	**64**

Glossary of Terms

CJI	Criminal Justice Inspection Northern Ireland
DHSSPS	Department of Health, Social Services and Public Safety
FMO	Forensic Medical Officer
GAA	Gaelic Athletic Association
GP	General Practitioner
HSC	Health and Social Care
IQ	Intelligence Quotient
LAPPP	Local Area Public Protection Panel
MASRAM	Multi Agency Sex Offender Risk Assessment and Management
MP	Member of Parliament
NICTS	Northern Ireland Courts and Tribunals Service
NIPS	Northern Ireland Prison Service
PACE	Police and Criminal Evidence Act 1984
PBNI	Probation Board for Northern Ireland
PSNI	Police Service of Northern Ireland
PPANI	Public Protection Arrangements for Northern Ireland
PPS	Public Prosecution Service for Northern Ireland
PPSA	Programme for the Prevention of Sexual Abuse
PPU	Public Protection Unit
RQIA	Regulation and Quality Improvement Authority
SOPO	Sexual Offices Prevention Order
SOSCARE	Social Services Client Administration and Retrieval Environment
STO	Supervision and Treatment Order
UNOCINI	Understanding the Needs of Children in Northern Ireland
WHSCT	Western Health and Social Care Trust

Acknowledgement

The Regulation and Quality Improvement Authority (RQIA) wishes to thank all those who assisted our Independent Review of the McDermott Brothers' Case.

RQIA appreciates that this has been a most challenging and difficult time for the survivors and their families. We thank the survivors who shared their experiences with representatives of RQIA during the review.

We also thank the Donagh Community Forum who met with representatives of RQIA and Criminal Justice Inspection (CJI) in Donagh on 25 October 2010. This meeting provided RQIA with a clear understanding of the geography of Donagh, and helped to provide a context to the views of the survivors and the wider Donagh community.

RQIA acknowledges the contribution of individual staff in a range of organisations during the review. These include: the Western Health and Social Care Trust; the Department of Health Social Services and Public Safety; Health and Social Care Board; and Northern Ireland Courts and Tribunals Service.

RQIA also acknowledge the specific advice on public protection arrangements in a health and social care context from Mr Nick Robinson, Principal Officer and PPANI lead in the Northern Health and Social Care Trust.

RQIA liaised closely with CJI on certain aspects of this review and we thank our colleagues for their cooperation.

1.0 Foreword and Executive Summary

James Francis, John Michael, Peter Paul, and Owen Roe McDermott were brothers who were raised in Donagh, a small rural community in Co. Fermanagh. The four brothers resided at the same address in Donagh, sharing a home with two of their adult sisters. On 1 May 2008 complaints were made to the PSNI about each of the four brothers by a number of individuals. These complaints centred on allegations of serious sexual assault and associated violence committed against male and female children.

It was apparent as the investigation progressed that the abuse of children had spanned a period from 1967 to 2001. A total of six survivors, all adults, made complaints to the police in the four month period from May to August 2008.

Following their arrest in July 2008, James Francis and Owen Roe McDermott were identified as potentially having a learning disability. This was later confirmed by a range of assessments by professionals within the Western Health and Social Care Trust (WHSCT). Similar assessments were also made by other independent professionals as part of criminal proceedings. The brothers had not been previously known to the learning disability service in the WHSCT.

On 6 October 2009, James Francis and Owen Roe McDermott attended Dungannon Crown Court, but were deemed by the court to be unfit to plead. This was followed by a trial of the facts at which both brothers were found to have committed the offences with which they had been charged.

At a disposal hearing in Omagh Crown Court on 18 June 2010, James Francis and Owen Roe McDermott each received a Supervision and Treatment Order (STO) for two years, with the supervising officer being named as a social worker from the WHSCT. The brothers were also made subject to Sexual Offences Prevention Orders (SOPO) for life. Both brothers are required to notify as sex offenders for the rest of their lives. Following the court proceedings both James Francis and Owen Roe McDermott returned to the family home in Donagh.

On the same date, John McDermott, who had pleaded guilty to a number of the offences was sentenced with a Custody Prevention Order of nine years, three years probation, a disqualification order and a SOPO for life. He is also required to notify as a sex offender for the rest of his life. John McDermott is currently serving a prison sentence.

Peter Paul McDermott pleaded not guilty to the charges made against him. On the 5 May 2010, the day following the commencement of his separate trial, he committed suicide.

Following the disposal hearing of James Francis and Owen Roe McDermott and their continued residence in the family home in Donagh, a number of the survivors and their representatives in the community expressed concern at the outcome of the criminal proceedings. These concerns related to a

number of factors, including the continued proximity of the men to children in the village. It was notable that the family home is close to the village playground, playgroup and after schools club. The survivors were also concerned at the outcome of proceedings based on the seriousness of the charges and offences.

At a range of public meetings in July and September 2010, involving criminal justice agencies and the WHSCT, the community and their political representatives questioned the organisations about the outcome and the perceived failings of the system in respect of this case. Further discussions were held at separate and joint evidence sessions of the Northern Ireland Assembly health, social services and public safety and justice committees.

On 30 September 2010, the Department of Health, Social Services and Public Safety (DHSSPS) commissioned the Regulation and Quality Improvement Authority (RQIA) to undertake an independent review of the WHSCT duties and responsibilities in relation to the WHSCT's involvement with the McDermott brothers (James Francis and Owen Roe McDermott) and with the survivors. The review was commissioned under the provisions of article 35(1)(b) of The Health and Personal Social Services (Quality, Improvement and Regulation)(Northern Ireland) Order 2003.

On 20 September 2010 the Minister of Justice requested Criminal Justice Inspection Northern Ireland (CJI) to undertake an inspection of how the criminal justice agencies had fulfilled their responsibilities in respect of sexual abuse cases involving the McDermott brothers. CJI was asked to provide a report. The aim of its inspection was to examine the effectiveness of justice agencies in dealing with the sexual offence cases up to the point of disposal.

It should be noted that whilst both of these reviews deal with the same case, they were commissioned separately by The Department of Health Social Services and Public Safety (DHSSPS) and the Department of Justice (DOJ), and have distinct and separate terms of reference. In order to minimise any further negative impact on the survivors of the abuse or the community of Donagh, both RQIA and CJI worked collaboratively when communicating with these groups.

Throughout this review RQIA has had a regard for impact of the abuse on the survivors as perpetrated by the McDermott brothers. As a result, RQIA planned for an engagement with survivors and their advocates at the earliest stage in this review. In that period RQIA, in conjunction with CJI, met with the survivors and their supporters on three occasions.

The period of four weeks set for this review did not allow for a comprehensive analysis of the impact on survivors. The report does not attempt to address all of the concerns expressed by those we met, but does aim to give a balanced view in detailing the role and responsibilities of the WHSCT in respect of the case.

It also outlines from the start that whilst the WHSCT has a number of key responsibilities, there are limitations to its role in the identification, care and support of survivors, unless they are referred or self refer to its services. RQIA, whilst not explicitly referencing the impact of the case on survivors in each section of the report was continuously mindful of how each key phase might have contributed to the palpable loss of confidence in the system; a view that was strongly expressed to us in all three of our exchanges with survivors.

The review outlines the complexity of the case and the key interchange that exists between criminal law and mental health legislation. RQIA aims to express the findings in such a way as to encourage future improvements in the health and social care system and across the interface of all of the agencies involved. RQIA is also mindful that the outcome of this review should aim to address its other core activities; keeping people informed, safeguarding the rights of all people using health and social care services and influencing policy.

It is evident that the WHSCT has duties that span a range of statutes. These include the provision of care and protection for children and vulnerable adults within its geographical boundary, and also a duty for the care and treatment of individuals identified to them as having a mental disorder or learning disability.

In ensuring that the terms of reference for this review have been properly addressed, RQIA examined in detail the full range of clinical and care records of the brothers; the full range of management communications and directives within the service; and, communication to and from other agencies and organisations associated with the case. This information was further validated through interviews with the range of WHSCT officers involved in the case.

RQIA concluded that the WHSCT has met the requirements of relevant legislation and policy in its supervision, care and treatment of James Francis and Owen Roe McDermott, and its governance and management arrangements relevant to the case.

With regard to child protection, RQIA found that the WHSCT had acted within the legislative framework governing child protection. In recognition of the distress caused to those associated with the case, the Gateway team discharged its statutory responsibilities around child protection in a sensitive and empathetic manner. This included a strategy for engagement with the community on child protection. A specific issue was identified in relation to the assessment of child protection risks in a relevant area of organised social activity. A recommendation has been made on how this should be addressed in the future.

One area for improvement centred on the potential for vital communication between the Gateway team and local schools to have been compromised during school holidays. As a result, a recommendation is made to address this issue on a regional basis.

RQIA considers that, in general, WHSCT contributed appropriately to the Public Protection Arrangements for Northern Ireland (PPANI) arrangements in this case, through the work of the WHSCT's Principal Officer. An initial lack of awareness of the role of the new PPANI arrangements across the organisation did not adversely impact on the response of the organisation to the PPANI process. A recognised need to ensure effective collaboration in this case after the brothers were designated at Category 1 was subsequently addressed by the WHSCT establishing a multiagency core group.

From the initial assessments of the brothers as having learning disabilities up to 30 September 2010, it was evident that WHSCT had provided the full range of care and treatment services to James Francis and Owen Roe McDermott, in keeping with their assessed needs.

RQIA recognised that the many issues surrounding this complex case have created significant difficulties in delivering care and treatment to the brothers and their immediate family. RQIA commends the professionalism and integrity of all staff involved in the care and treatment of the brothers, which was evidenced during this review.

It was evident that, during the early period after the disposal hearing, there was a lack of clarity within the WHSCT as to its duties and powers in relation to the STOs which had been imposed by the court. This lack of clarity led to actions which, in retrospect, were not fully appropriate. This led to the WHSCT instigating daily supervision and the issuing of a direction to the brothers to be admitted to hospital. RQIA considers that neither of these actions were appropriate in the circumstances.

RQIA found that following the admission of the brothers to hospital on a voluntary basis, the supervising officer continued to exercise her responsibilities in relation to the STOs up to 30 September 2010, the endpoint for this review. She maintained contact with the brothers in hospital and also with family members in Donagh.

The WHSCT has a key responsibility for good governance, which includes effective communication with a wide range of relevant stakeholders. The management of the McDermott case has been complex for WHSCT and has required sensitive handling and communication. The WHSCT has had to ensure it upholds its duties under the Mental Health (Northern Ireland) Order 1986 and its obligations to protect children and vulnerable adults. It must be recognised that the WHSCT in its communication with the community and in other public forums must maintain its legal duty of confidentiality for those in its care. RQIA considers that within the governance arrangements, risks were managed at appropriate levels. Issues and concerns in relation to the case were shared and discussed at the WHSCT's Senior Management team and the WHSCT Board. The WHSCT maintained continuous and open lines of communication with the Health and Social Care Board and DHSSPS.

In assessing the actions of the WHSCT in relation to communication with the survivors, and the provision of services to support them, RQIA found that

some of the survivors had strongly held negative views of the WHSCT's response to their needs for individual care and support. There is an obligation on all health and social care trusts, as part of a multiagency response, to engage more proactively with survivors of sexual abuse, and to ensure that survivors know how to access services.

RQIA recognises that the WHSCT met with the Donagh community and was mindful of its duty of confidentiality and the limitations of the powers available to it under the STOs.

It was evident that the WHSCT did provide additional funding to NEXUS in relation to an increase in demand for its services from the Donagh area. NEXUS services were welcomed by those survivors who had accessed them, although the period for which services could be provided was considered to be too short. RQIA recognises that there were no specific referrals to the trust's services from PSNI. It may not have been entirely clear to the survivors and to the community representatives that some of the counselling services provided by voluntary organisations are commissioned by the trust to act on its behalf.

A recommendation has been made on developing effective, multiagency mechanisms to disseminate information about available services to survivors of sexual abuse as early as possible following disclosure of a complaint to the PSNI.

RQIA considers that the WHSCT's specific engagement with other agencies, through the formal multiagency public protection processes under PPANI, was effective.

It was also evident that the WHSCT fulfilled its responsibilities in relation to the criminal justice system. It provided an appropriate adult service when requested and responded appropriately to a court direction to prepare a report to set out the WHSCT's views in relation to disposal. WHSCT staff maintained effective working arrangements at operational level with colleagues from PSNI.

During the course of the review, RQIA identified two areas that require further consideration in the management of this and similar cases in future. As part of its work, RQIA met with members of the wider Donagh community who had organised themselves through the Donagh Community Forum. Some of the survivors of the abuse were also part of that forum. The community is recognised as a key stakeholder. The WHSCT did meet on three occasions following the disposal hearing to clarify issues and concerns held by the community. It was evident from RQIA's discussion with the community that there remains the strongly held view of survivors and the Donagh community that the WHSCT had failed to communicate with them effectively on this case. There is evidence from the outcome of the joint meeting held on 14 September 2010 that the community and the WHSCT both recognised the need for continuing dialogue. RQIA considers that this dialogue will result in a

better understanding as to how the WHSCT can continue to engage effectively with survivors and with the local community in the future.

A further issue that arose through the course of the review was the wide ranging and different understandings of the working and management of STOs. This report aims to bring some clarity to the origins of these orders, noting that they were primarily aimed at providing supervision of care and treatment in a community setting.

It became increasingly clear to RQIA that there should be a detailed review of the experience of health and social care trusts in relation to the role of the Supervising Officer in respect of STOs across Northern Ireland to identify learning points which can be shared across HSC organisations. The outcome of such a review should inform the development of new guidance for HSC organisations on the exercise of responsibilities in relation to STOs.

Having reviewed the actions of the WHSCT, RQIA concluded that the trust has discharged its statutory functions in respect of this case. In line with the terms of reference for this review, RQIA has identified a number of important learning points leading to seven recommendations.

Glenn Houston
Chief Executive and Chairman of the Review Team

2.0 The Regulation and Quality Improvement Authority

Background

The Regulation and Quality Improvement Authority (RQIA) was established in 2005 under The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003. RQIA is the independent body responsible for monitoring and inspecting the quality and availability of health and social care services in Northern Ireland, and encouraging improvements in the quality of those services.

RQIA has a key role in assuring the quality of services provided by the health and social care board, trusts and agencies. This activity is undertaken through specific reviews of clinical and social care governance arrangements within these bodies, as set out in RQIA's Three-Year Review Programme 2009-12.

RQIA also registers and inspects a wide range of health and social care services. Our inspections are based on service specific regulations and minimum care standards, which aim to ensure that both the public and service providers know what quality of service is expected.

With the transfer of duties of the Mental Health Commission to RQIA under the Health and Social Care (Reform) Act (Northern Ireland) 2009, RQIA has a range of responsibilities for people with a mental disorder and those with a learning disability.

RQIA's Corporate Strategy 2009-12 identifies four core activities which are integral to how RQIA undertakes all aspects of its work. These are: improving care; informing the population; safeguarding rights; and influencing policy.

This review has been undertaken under article 35(1)(b) of The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003.

3.0 Terms of Reference

On 30 September 2010, the Department of Health, Social Services and Public Safety (DHSSPS) commissioned an independent review of the Western Health and Social Care Trust's (WHSCT) duties and responsibilities in relation to the McDermott case (James Francis and Owen Roe Mc Dermott). This commissioned Review, under article 35(1)(b) of The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, will cover the time period from the date of arrest of the brothers to 30 September 2010.

The terms of reference of the review are:

1. To describe the discharge of the Western Health and Social Care Trust's statutory duties, and responsibilities in regard to the supervision, care and treatment of James Francis and Owen Roe McDermott from the point at which they were arrested, in relation to offences pertaining to sexual abuse, to 30 September 2010.

2. To describe the actions of the Western Health and Social Care Trust in relation to communication with the survivors of Donagh abuse, and the provision of services to support them.

3. To review the Western Health and Social Care Trust's actions, including governance and management arrangements relating to the supervision, care and treatment of the brothers, taking account of the relevant legislation, policy and guidelines.

4. To examine the effectiveness of the Western Health and Social Care Trust's engagement with other statutory organisations involved in the management of the case, including public protection.

5. To consider other relevant matters that emerge during the course of the review.

6. To identify any learning from the case and make recommendations for health and social care organisations.

7. To identify any learning to further promote joint working with criminal justice agencies in the future management of such cases.

4.0 Methodology

In examining the WHSCT's actions in this review, RQIA appointed a specific review team for the purposes of the review. The team was selected from staff within RQIA who were deemed to have the appropriate knowledge, skills and experience to review the case.

Glenn Houston	Chief Executive RQIA and Chairman of Review
Phelim Quinn	Director of Operations and Chief Nurse Advisor
Dr David Stewart	Director of Service Improvement and Medical Director
Lorna Conn	Inspector/Quality Reviewer
Fiona Goodman	Head of Children's Services Regulation
Virginia McVea	Human Rights Advisor
Audrey Murphy	Mental Health Officer
Philip O'Hara	Children's Services Inspector/Quality Reviewer
Claire Richardson	Project Manager
Malachy Finnegan	Communications Manager
Louise Curran	Administrative Manager
Anne McKibben	Administrative Officer

RQIA carried out an extensive examination of the full range of clinical and care records, which detailed the actions of individual professionals involved in the care and treatment of the McDermott brothers. The team also examined a range of management communications and directives with the service, and communication from other agencies and organisations associated with the case.

The team interviewed a wide range of managers and health and social care professionals involved in the care and treatment of the McDermott brothers and their family.

In examining the WHSCT's role in respect of the survivors of the abuse in this case, RQIA committed to engage actively with the survivors. To avoid the need for survivors to meet separately with both RQIA and Criminal Justice Inspection Northern Ireland (CJI) during the course of the parallel reviews, the two organisations agreed to offer combined meetings with survivors. During the meetings, RQIA asked survivors about their experience of communication with and services received from the WHSCT. Whilst not specific to the terms of reference of the review, RQIA also met with representatives of the Donagh community, some of whom acted as representatives of the survivors during the meetings.

The review commenced following agreement of the terms of reference on 6 October 2010 and was completed on 8 November 2010.

5.0 Context

5.1 James Francis, John Michael, Peter Paul, and Owen Roe McDermott were brothers who were raised in Donagh, a small rural community in Co. Fermanagh. The four brothers resided at the same address in Donagh, sharing a home with two of their adult sisters. On 1 May 2008 complaints were made to the PSNI about each of the four brothers by a number of individuals. These complaints centred on allegations of serious sexual assault and associated violence committed against male and female children.

5.2 It was apparent as the investigation progressed that the abuse of children had spanned a period from 1967 to 2001. A total of six survivors, all adults, made complaints to the police in the four month period from May to August 2008.

5.3 Following their arrest in July 2008, James Francis and Owen Roe McDermott were identified as potentially having a learning disability. This was later confirmed by a range of assessments by professionals within the Western Health and Social Care Trust (WHSCT). Similar assessments were also made by other independent professionals as part of criminal proceedings. The brothers had not been previously known to the learning disability service in the WHSCT.

5.4 On 6 October 2009, James Francis and Owen Roe McDermott attended Dungannon Crown Court, but were deemed by the court to be unfit to plead. This was followed by a trial of the facts at which both brothers were found to have committed the offences with which they had been charged.

5.5 At a disposal hearing in Omagh Crown Court on 18 June 2010, James Francis and Owen Roe McDermott each received a Supervision and Treatment Order (STO) for two years, with the supervising officer being named as a social worker from the WHSCT. The brothers were also made subject to Sexual Offences Prevention Orders (SOPO) for life. Both brothers are required to notify as sex offenders for the rest of their lives. Following the court proceedings both James Francis and Owen Roe McDermott returned to the family home in Donagh.

5.6 On the same date, John McDermott, who had pleaded guilty to a number of the offences was sentenced with a Custody Prevention Order of nine years, three years probation, a disqualification order and a SOPO for life. He is also required to notify as a sex offender for the rest of his life. John McDermott is currently serving a prison sentence.

5.7 Peter Paul McDermott pleaded not guilty to the charges made against him. On the 5 May 2010, the day following the commencement of his separate trial, he committed suicide.

5.8 Following the disposal hearing of James Francis and Owen Roe McDermott and their continued residence in the family home in Donagh, a number of the survivors and their representatives in the community expressed concern at the outcome of the criminal proceedings. These concerns related to a number of factors, including the continued proximity of the men to children in the village. It is notable that the family home is close to the village playground, playgroup and after schools club. The survivors were also concerned at the outcome of proceedings based on the seriousness of the charges and offences.

5.9 At a range of public meetings in July and September 2010, involving criminal justice agencies and the WHSCT, the community and their political representatives questioned the organisations about the outcome and the perceived failings of the system in respect of this case. Further discussions were held at separate and joint evidence sessions of the Northern Ireland Assembly health, social services and public safety and justice committees.

5.10 On 30 September 2010, the Department of Health, Social Services and Public Safety (DHSSPS) commissioned the Regulation and Quality Improvement Authority (RQIA) to undertake an independent review of the WHSCT duties and responsibilities in relation to the WHSCT's involvement with the McDermott brothers (James Francis and Owen Roe McDermott) and with the survivors. The review was commissioned under the provisions of article 35(1) (b) of The Health and Personal Social Services (Quality, Improvement and Regulation)(Northern Ireland) Order 2003.

5.11 On 20 September 2010 the Minister of Justice requested Criminal Justice Inspection Northern Ireland (CJI) to undertake an inspection of how the criminal justice agencies had fulfilled their responsibilities in respect of sexual abuse cases involving the McDermott brothers. CJI was asked to provide a report. The aim of this inspection was to examine the effectiveness of justice agencies in dealing with the sexual offence cases up to the point of disposal.

5.12 It should be noted that whilst both of these reviews deal with the same case, they were commissioned separately by the Department for Health, Social Services and Public Safety (DHSSPS) and the Department of Justice (DOJ), and have distinct and separate terms of reference. In order to minimise any further negative impact on the survivors of the abuse or the community of Donagh, both RQIA and CJI worked collaboratively when communicating with these groups.

6.0 Description of Chronology of Events - McDermott Case

Introduction

On 30 July 2008, a WHSCT social worker was contacted by the Police Service of Northern Ireland (PSNI), in line with standard procedures, to act as an appropriate adult during interviews of James Francis McDermott and Owen Roe McDermott at Enniskillen police station.

This was the first recorded involvement of the WHSCT staff with the two McDermott brothers in relation to their learning disability.

This chronology describes the sequence of involvement of WHSCT in relation to the terms of reference for this review. The chronology has been divided into three time periods:

1. From the first involvement by a WHSCT social worker on 30 July 2008, to a hearing at Dungannon Crown Court on 6 October 2009, when the judge found the two brothers were unfit to plead and adjourned the case for a finding of fact hearing.

2. From 7 October 2009 until the case was concluded at Omagh Crown Court on 18 June 2010 when it was determined by the judge that the two brothers would be subject to supervision and treatment orders for two years and sexual offences prevention orders for life.

3. From 19 June 2010 until 30 September 2010 (the specified end date for consideration by RQIA in the terms of reference for this review).

The chronology has been developed using documentation provided by WHSCT, DHSSPS and the Health and Social Care Board (HSC Board) and from information provided at meetings with relevant WHSCT staff.

6.1 Time Period 1 - From 30 July 2008 to 6 October 2009

6.1.1 On 30 July 2008, a WHSCT social worker was requested by PSNI to attend Enniskillen police station to offer appropriate adult consultation during interviews of James Francis and Owen Roe McDermott. The interview of James Francis McDermott did not proceed at that time, however, Owen Roe McDermott was interviewed twice that day in the presence of the appropriate adult from the WHSCT.

6.1.2 On 31 July 2008, the WHSCT Gateway team received a child protection referral from PSNI in relation to four McDermott brothers, all residing at the same address in Donagh. The Gateway service is the first point of contact for anyone who has a query or concern in relation to child protection or safeguarding.

6.1.3 On 4 August 2008, the WHSCT Gateway team visited the McDermott home and interviewed the four brothers. Details were requested of any children who visited the home or any other children with whom the brothers had contact. The Gateway team then initiated follow-up action in relation to child protection procedures.

6.1.4 On 20 August 2008, a consultant psychiatrist with a special interest in learning disability carried out fitness to be interviewed assessments on James Francis and Owen Roe McDermott at the request of their defence solicitor. He assessed each brother as being unfit to be interviewed. Although the consultant is employed by the WHSCT, the assessments were carried out on a private basis. Having established that the brothers had learning disabilities, he initiated follow-up action with regard to the further assessment and care of the brothers.

6.1.5 On 31 August 2008, the same consultant psychiatrist referred the two brothers to the WHSCT Clinical Psychology Learning Disability team for assessment.

6.1.6 On 3 September 2008, the same consultant psychiatrist asked for James Francis McDermott to be included on the WHSCT informal register of people with a learning disability. The consultant psychiatrist's recollection is that he also requested, or intended to request, that Owen Roe McDermott should be included on the register at that time. On finding that this had not been done, he made a further request and Owen Roe McDermott was then included on the register on 5 August 2009.

6.1.7 On 9 September 2008, a WHSCT social worker was asked by PSNI to attend Enniskillen police station to offer appropriate adult consultation during interviews of James Francis and Owen Roe McDermott. An interview was carried out with Owen Roe McDermott, with the appropriate adult present. However, an interview with James Francis McDermott did not take place, as he was considered unfit for interview at that time.

6.1.8 On 28 September 2008, the WHSCT Adult Learning Disability team received a referral letter concerning James Francis McDermott from his general practitioner (GP).

6.1.9 On 27 November 2008, the WHSCT representative on the Local Area Public Protection Panel (LAPPP) attended a meeting of the panel. The panel considered the cases of James Francis and Owen Roe McDermott. The WHSCT Principal Officer for the Public Protection Arrangements for Northern Ireland (PPANI) advised RQIA about the information he had provided to the meeting. The WHSCT PPANI representative is a trust employee whose key responsibility is to represent the trust's views and services within the PPANI process. The WHSCT Principal Officer for PPANI had informed LAPPP that, in relation to child protection, all Gateway interviews and risk assessments had been completed by that date, except for contact with one member of the extended family. The panel determined that, in relation to public protection, the brothers should each be placed at Category P (Pending). This category is used when further information is being sought from the agencies represented on the panel.

6.1.10 On 29 January 2009, the classification of both brothers was considered again at a meeting of the LAPPP. The WHSCT representative reported that contact had been made with the local playgroup, primary school and after school club. A need had also been identified to contact the chairman of the local hunt club with regard to access by the brothers to young people. The panel determined in relation to public protection that the two brothers should each be placed at Category 2, which is defined as:

"Someone whose previous offending (or current alleged offending in the case of potentially dangerous persons), current behaviour and current circumstances presents clear and identifiable evidence that they could cause serious harm through carrying out a contact sexual or violent offence." (PPANI Guidance to Agencies, May 2008)

6.1.11 On 23 April 2009, the LAPPP met and was advised by the WHSCT representative that agreed actions in relation to child protection had been carried out by the WHSCT. The LAPPP classification for each brother remained at Category 2.

6.1.12 On 9 July 2009, the two brothers were each considered by the LAPPP, which was attended by the WHSCT representative. The panel determined that the brothers should each now be placed at Category 1, which is defined as:

"Someone whose previous offending (or current alleged offending in the case of potentially dangerous persons), current behaviour and current circumstances presents little evidence that they will cause serious harm through carrying out a contact sexual or violent offence." (PPANI Guidance to Agencies, May 2008)

6.1.13 On 5 August 2009, the WHSCT consultant psychiatrist with a special interest in learning disability requested that Owen Roe McDermott should be placed on the WHSCT's informal register of people with a learning disability.

6.1.14 On 6 August 2009, two WHSCT clinical psychologists wrote to the consultant psychiatrist with a special interest in learning disability, to set out the findings of their assessment of James Francis McDermott. They apologised for an 11 month delay, which was stated as being due to staff shortages.

6.1.15 On 6 August 2009, a WHSCT consultant clinical psychologist wrote to the consultant psychiatrist with a special interest in learning disability to set out the findings of the assessment of Owen Roe McDermott. The consultant clinical psychologist apologised for an 11 month delay in carrying out this assessment.

6.1.16 On 17 August 2009, the WHSCT social worker allocated to the cases of the McDermott brothers completed a social circumstances report in response to the referral to learning disability services.

6.1.17 On 7 September 2009, the WHSCT consultant clinical psychologist who had completed the assessment of Owen Roe, referred both brothers to the WHSCT Programme for the Prevention of Sexual Abuse (PPSA) to consider possible therapeutic interventions.

6.1.18 On 18 September 2009, the consultant psychiatrist who had carried out the initial fitness to be interviewed assessments on James Francis and Owen Roe McDermott carried out further assessments of both brothers in relation to fitness to plead. These were performed at the request of the brothers' defence solicitor, on a private basis. The consultant submitted reports on each brother to inform the court. He also submitted the WHSCT psychological assessment reports provided to him on 6 August 2009, as these reports had informed his opinion in relation to fitness to plead. Other clinical reports were provided to the courts which were out-with the responsibilities of the WHSCT.

6.1.19 On 6 October 2009, at Dungannon Crown Court, the judge found James Francis and Owen Roe McDermott to be unfit to plead. The judge adjourned the case for a finding of facts hearing.

6.2 Time Period 2 - From 7 October 2009 to 18 June 2010

6.2.1 On 26 October 2009, a meeting was held between members of the WHSCT Adult Learning Disability team to consider next steps in relation to the care and treatment of James Francis and Owen Roe McDermott following the decision that they were unfit to plead. The action plan from the meeting noted:

- Similar cases and situations would be discussed at the Adult Learning Disability senior management team to ensure coordination of approach.
- WHSCT Family and Childcare team had been informed of the case.
- A preliminary report on the McDermott family's situation had been completed by the assigned social worker. A risk assessment would be required before any consideration of day care for the brothers.
- Possible support was to be sought from PPSA in relation to risk assessment.
- Advice would be sought as to possible treatment services which could be provided by the WHSCT.
- There was a potential need for legal advice prior to the court case and disposal.
- It was confirmed that both brothers were on the WHSCT informal register of people with a learning disability.

6.2.2 On 26 November 2009, a jury at Dungannon Crown Court found that James Francis McDermott and Owen Roe McDermott had committed the acts specified in the offences with which they had been charged.

6.2.3 On 1 December 2009, the Adult Learning Disability team was advised by the PPSA team that specialist assessments should be requested for both James Francis and Owen Roe McDermott from Forensic Learning Disability Services at Muckamore Abbey Hospital.

6.2.4 On 14 December 2009, the solicitors for James Francis and Owen Roe McDermott wrote to the WHSCT consultant psychiatrist with a special interest in learning disability to advise that the brothers would be sentenced on 29 January 2010. The hearing was adjourned and subsequently took place on 18 June 2010. In their letter, the solicitors stated they would require a report from a competent expert to provide an opinion to the court, on behalf of the defendants, as to whether or not they should be regarded as dangerous, within the meaning of the legislation (Mental Health (Northern Ireland) Order 1986) and therefore should be made subject to hospital orders.

6.2.5 On 16 December 2009, the Assistant Director for Adult Learning Disability Services sent a memo to members of the Adult Learning Disability team, setting out actions which would be required to inform the response to the letter from the brothers' solicitors. These actions

would include a multidisciplinary discussion on the care plans for the brothers.

6.2.6 On 23 December 2009, a risk assessment was carried out jointly by the social worker, who had been previously assigned to the family, and a social worker to whom the case was then allocated.

6.2.7 On 8 February 2010, the WHSCT's consultant psychiatrist with a special interest in learning disability was advised in a letter from the PPSA lead of potential experts who could provide a specialist psychological assessment of the brothers. This would help determine the treatment needs of the brothers and the environment in which the treatment would best be conducted. It was considered likely that PPSA staff would be able to provide at least some of the treatment. The letter recommended that it would be important for a meeting to be held involving clinicians and service managers in learning disability and mental health services to plan for such cases in future.

6.2.8 On 18 February 2010, the two brothers were referred by WHSCT to a consultant forensic and clinical psychologist, employed by the Southern Health and Social Care Trust, for a specialist assessment, focusing on risk of sexual offending.

6.2.9 On 9 March 2010, the solicitors for the two brothers wrote to the Northern Ireland Courts and Tribunals Service (NICTS) stating that it would be appropriate to have the views of WHSCT available to the court in relation to possible disposal options under article 50A of the Mental Health (Northern Ireland) Order 1986.

6.2.10 On 30 March 2010, following the application from the solicitors for the McDermott brothers, the NICTS wrote to the Chief Executive of the WHSCT advising that the judge had directed that a report was to be prepared setting out the WHSCT's views.

6.2.11 In April 2010, social history reports were prepared by the social worker assigned to the McDermott brothers for submission to NICTS, to inform the disposal decisions.

6.2.12 On 5 May 2010, Peter Paul McDermott, a brother of James Francis and Owen Roe McDermott, also accused of abuse, committed suicide. He had been living at the family home in Donagh while awaiting trial. The assigned social worker arranged for visits to the family to take place by a Suicide Liaison Officer from the WHSCT Family Liaison Service. The Suicide Liaison Officer made several support visits to the family over subsequent weeks.

6.2.13 On 5 May 2010, the WHSCT received interim specialist forensic assessments of James Francis and Owen Roe McDermott which had been commissioned from a consultant forensic and clinical psychologist.

6.2.14 On 17 and 26 May 2010, multidisciplinary liaison meetings took place involving WHSCT clinicians and managers involved with the case. The meetings included discussion on the preparation of reports for the disposal hearing, and potential care and treatment options for the brothers after the court hearing, depending on the disposal decisions taken.

6.2.15 On 7 June 2010, a report was provided by the WHSCT to NICTS in response to the direction of 30 March 2010. The report stated that the view of the WHSCT was that neither hospital orders nor guardianships were necessary or required to address the identified needs of James Francis and Owen Roe McDermott. The appropriate social and therapeutic interventions could be offered as outlined in the report. Individual social history reports in relation to each brother were attached.

6.2.16 On 10 June 2010, the WHSCT Director of Adult Mental Health and Disability Services wrote to the HSC Board outlining the position in relation to the case. He advised that support from the HSC Board in its role as commissioner may be required if hospital orders were directed by the judge.

6.2.17 On 18 June 2010, the WHSCT officers who attended the disposal hearing at Omagh Crown Court were:

- The consultant psychiatrist with a special interest in learning disability who had prepared a report for the court and who was called as a witness during the hearing.
- The social worker assigned to the McDermott family who had prepared social work reports on each brother. She was not called as a witness, but was asked by the judge if she was prepared to act as a supervising officer for James Francis and Owen Roe McDermott in relation to the issuing of STOs for each brother. She stated her agreement to this request.
- The Head of Adult Learning Disability Community Services.
- The Suicide Liaison Officer who had been supporting the family since the death of Peter Paul McDermott. He attended to provide support to members of the family present in court.

The judge concluded the case and determined that the two brothers would be subject to STOs for two years and sexual offences prevention orders (SOPOs) for life.

6.3 Time Period 3 - From 19 June 2010 to 30 September 2010

6.3.1 On 25 June 2010, the social worker assigned as supervising officer in relation to the STOs, which were now in place, received a copy of the court order. She had already commenced visits to the McDermott family home in relation to her designated role.

6.3.2 On 28 June 2010, a meeting was convened by DHSSPS to discuss the care plan for the brothers. The meeting included representatives of DHSSPS, HSC Board and WHSCT. The actions agreed at the meeting included:

- The WHSCT to provide, by 29 June 2010, an outline of the arrangements in place to ensure the safety of children in the community, the McDermott brothers and their carers.
- The WHSCT to provide an interim care plan by 9 July 2010, and a final comprehensive plan by 30 July 2010, setting out comprehensive arrangements for the management, treatment and care of the McDermott brothers, addressing all of the relevant issues and including the involvement of the other relevant agencies. The plan should specifically address the needs of the victims, the needs of the wider community and access to services of any other victims yet to come forward.
- The WHSCT to seek support from the Probation Board for Northern Ireland (PBNI) and from the PSNI in the management of the case whilst the WHSCT remained the lead organisation.
- Agree formally and in writing the roles and responsibilities of PSNI and include this in the comprehensive care plan, by the end of July 2010.
- The WHSCT to seek legal advice and to consider a further referral to the LAPPP, particularly in relation to the decision to allocate Category 1 status to the McDermott brothers.
- The WHSCT to consider taking legal advice on the appropriateness of the STOs, in particular the designation of the WHSCT as lead organisation.
- The WHSCT to consider the appropriateness of the named social worker at that time and to ensure that professional support was provided.

6.3.3 On 29 June 2010, the WHSCT established a multidisciplinary strategic group to oversee the management of the case with representation from directors, assistant directors and key staff from Adult Learning Disability Services and Children's Services. The group would meet monthly, with a core group to meet weekly. The senior supervising officer would chair the core group with representation from psychiatry, Gateway/family and children intervention, psychology, PPSA, the Suicide Prevention Officer and PSNI. An action plan was established which included:

- Contact to be made with the McDermott family with regard to a possible voluntary admission of the two brothers to a hospital in Northern Ireland for treatment.
- Visits by social services to the McDermott family home to take place on a daily basis.
- Social services to liaise with the McDermott family in relation to support required and to offer carers' assessments.
- The WHSCT to establish a community support plan to provide support and advice to the local population, and signpost onward referral to appropriate specialist services.
- Initiation of vulnerable adult procedures in relation to the two brothers.
- Preparation of an information leaflet for the community in relation to the protection of children and young people, and giving contact details of support services for those who had been victims of abuse.
- Issue of a press release to advise the community of referral pathways to a range of services provided via the WHSCT.

6.3.4 On 29 June 2010, the supervising officer discussed the possibility of hospital admission for treatment of the brothers with family members. They agreed to consider this option, but expressed concern about the possibility of the brothers not subsequently being released from hospital.

6.3.5 On 29 June 2010, WHSCT provided a report to the HSC Board setting out the management arrangements emanating from the recent court order and enclosing the agreed action plan from the meeting held earlier that day.

6.3.6 On 29 June 2010, the WHSCT Director of Adult Mental Health and Learning Disability Services received a message to contact a local councillor who had telephoned when he was at a meeting. He returned the call later that day but the councillor was not then available. The councillor returned his call on 1 July 2010 and the WHSCT director then briefed the councillor on the work being undertaken by the WHSCT at that time in relation to the case. The councillor invited WHSCT representatives to a meeting with the Donagh Community Forum on 5 July 2010 and the director agreed that the WHSCT would attend.

6.3.7 On 1 July 2010, a solicitor wrote on behalf of the WHSCT to the solicitors acting for the McDermott brothers advising that it was the view of the WHSCT that the welfare and treatment of the brothers would be best served at that point in time, by their accommodation in the safe environment of a learning disability unit. The WHSCT's view was that the brothers would be accommodated on a voluntary basis and it confirmed that there was no intention to seek the detention of the brothers under the Mental Health (NI) Order 1986. The letter requested a response by the following day.

6.3.8 On 2 July 2010, WHSCT plans were in place for the brothers to be admitted to a hospital on a voluntary basis. However, a member of the McDermott family intervened and cited the terms of the STOs as giving the brothers the right to remain at home. Following this intervention, the solicitor acting on behalf of the WHSCT, wrote to the solicitor acting for the McDermott brothers. The letter gave notice that by virtue of the terms of the STOs imposed upon the brothers, the supervising officer had determined that, with immediate effect, the brothers were to reside at a named hospital. The letter stated that if the brothers failed to comply with this direction they would be in breach of the terms of the STOs.

6.3.9 On 2 July 2010, the solicitors acting for the McDermott brothers sought leave to apply for a judicial review of the decisions made on 2 July 2010 by the supervising officer and WHSCT in respect of the two brothers. WHSCT was originally advised that the leave hearing would be on 3 July 2010 but it was subsequently listed for on 5 July 2010. The hearing did not proceed, as copies of STOs were not available. However, discussions did take place between legal representatives at the High Court.

6.3.10 On 5 July 2010, following the discussions between the legal representatives at the High Court, the WHSCT's Head of Adult Learning Disability Community Services advised its officers by email that the WHSCT would not now pursue hospital residence for the brothers on the basis of the terms of the STOs. He stated that the legal discussions had given further clarity around the role and responsibility of the WHSCT in relation to the STOs. It was now his understanding that the responsibility of the WHSCT was to monitor and supervise both men in regard to their compliance with the STOs, in the context of its therapeutic interventions as a health and social care agency. He understood that any issues or concerns about safety in the community were a matter for PSNI. If WHSCT officers had associated concerns, they were obliged to liaise with PSNI and other appropriate agencies.

6.3.11 On 5 July 2010, the WHSCT was represented at a meeting of Donagh Community Forum by the Director of Adult Mental Health and Disability Services, the Head of Adult Learning Disability Services and the Principal Practitioner for Child Protection. Representatives of PSNI and the PBNI also attended.

6.3.12 On 8 July 2010, a meeting was convened by the WHSCT Director of Adult Mental Health and Disability Services to brief its officers involved in the case. It was agreed that, following legal advice, the supervision of the McDermott brothers in relation to the STOs would now take place on a once per week basis and that a carers assessment would be offered again to family members. Consideration was to be given regarding child protection advice and guidance for children returning to school in Donagh in September 2010.

6.3.13 On 9 July 2010, the Deputy Secretary of the Social Policy Group at DHSSPS wrote to the Chief Executive of the HSC Board, and copied the letter to the Chief Executive of WHSCT. The letter requested that the HSC Board should work in collaboration with the WHSCT, to agree a comprehensive care plan taking account of the needs of individuals; the needs of the broader community; and, the need to promote access to services for survivors, including any who may yet come forward with allegations of abuse.

6.3.14 On 16 July 2010, the DHSSPS convened a meeting with regard to the case which was attended by the Chief Executive and two directors from the WHSCT. It was agreed that the WHSCT Chief Executive would write to the PBNI to seek an urgent meeting of LAPPP to review the assessed category of risk of the two McDermott brothers.

6.3.15 On 16 July 2010, WHSCT convened the first meeting of a multiagency core group. The terms of reference for the multidisciplinary group were defined as being:

"To oversee and co-ordinate operational service delivery to James Francis and Owen Roe McDermott following the supervision and treatment orders handed down by the Court on 18 June 2010."

6.3.16 On 19 July 2010, the Director of Social Policy Group at DHSSPS wrote to the WHSCT Chief Executive enclosing a list of 26 questions. The questions were directed to both the Minister of Justice and the Minister for Health, Social Services and Public Safety. The list of questions was provided during a meeting, held on 14 July 2010, with some of the survivors of sexual abuse and representatives of the Donagh community. The meeting was chaired by the Minister of Justice and was attended by officers from DHSSPS. The WHSCT was asked to provide a formal response to a number of the questions.

6.3.17 On 19 July 2010, the Chief Executive and other WHSCT representatives attended a public meeting in Donagh organised by the Donagh Community Forum. There were about 200 people in attendance, including local political representatives from different parties and representatives of the media. Members of the McDermott family were also present. During the meeting, WHSCT representatives described their roles in relation to child care issues, support for survivors and welfare and treatment of the brothers. The WHSCT advised those present that it had received legal advice that it would be unlawful for the WHSCT to remove the brothers against their wishes from their home to a hospital setting.

6.3.18 On 20 July 2010, the supervising officer for the STOs visited the McDermott family and, following an assessment of the needs of the brothers and their sisters at that time, made an offer of a period of respite care in a hospital setting for the two brothers. A letter was sent by a solicitor on behalf of the WHSCT to the brothers' solicitor

confirming that the offer of a respite placement and treatment was on the basis of the assessed needs of the brothers. The letter stated that the brothers would be accommodated on a voluntary basis.

6.3.19 On 20 July 2010, WHSCT agreed to a request for funding the cost of installing additional safeguarding measures at the building used by the local playgroup and the after school club in Donagh, which is close to the McDermott family home.

6.3.20 On 21 July 2010, a meeting of relevant WHSCT managers and clinicians was convened to discuss the management arrangements for the immediate admission of the McDermott brothers for respite care and to agree an action plan. A risk assessment of the proposed accommodation was carried out and staffing and care plans put in place. Staff were to be reminded of the WHSCT confidentiality policy with no personal details to be disclosed, except to nominated relatives.

6.3.21 On 21 July 2010, the WHSCT Chief Executive was advised by PSNI that an initial referral to have the LAPPP reconsider the cases of the McDermott brothers had been refused, as PPANI administration considered that they did not meet the criteria for inclusion. PSNI had already made a second referral including additional information. Later that day, the WHSCT Chief Executive wrote to PPANI administration stating that she considered that it was essential and necessary that there was an urgent review of the brothers' categorisation under PPANI and asked that an early meeting of LAPPP take place. She included completed PPANI referral forms in respect of each brother.

6.3.22 On 22 July 2010, the WHSCT Chief Executive received an email from PPANI in relation to her referrals from the previous day. The email advised that the concerns raised by the Chief Executive did not meet the significant concerns threshold as required by the PPANI Manual of Practice. The email also informed the Chief Executive that PPANI does not assess prisoners or hospital patients until a release is planned.

6.3.23 On 22 July 2010, James Francis and Owen Roe McDermott came to hospital and were admitted on a voluntary basis for respite care and treatment.

6.3.24 On 23 July 2010, the WHSCT Chief Executive received a letter from solicitors representing two of the survivors in the case and the Donagh Community Forum. The letter set out perceived problems in the implementation of the STOs, and recommended two options through which they could potentially be strengthened. The first option described was the proposed use of section 49 of the Judicature (Northern Ireland) Act 1978 which enables a crown court judge to vary any order made by the crown court within 56 days of making the order. The second was for the supervising officer to apply to the Petty Sessions Court in Enniskillen for an order amending the STOs. The

letter was copied to the Public Prosecution Service for Northern Ireland (PPS).

6.3.25 On 23 July 2010, the Acting Regional Prosecutor for the PPS wrote to the WHSCT Chief Executive in relation to the letter and asked if the assessment of the brothers had changed and if WHSCT intended to apply to the court to vary the residence condition in the STOs. The PPS letter was not initially received by WHSCT and only came to the trust's attention through a follow-up phone call and a subsequent letter from the PPS sent on 10 August 2010.

6.3.26 On 27 July 2010, a meeting was held to review the inpatient action plan regarding the McDermott brothers.

6.3.27 On 29 July 2010, at a meeting convened by DHSSPS, it was agreed that the WHSCT should include contingency arrangements within the comprehensive management plan which was being developed and that the WHSCT should consider if assistance from the probation service should be sought. The WHSCT representatives advised that information was being prepared in relation to those questions posed at the meeting 14 July 2010 on which it had been asked for comment.

6.3.28 On 2 August 2010, the WHSCT provided its response to the DHSSPS on the questions posed by the Donagh Community Forum at the meeting held on 14 July 2010, which had been chaired by the Minister of Justice.

6.3.29 On 5 August 2010, the WHSCT provided the HSC Board with a comprehensive care plan in relation to the STOs for both James Francis and Owen Roe McDermott.

6.3.30 On 5 August 2010, the consultant forensic and clinical psychologist who had been commissioned by the WHSCT provided final reports on James Francis and Owen Roe McDermott to inform their ongoing treatment.

6.3.31 On 6 August 2010, the McDermott brothers were transferred to alternative accommodation within the hospital site, as concerns had been raised by the families of other patients at the hospital.

6.3.32 On 6 August 2010, the Chief Executive of the HSC Board wrote to the Deputy Secretary DHSSPS, copied to the WHSCT Chief Executive, to state that the HSC Board was content with the WHSCT's comprehensive care plan.

6.3.33 On 9 August 2010, the WHSCT convened a meeting with representatives of PSNI and the HSC Board Regional Child Protection Committee. This was under the auspices of the Cooperating to Safeguard Children, May 2003 (DHSSPS),and the Protocol for Joint Investigation by Social Workers and Police Officers of Alleged and

Suspected Cases of Child Abuse - Northern Ireland, September 2004. The attendees at this meeting concluded that the criteria for organised abuse, as defined with the Protocol for Joint Investigation, were not met in this case.

6.3.34 On 13 August 2010, a solicitor wrote on behalf of WHSCT, in response to the letter (23 July 2010) from the solicitors acting on behalf of two complainants and the Donagh Community Forum (ref 4.3.24). The letter advised that the brothers had agreed to be admitted to hospital. It further advised that the brothers remained subject to PPANI arrangements and the WHSCT would continue to communicate with PSNI in relation to all matters relevant to the circumstances of the brothers.

6.3.35 On 13 August 2010, a solicitor wrote, on behalf of WHSCT, to the Acting Regional Prosecutor for the PPS and advised that the WHSCT view was that an application under section 49 of the Judicature (Northern Ireland) Act 1978 was a matter for the PPS. The letter advised that the WHSCT was continuing to liaise with PSNI in relation to the case.

6.3.36 On 13 August 2010, the multiagency core group met with some revisions to membership to reflect that the brothers were now in hospital.

6.3.37 On 16 August 2010, the Director of Mental Health and Disability Policy at DHSSPS wrote to the WHSCT Chief Executive to advise that it had been noted that a copy of the STO did not include a requirement in relation to residence even though the judge had stipulated in the judgement that "there will be a requirement that you reside at an address approved by your supervising officer". She suggested that the supervising officer should consider bringing this apparent omission to the attention of the crown court clerk.

6.3.38 On 20 August 2010, amended STOs were issued for James Francis and Owen Roe McDermott to include requirements that they reside at an address approved by the supervising officer.

6.3.39 On 27 August 2010, at a meeting convened by DHSSPS, the HSC Board confirmed that its officers had worked closely with the WHSCT in drafting the comprehensive care plan and that the HSC Board role was now in relation to monitoring the delivery of the plan.

6.3.40 On 2 September 2010, the Northern Ireland Assembly Committee for Justice considered the case of the McDermott brothers.

6.3.41 On 8 September 2010, a solicitor acting on behalf of the WHSCT wrote to the solicitors representing two survivors and the Donagh Community Forum in response to further correspondence of 20 August 2010. The letter advised that the WHSCT had very carefully considered the

question of a variation in the existing STOs and had taken senior counsel advice. It was the view of the WHSCT that there had been no relevant change in circumstance since the judgement on 18 June 2010 that would warrant an application for variation of the existing order.

6.3.42 On 9 September 2010, the WHSCT Chief Executive, at the request of the DHSSPS, attended a meeting of the Northern Ireland Assembly Committee for Health, Social Services and Public Safety.

6.3.43 On 14 September 2010, the Donagh Community Forum, facilitated by the MP for Fermanagh and South Tyrone, met with representatives of the WHSCT, HSC Board, PSNI and the Department of Justice. A joint statement was issued on 15 September 2010 reflecting that the meeting had been long, positive and constructive and had helpfully clarified the roles and responsibilities of the statutory agencies. The statement acknowledged the continuing deep hurt felt by the community and stated that all present had agreed to maintain effective lines of communication and, as a priority, they would work together to deal with the complex issues that had been identified as a result of this case.

6.3.44 On 15 September 2010, a letter was issued on behalf of the Lord Chief Justice to the Minister of Justice, in relation to the McDermott case, in light of the ongoing discussion of the case at the Northern Ireland Assembly. The letter included references to the report provided by WHSCT and the oral evidence provided at the court hearing on 18 June 2010.

6.3.45 On 17 September 2010, the multiagency core group met and discussed ongoing management arrangements in relation to the brothers.

6.3.46 On 23 September 2010, the Northern Ireland Assembly's Committee for Health, Social Services and Public Safety and the Committee for Justice held a joint evidence session on the implications of the McDermott case.

6.3.47 On 27 September 2010, the Chairman and Chief Executive of the WHSCT met with one of the survivors regarding the management of the case.

6.3.48 On 30 September 2010, the Northern Ireland Assembly's Committee for Health, Social Services and Public Safety and Committee for Justice held a further joint evidence session on the implications of the McDermott case. The Minister for Health, Social Services and Public Safety advised those present that he had written to the Chief Executive of RQIA to ask RQIA to carry out an independent review of the clinical and social care aspects of the case.

6.3.49 On 30 September 2010, the endpoint for consideration in this review, the McDermott brothers were continuing to receive treatment and care

in hospital and continued to be subject to the following orders and processes:

- STOs with a designated WHSCT social worker as the supervising officer
- Sexual offences prevention orders (SOPOs) with PSNI as the lead agency
- PPANI arrangements where they were each assigned Category 1 with PSNI as the lead agency

7.0 Findings

Introduction

Integrated health and social care trusts in Northern Ireland carry out an extensive range of functions in relation to the provision of treatment and care. The McDermott brothers' case involved a wide range of staff from different teams and professional backgrounds across the WHSCT. In addition to the exercise of its functions as a direct provider of services, the WHSCT also commissions services from the voluntary sector which were relevant in this case.

In preparing this report, RQIA considered seven key roles and responsibilities of the WHSCT as follows:

- child protection
- contribution to public protection arrangements
- provision of care and treatment to the McDermott brothers
- roles in relation to survivors of sexual abuse
- responsibilities in relation to the criminal justice system
- responsibilities in relation to STOs
- governance, including internal coordination and communication

7.1 Child Protection

7.1.1 Social Services Gateway teams are the first point of contact for anyone who has a query or concern in relation to child protection or safeguarding. The DHSSPS issued guidance for trusts in April 2008 around gateway processes, Gateway Services - Processes, Guidance for Northern Ireland Health and Social Care Trusts, April 2008. The Gateway service has responsibility to receive and process referrals through the completion of an initial assessment, Understanding the Needs of Children in Northern Ireland, (UNOCINI). UNOCINI is the regional assessment tool used to facilitate decision making in respect of child protection referrals.

7.1.2 Within the WHSCT the Gateway service is provided by three teams located in Londonderry, Omagh and Enniskillen. Each team consists of social workers and senior practitioners who report to a social work manager. There is a direct reporting line from the Gateway team through to the Director of Women and Children's Services (Executive Director of Social Work). RQIA examined the WHSCT's organisational structure, which confirmed the reporting lines were clear. The Gateway team in Enniskillen had responsibility for all referrals and assessments undertaken in relation to child protection and safeguarding matters relating to the case.

7.1.3 On 31 July 2008, the WHSCT Gateway team received a child protection referral from PSNI in relation to four McDermott brothers who were residing at the same address in Donagh. On 4 August 2008, the Gateway team visited the McDermott home and interviewed the four brothers. The Gateway team had a subsequent re-referral on 9 July 2010 as part of the comprehensive management plan which was put in place by the WHSCT with regard to the McDermott case.

The Child Protection Assessments of the McDermott Brothers' Extended Family

7.1.4 In August 2008, in line with the requirements of Cooperating to Safeguard Children, May 2003 (DHSSPS), five families related to the McDermott brothers were visited and assessed by the WHSCT Gateway team. This included the assessment of 10 children. In July 2010 the same families and children were the subject of reassessment. One other family was assessed following the birth of a child after the original referral in 2008. All the assessments were undertaken using the UNOCINI model of assessment. The information from these assessments was passed to the WHSCT's Principal Officer for PPANI.

7.1.5 RQIA found that the Gateway team had acted in accordance with regional child protection policies and procedures (Cooperating to Safeguard Children May 2003 (DHSSPS) and gateway service processes Guidance for Northern Ireland Health and Social Care Trusts April 2008 (DHSSPS). The UNOCINI assessments were also

completed within departmental guidelines and the cases were closed in accordance with the above child protection policies and procedures.

7.1.6 A review of assessment documentation and interviews with Gateway team staff, by RQIA, highlighted the following:

- All five families sought legal support and were advised to cooperate with social services in safeguarding their children.

  In these assessments undertaken in 2008 and 2010 parents did not give consent to their children being interviewed without a parent present. According to Gateway management this parental response is not uncommon. Gateway staff reported there were no concerns in any of the assessments of the families which required social work staff to speak to the children without parents being present.

- The guidance for interviewing children is set out at chapter 5, Cooperating to Safeguard Children, May 2003 (DHSSPS). The assessments of the families was supported by the social worker's observations of the interaction between parents and children; the dynamic within the families; the child centred nature of the physical environment; and parents' responsiveness to their responsibilities around safeguarding and protection of their children.

  In 2008 and 2010 the assessments were completed during the school holiday period. All relevant schools were informed by letter of the referrals to Gateway, the reason for the referral and the subsequent outcomes. However, no direct contact occurred between social services and the schools as part of the Gateway assessment processes in either 2008 or in 2010.

  The education component of the assessment was informed through discussion with the parents and children and an examination of school reports. Letters were sent to all schools providing contact details should the school have concerns in relation to any of the children.

  Although letters were sent to the relevant schools, direct contact with teaching staff was not made. On both occasions, the assessments were undertaken during school holidays. Best practice would indicate that follow-up contact should have been made with the schools at the earliest opportunity.

  Educational input is fundamental to the UNOCINI assessment. Education authorities have clear roles and responsibilities in relation to the protection of children. These are set out in Cooperating to Safeguard Children, May 2003 (DHSSPS). Child protection incidents may arise during school holidays. It is,

therefore, incumbent on social services to work with education authorities to develop protocols and arrangements during these periods to ensure a comprehensive assessment of children at potential risk.

- The assessments undertaken in 2008 and 2010 were carried out by the same practitioner (social work manager). As the families were in some distress as a result of the events, it was the WHSCT's view that involving the same practitioner for the reassessment would be appropriate to the circumstances. It also provided an opportunity for the same social worker to see and speak to the children directly.

The Gateway Team Response to Child Protection and Safeguarding within the Wider Donagh Community

7.1.7 The review team found that the WHSCT adopted an engagement strategy with the wider Donagh community. In July 2010, the Gateway team undertook a reassessment of the extended families and a further family member where a child had been born after the original assessments in August 2008.

7.1.8 The WHSCT issued leaflets within the Donagh area outlining contact details of the Gateway team and inviting contact in respect of any concerns relating to child protection.

7.1.9 Three meetings took place between relevant senior WHSCT staff and representatives of the local community on 5 July, 19 July and 14 September 2010. These meetings covered safeguarding issues relating to the case. On each occasion information and guidance was provided about the process of referral to the Gateway team in the event of the emergence of child protection concerns.

7.1.10 WHSCT reacted positively through its Family Support service to a request for funding additional safeguarding measures at the building used by the pre-school playgroup and the after school club in Donagh which is located in close proximity to the McDermott family home.

7.1.11 On 9 August 2010, in accordance with child protection procedures, a meeting was convened by the WHSCT to consider if the situation in Donagh met the criteria for organised abuse. This meeting was attended by senior WHSCT staff, a senior HSC Board representative and PSNI officers. It was concluded that in accordance with Cooperating to Safeguard Children, May 2003 (DHSSPS), and the Protocol for Joint Investigation by Social Workers and Police Officers of Alleged and Suspected Cases of Child Abuse - Northern Ireland, September 2004, the specific circumstances in Donagh did not meet the definition of organised abuse, but these would be kept under continuing review.

Conclusion

7.1.12 RQIA concluded that the WHSCT had acted appropriately within the legislative framework governing child protection. In recognition of the distress caused to those associated with the case, the Gateway team discharged its statutory responsibilities around child protection in a sensitive and empathetic manner.

7.1.13 The WHSCT implemented an engagement strategy with the community to promote awareness of safeguarding and child protection. Specific advice and guidance were provided highlighting referral procedures to the Gateway team.

Recommendation

7.1.14 The Regional Child Protection Committee should engage with the HSC trusts and with the education and library boards to consider amending the existing regional protocol to ensure that there is effective education service input into child protection processes at all times including school holiday periods.

7.2 Contribution to Public Protection Arrangements

7.2.1 Public Protection Arrangements for Northern Ireland (PPANI), set up as a result of Criminal Evidence (Northern Ireland) Order 1999, refers to the arrangements established for the risk management of sexual and violent offenders, and certain potentially dangerous persons, whose assessed risks require multiagency input to the delivery of individual risk management plans. PPANI is not a statutory body in itself. It is a set of arrangements through which agencies can work together and share information in discharging their statutory responsibilities, in a coordinated manner, to better protect the public. At all times participating agencies retain their full statutory responsibilities and obligations. The three criminal justice agencies (PSNI, PBNI and the Northern Ireland Prison Service (NIPS)) and social services have clearly defined roles in public protection. This is reflected in guidance, PPANI Guidance to Agencies May 2008, issued by the Northern Ireland Office.

7.2.2 The guidance also sets out the mechanisms and criteria that the LAPPP must use in the assessment and reassessment of the category. These assessments take account of any potential infringements of the perpetrators human rights. The trust's Principal Officer for PPANI advised RQIA that these processes applied in respect of James Francis and Owen Roe McDermott.

7.2.3 In June 2009, WHSCT appointed a principal officer for PPANI in relation to its role in public protection arrangements. Whilst this was a new appointment, the officer appointed had been involved previously in the Multi Agency Sex Offender Risk Assessment and Management (MASRAM) arrangements on behalf of the WHSCT. The Principal Officer is a member of the Family and Childcare directorate within the WHSCT.

7.2.4 In August 2008, James Francis and Owen Roe McDermott along with their two brothers were referred by the PSNI into the public protection arrangements as potentially dangerous persons. This was the trigger for the involvement of the WHSCT Principal Officer in the public protection arrangements who attended a meeting of the LAPPP held on 27 November 2008.

7.2.5 As the WHSCT representative on LAPPP, the Principal Officer initially checked the WHSCT's social services data base (SOSCARE) to establish if the brothers or their extended family had any previous involvement with social services. He also checked with the WHSCT's Gateway team and learned that following the referral of the case by the PSNI to the Gateway team, the team had completed risk assessments in all but one of the extended family contacts.

7.2.6 At the meeting of the LAPPP held on 27 November 2008, James Francis and Owen Roe McDermott were each placed at Category P

(Pending) in relation to risk. This category was to enable the various agencies involved to gather further and more detailed information on risk.

7.2.7 The next LAPPP was held on 29 January 2009. By this time, the work of the Gateway team in respect of child protection risk assessments had been completed and the Principal Officer had made contact with the local pre-school playgroup, primary school and after school club. This was in line with the agreed actions of the LAPPP. At the meeting of the LAPPP both James Francis and Owen Roe McDermott were then assessed as Category 2 which is defined as:

"Someone whose previous offending (or current alleged offending in the case of potentially dangerous persons), current behaviour and current circumstances present clear and identifiable evidence that they could cause serious harm through carrying out a contact sexual or violent offence." (PPANI Guidance to Agencies, May 2008)

7.2.8 During the LAPPP on 29 January 2009, it was highlighted that the brothers had been interested in hunting with dogs. This activity could have enabled them to have contact with children and young people. The WHSCT's Principal Officer subsequently spoke with the chairman of the local hunt club to ensure that the club was aware of the need for protection arrangements at hunts and hunt functions.

7.2.9 The categorisation of the two brothers remained unchanged at Category 2 at the next meeting of the LAPPP on 23 April 2009. On 9 July 2009, the category was reassessed as Category 1. Category 1 is defined as:

"Someone whose previous offending (or current alleged offending in the case of potentially dangerous persons), current behaviour and current circumstances present little evidence that they will cause serious harm through carrying out a contact sexual or violent offence." (PPANI Guidance to Agencies, May 2008)

7.2.10 RQIA has been advised that when cases are allocated Category 1, they are not routinely reviewed by the multiagency LAPPP. A lead agency for public protection is designated in relation to the case. In the case of the two McDermott brothers the designated lead agency was PSNI. A designated risk manager was allocated by PSNI.

7.2.11 RQIA noted during the inspection of documentation that the brothers had an interest in and attended the local Gaelic Athletic Association (GAA) club. Following examination of the risk assessment forms completed by the Gateway team on the extended family, there were references to young people attending the club. RQIA sought clarification as to whether the GAA club was provided with similar advice as that provided to the local hunt club, and understands this was not done by WHSCT. This omission had potential implications for

protection and safeguarding strategies for the children and young people attending the GAA club.

7.2.12 RQIA recognises that the Principal Officer was formally appointed in June 2009. Members of the Adult Learning Disability team advised RQIA that they were not aware of the new appointment for several months. However, during the period when the report for the court was being prepared, this situation had been rectified, enabling the Principal Officer to contribute to the multidisciplinary discussions input into the process during multidisciplinary discussions.

7.2.13 Following the disposal hearing, WHSCT raised the issue on several occasions of a possible referral of the brothers back to the LAPPP for consideration of a potential review of their Category 1 designation. This was due in part to the WHSCT's view that it was essential that there was effective multiagency involvement in this case. The Chief Executive and others within the WHSCT contacted PPANI administration to ask for the category to be reconsidered. The WHSCT was advised that this could not happen as PPANI considered that there was no significant change in circumstances or new information that would support a reassessment. The brothers' assessment as Category 1 remained in place at 30 September 2010. The PSNI remain as the lead agency.

Conclusion

7.2.14 RQIA considers that, in general, in this case the WHSCT contributed appropriately to the PPANI arrangements, through the work of its Principal Officer. The Principal Officer consistently attended all LAPPP meetings. An initial lack of awareness of the role of the new PPANI arrangements across the WHSCT did not impact on its response to the PPANI process. A recognised need to ensure effective collaboration in this case after the brothers were designated as Category 1 was subsequently addressed by the WHSCT establishing a multiagency core group.

Recommendations

7.2.15 The WHSCT should ensure that all relevant staff are aware of the PPANI arrangements and the roles and responsibilities of the WHSCT Principal Officer.

7.2.16 The WHSCT should ensure that its scoping of child protection risks takes account of all relevant areas to include areas of formal or informal social activity.

7.3 Provision of Care and Treatment to the McDermott Brothers

7.3.1 In the WHSCT, services for adults with a learning disability are managed by the Adult and Mental Health and Disability Directorate. The director is a member of the trust's Senior Management team. The WHSCT provides a wide range of services for people with a learning disability in both community and hospital settings. The WHSCT also contracts for services provided in residential and nursing homes and provides funding to voluntary organisations for advocacy and befriending schemes.

7.3.2 Having reviewed an extensive range of documentation relating to the care and treatment of James Francis and Owen Roe McDermott, RQIA established that service provision by WHSCT related to the following service areas:

- assessment and registration
- provision of services in the community
- provision of services in hospital
- treatment of offenders
- support of families following a suicide

Assessment and Registration

7.3.3 The assessment of individuals newly referred to learning disability services normally includes four main components:

- an examination by a consultant psychiatrist
- an assessment of intelligence quotient (IQ) by a clinical psychologist
- a social history report provided by a social worker
- a carers assessment

7.3.4 Prior to their arrest in July 2008, James Francis and Owen Roe McDermott were not known to learning disability services in the WHSCT.

7.3.5 On 20 August 2008, a consultant psychiatrist with a special interest in learning disability was asked to carry out assessments of each brother, on a private basis, by a solicitor acting on their behalf. The consultant assessed each brother as having a learning disability and he initiated actions within the WHSCT for their ongoing care, even though he was acting in a private capacity at that time. His decision to refer the brothers for further assessment and treatment was good practice which RQIA considered appropriate to the circumstances.

7.3.6 The same consultant psychiatrist followed up his initial examination with a referral to WHSCT psychology services for a formal assessment of the two brothers. These assessments did not happen for 11 months

which RQIA has established was not uncommon, in view of significant shortages of psychology staff in the specialist area of learning disability. Whilst this delay had no material impact on the assessment of the brothers' condition or subsequent reports to the court it raises a concern about the availability of resources for this service in the WHSCT.

7.3.7 Social history assessments were carried out in relation to both brothers on 17 August 2009, after the psychology assessments.

7.3.8 The WHSCT maintains an informal register of adults with a learning disability to assist in the coordination of services. The consultant psychiatrist who made the initial assessment of each brother has advised RQIA that his intention was to refer both brothers for inclusion on the register after his assessment. James Francis McDermott was registered on 3 September 2008. The consultant later found out that Owen Roe McDermott was not on the register, and made a re-referral on 5 August 2009. RQIA has confirmed that the different dates of inclusion on the register made no material difference to the assessment, care or treatment of the brothers.

7.3.9 RQIA has concluded that the initial assessment and treatment of the McDermott brothers followed good practice. An administrative delay in placing one brother on the WHSCT register had no impact on his care.

Provision of Services in the Community

7.3.10 The assessment of need for support services in the community is carried out by social services. A social worker who was allocated the case carried out an initial assessment of the needs of the McDermott brothers on 17 August 2009. The social worker noted that two McDermott sisters were providing all their care and support needs, and that the brothers spent much of their time within the family home. The social worker offered possible social services support in the form of day care attendance. The social worker also offered to carry out an assessment of the needs of the family carers. The family declined both offers, with the possibility of considering them further, following the completion of the court case.

7.3.11 In December 2009, the responsibility for the case transferred to another social worker. The two social workers completed a joint assessment of the family circumstances at that time, which provides evidence of effective handover of the case. The newly allocated social worker subsequently made further offers of day care and carer support, but these were again declined by the family.

7.3.12 In April 2010, the assigned social worker carried out further assessments of the needs of each brother and prepared social history reports to inform their ongoing management, and the deliberations of the court.

7.3.13 RQIA has found that the social worker assigned to the case for the period up to the hearing provided a high level of support to the family, in particular, following the suicide of Peter Paul McDermott. She subsequently agreed in court on 18 June 2010 to take on the role of supervising officer in relation to the STOs which is considered in section 7.6 of this report.

7.3.14 Following the disposal hearing, the assigned social worker continued to provide support to the family, both before and after the admission of the brothers to hospital. Her assessment of the needs of the brothers and their carers led directly to an offer of a period of respite in hospital and their subsequent admission to hospital on a voluntary basis.

7.3.15 RQIA concluded that the WHSCT fulfilled its responsibilities for provision of services in the community in this case. Social services support was offered to the McDermott family who decided not to avail of the offers.

Provision of Services in Hospital

7.3.16 James Francis and Owen Roe McDermott were admitted to hospital on 22 July 2010. These admissions were on a voluntary basis and followed discussion with the brothers, their family and their legal representatives on the assessed need for a period of respite.

7.3.17 RQIA found that, as part of the admission process, appropriate risk assessments had been carried out by WHSCT. These included risk assessments in respect of other patients and visitors to the hospital.

7.3.18 Although the initial environment in which the brothers were accommodated had been risk assessed, and appropriate supervision arrangements were in place, concerns were raised by the families of other patients as to the safety of their family members following the admission of the brothers. RQIA considers that the response of WHSCT to provide alternative accommodation was appropriate at that time.

7.3.19 Multidisciplinary meetings were convened to ensure the effective provision of care and treatment to the brothers on a daily basis by ward medical and nursing staff. The code of confidentiality has been correctly observed with regard to the ongoing treatment of the brothers.

7.3.20 The WHSCT has kept all aspects of the treatment and care of the brothers under continuing review since their admission to hospital and has ensured that relevant authorities have been provided with information, as appropriate.

Treatment of Offenders

7.3.21 The WHSCT has established a Programme for the Prevention of Sexual Abuse (PPSA), which is provided by a trust-wide specialist multidisciplinary team. The team provides treatment and support to patients and clients who are referred as a result of sexual abuse issues. PPSA also provides a treatment programme for those who have perpetrated sexual abuse.

7.3.22 In September 2009, James Francis and Owen Roe McDermott were referred to PPSA by a clinical psychologist with regard to the possible initiation of treatment. PPSA advised that before treatment could be offered an initial assessment should be carried out by a specialist in forensic psychology. Each brother was subsequently referred for assessment by a consultant forensic and clinical psychologist from outside the WHSCT. Initial reports were provided to clinicians in the WHSCT in May 2010. These reports were used to inform the WHSCT's response to the request from NICTS for reports in advance of the disposal hearing. The specialist assessments have also informed potential treatment options to be delivered to the brothers. Final reports were provided to the court by the consultant in August 2010.

7.3.23 Members of the PPSA team informed RQIA that PPSA is delivering a programme of treatment for each brother as stated in the WHSCT report, which was submitted to the court.

Support of Families Following a Suicide

7.3.24 WHSCT has established a Family Liaison Service to support families bereaved by suicide. This service is provided in line with the objectives of Protect Life, a Shared Vision - The Northern Ireland Suicide Prevention Strategy and Action Plan 2006-2011. Those bereaved by suicide are considered to be a vulnerable and high risk group, and are a priority for support within the strategy. The Family Liaison Service is provided by two suicide liaison officers who work across the WHSCT. The service carries out an assessment of the needs of a family and provides practical support and guidance at what is an extremely difficult time for all families.

7.3.25 Following the suicide of Peter Paul McDermott on 5 May 2010, the assigned social worker and the PSNI made contact with the Family Liaison Service. A Suicide Liaison Officer made contact with the family and provided significant support to them during the weeks immediately after the suicide. The Suicide Liaison Officer also provided support to family members when they attended court at the disposal hearing.

Conclusion

7.3.26 RQIA has concluded that the WHSCT provided the full range of care and treatment services to James Francis and Owen Roe McDermott, in keeping with their assessed needs, from their initial assessment as having learning disabilities up to 30 September 2010.

7.3.27 RQIA recognised that the many issues surrounding this complex case have created significant difficulties in delivering care and treatment to the brothers and their immediate family. RQIA acknowledges the professionalism and integrity of all staff, which was evidenced during this review.

7.4 Roles in Relation to Survivors of Sexual Abuse

7.4.1 To examine the WHSCT's role in supporting survivors, RQIA committed to actively engaging with the survivors during this review. Although not specifically mentioned in the terms of reference of the review, RQIA also met with representatives of the wider Donagh community, some of whom identified themselves as representatives and supporters of the survivors.

7.4.2 To avoid the need for survivors to meet separately with both RQIA and CJI during the course of the parallel reviews, the two organisations agreed to offer combined meetings to survivors. During the meetings, RQIA was able to seek the views of survivors about their experience of communication and the services received from the WHSCT. The issues raised are considered within the following areas:

- provision of trauma and counselling services
- communication
- support services for victims

Provision of Trauma and Counselling Services

7.4.3 The WHSCT provides a wide range of health and social care services to its population. In most cases the WHSCT provides these services directly as the primary provider. However, at times the WHSCT commissions services from the community and voluntary sector to ensure appropriate access to skilled services across its area.

7.4.4 The WHSCT advised RQIA of the specific trauma and counselling services provided by, or funded by the WHSCT, which are designed to help survivors of sexual abuse. These include:

- the Programme for the Prevention of Sexual Abuse (PPSA)
- NEXUS
- The Aisling Centre Enniskillen

7.4.5 The WHSCT commissions services from NEXUS and The Aisling Centre which are both voluntary organisations. The WHSCT also provides a range of counselling and psychological support services as part of its mental health profile which may also be accessed by survivors of sexual abuse.

7.4.6 Referrals for counselling for the survivors of sexual abuse come from a variety of sources. These include referrals from the Psychiatric Primary Care Liaison Service, Community Mental Health teams, GPs, psychiatric admission wards, voluntary agencies and self referrals.

7.4.7 RQIA examined information from the WHSCT in relation to the services provided by NEXUS, a service specifically aimed at addressing the

needs of survivors of sexual abuse. Some of the survivors told RQIA that they had accessed this service.

7.4.8 The WHSCT has a recurring contract with NEXUS for service provision for counselling and related services. In the current financial year, 2010-11, in response to a request from NEXUS that it was experiencing increased referrals and waiting times, the WHSCT provided NEXUS with additional funding for service provision. RQIA has been advised that a significant proportion of the increased number of referrals were from survivors in the Donagh community.

7.4.9 With the support of the DHSSPS Sexual Violence Unit, the WHSCT has also been able to provide, over the past three years, additional funding to NEXUS. NEXUS has advised the WHSCT that it had also received extra funding from the Fermanagh District Partnership, of which the WHSCT is a member, which has enabled NEXUS to employ a dedicated part-time worker for the Donagh area.

7.4.10 Further information supplied by the WHSCT from NEXUS identified that clients connected with the Donagh case had availed of services from 2008. Two survivors had attended before they had reported abuse to the police. NEXUS advised the WHSCT that up to 15 clients connected with the case had availed of their services. NEXUS currently has a waiting list for their services.

7.4.11 NEXUS has advised the WHSCT that it has attended community meetings in Donagh, in a supportive role.

7.4.12 The WHSCT informed RQIA that it had put in place a triage service in response to the Donagh community's concerns. Mental health services identified a number of key individuals who were made available to respond to additional referrals and would refer onwards to appropriate WHSCT or voluntary services, depending on the severity of trauma symptoms.

7.4.13 RQIA was advised by some of the survivors that they had sought support and counselling from NEXUS. One stated that the services they received were good, but felt that the referral was self generated and that information and adequate signposting to the service was not made available for the survivors or the local community. There was criticism that the course of therapy offered by NEXUS only lasted for a period of six weeks. This was perceived as too short, given the trauma that a number of survivors had experienced.

Communication

7.4.14 RQIA found that, in general, the survivors who met the team described a negative perception of their experience of communication from the WHSCT. Some survivors stated that the WHSCT had made no proactive contact with them to ascertain whether they required care

and support as a result of their experiences. Others stated that, in their view, the WHSCT only became engaged when there was media coverage and that led to the setting up and attendance at a number of public meetings in Donagh. The survivors indicated that the WHSCT distributed information leaflets on the services available to survivors at these meetings.

Support Services for Survivors

7.4.15 There are various points at which support services for survivors can be accessed, as referenced in the Criminal Evidence (Northern Ireland) Order 1999. This includes onward referral by criminal justice agencies to health and social care. This legislation sets out a range of special measures to assist vulnerable or intimidated witnesses. Special measures are, for example, the provision of screening in court. The legislation states that measures should begin in the interview process and interagency work. This could include signposting and access to counselling services in some cases. In this instance no referrals were made by the PSNI for health and social care services. This meant that the WHSCT was not in a position to identify survivors.

7.4.16 Victim Support Northern Ireland is a charity which helps people affected by crime. It offers a free and confidential service, whether or not a crime has been reported. The charity offers a range of services including: criminal injuries compensation service; help for victims in the form of advice counselling and support; and help for witnesses. This can include: offering witnesses a chance to visit the court before giving evidence; explaining court procedures; accompanying a victim or witness into the court room; and offering the opportunity to talk over the case when it has ended.

7.4.17 Survivors advised RQIA that in this case they considered that the agencies providing support to them were not well coordinated. A number of the survivors believed that support should have been offered at the point at which they were making their statements.

7.4.18 Some survivors stated that the only service that they could identify as being provided by the WHSCT was the Gateway service, which was highlighted to the survivors and to the wider community at a public meeting in July 2010. The survivors also stated that a child protection advisor from the WHSCT had offered advice to parents on how to talk to their children about protection. However, they stated that they found it difficult to talk about some of these issues to their children and young people. The WHSCT advised RQIA that its officers present at the meeting drew specific attention to the NEXUS service. The WHSCT Chief Executive invited survivors present to speak to the NEXUS representative following the meeting.

Conclusion

7.4.19 Some of the survivors had strongly held, negative views of the WHSCT's contributions to their care and support. RQIA considers that there is a need to identify how trusts, as part of a multiagency response, can engage more proactively with survivors of sexual abuse, and ensure that there is clarity about how to access services.

7.4.20 RQIA found that the WHSCT provided additional funding to NEXUS in relation to an increase in demand for its services from the Donagh area. NEXUS services were welcomed by those survivors who had accessed them, although the period for which services could be provided was considered to be too short.

Recommendation

7.4.21 HSC organisations should review their arrangements to ensure that there are effective mechanisms to disseminate information about available services to survivors of sexual abuse and should work proactively with criminal justice agencies to ensure that advice and support is made available as early as possible following disclosure to the PSNI.

7.5 Responsibilities in Relation to the Criminal Justice System

7.5.1 Throughout this case, the WHSCT was required to work closely with criminal justice agencies and to discharge specific functions. RQIA has examined the roles and responsibilities of the WHSCT in relation to the following processes during the case:

- PSNI interview processes
- fitness to plead hearing
- disposal hearing
- liaison with PSNI

PSNI Interview Processes

7.5.2 Following the arrest of four of the McDermott brothers on 30 July 2008, PSNI asked the WHSCT to provide an appropriate adult service for James Francis and Owen Roe McDermott. Under the Police and Criminal Evidence Act 1984 (PACE) Code of Practice, custody sergeants are required to request an appropriate adult to be present whenever they consider a suspect may be mentally disordered or otherwise mentally vulnerable (para 11.15 of PACE code C). On that day, a social worker from the WHSCT attended Enniskillen police station as an appropriate adult for the two brothers. On that occasion only the interview of Owen Roe McDermott proceeded with the presence of the social worker as an appropriate adult. James Francis McDermott was not interviewed as he was deemed unfit for interview by those present.

7.5.2 On 20 August 2008, a consultant psychiatrist did carry out fitness to be interviewed assessments on James Francis and Owen Roe McDermott at the request of their defence solicitor. He found them unfit to be interviewed. These assessments were carried out on a private basis and were not the responsibility of the WHSCT.

7.5.3 On 9 September 2008 a WHSCT social worker attended Enniskillen police station to act as an appropriate adult for James Francis and Owen Roe McDermott. It was noted on the social work record that the interview with James Francis did not proceed as the Forensic Medical Officer (FMO) and the appropriate adult found him unfit to be interviewed.

7.5.4 The interview with Owen Roe McDermott took place with the social worker acting as the appropriate adult. The social worker noted that Owen Roe McDermott may have a learning disability. The solicitor for both brothers was present throughout the proceedings. It was noted on the appropriate adult record that the solicitor present was "...challenging re PACE regulations and regarding decision made for interview to proceed." Other clinical reports were provided to the courts which were outwith the responsibilities of the WHSCT.

7.5.5 There were no further requests for the WHSCT to act as an appropriate adult in the case. RQIA considers that WHSCT fully discharged its responsibilities in providing an appropriate adult for these proceedings.

Fitness to Plead Hearing on 6 October 2009

7.5.6 The submission of not fit to stand trial, or unfitness to plead, is made under The Criminal Justice (Northern Ireland) Order 1996. The criminal procedure outlined in legislation requires that before making a determination, the court must have considered written or oral evidence from at least two registered medical practitioners, at least one of whom must have been approved by the Secretary of State as having special experience in the diagnosis and treatment of mental disorder. Such a doctor is known as a Part II Doctor in relation to mental health legislation.

7.5.7 Guidance to doctors on providing reports as expert witness is available from the Acting as an Expert Witness 2008 (General Medical Council). The guidance states that:

"The role of an expert witness is to assist the court on specialist or technical matters within their expertise. The expert's duty to the court overrides any obligation to the person who is instructing or paying them. This means that you have a duty to act independently and not be influenced by the party who retains you."

7.5.8 On 1 January 2004, a practice direction from the High Court of Justice in Northern Ireland (No 1. 2003) came into effect. This requires any expert witness who prepared a report for the court after that date to complete a specific signed declaration, which includes among other requirements the statement:

"I understand that my primary duty in furnishing written reports and giving evidence is to assist the court and that this takes priority over any duties which I may owe to the party or parties by whom I have been engaged or by whom I have been paid or am liable to be paid. I confirm that I have complied and will continue to comply with this duty."

7.5.9 It should be noted that efforts were made earlier in the case by the defence solicitors to secure a psychiatrist opinion for the assessment of fitness to be interviewed. It was only when a list of other psychiatrists was exhausted that the consultant psychiatrist with a specialist interest in learning disability agreed to provide the assessment in the interests of justice. It should also be noted that in Northern Ireland, the potential cohort from whom a consultant psychiatrist with specialist interest in learning disability is small and in fact this consultant is the only one employed in the WHSCT.

7.5.10 One of the private reports submitted to the court in relation to the fitness to plead hearing was prepared by a consultant psychiatrist with

a special interest in learning disability, who was also an employee of the WHSCT. In his role as an employee of the WHSCT, he had also referred the two brothers' learning disabilities. As part of his report, the consultant psychiatrist incorporated two reports from the clinical psychology department in the WHSCT that outlined an assessment of the brothers' IQs and social functioning. The consultant psychiatrist advised RQIA that he had included the reports with the knowledge of the consultant clinical psychologist, in view of his duty to inform the court of the basis on which he had reached his clinical assessment of the brothers. The consultant clinical psychologist confirmed this position to RQIA.

7.5.11 RQIA considers that the action of the consultant psychiatrist in submitting an expert report to the court and including the clinical reports which had informed his professional view, in these circumstances, was carried out in keeping with professional guidance. The consultant advised RQIA that he had completed the appropriate declaration to the court in relation to his private report to the court.

7.5.12 The WHSCT as an organisation did not have any role in relation to the proceedings in the fitness to plead hearing, or in the subsequent trial of the facts hearing held on 26 November 2009.

Disposal Hearing on 18 June 2010

7.5.13 Following the hearing on 26 November 2009, at which James Francis and Owen Roe McDermott were found to have carried out the offences with which they had been charged, the solicitors for the two brothers wrote to the consultant psychiatrist who had carried out the initial assessment of the brothers and had prepared a private report for the fitness to plead hearing. The letter, dated 14 December 2009, advised that the solicitors were seeking a report from a competent expert to provide an opinion to the court as to whether the brothers should be regarded as dangerous within the meaning of the legislation, and whether as a result they should be made subject of hospital orders. Within the same letter it was noted that the Crown had asked an independent consultant with expertise in forensic psychiatry to undertake a medical report for the benefit of the court on disposal options available to it.

7.5.14 The WHSCT Adult Learning Disability team started work to prepare a report for the court. The court hearing was adjourned in January 2010.

7.5.15 The NICTS wrote to the WHSCT on 30 March 2010 directing the provision of a report which had been requested by the solicitors. This report was to set out the views of the WHSCT in relation to possible disposal options as set out under article 50A of the Mental Health (Northern Ireland) Order 1986.

7.5.16 Following multidisciplinary discussions and an expert external assessment by a consultant forensic and clinical psychologist, a report was prepared on behalf of the WHSCT and submitted to the court before the disposal hearing. The report stated that it was the view of WHSCT that neither hospital nor guardianship orders were necessary or required for the brothers. The report set out a package of social and therapeutic interventions which the WHSCT could provide for the brothers in the community. Individual social history reports in relation to each brother were also provided to the court. Legal advice was sought from the WHSCT's advisors before the reports were submitted, and advice was provided on who should attend the court from the WHSCT. These reports did not make a specific recommendation on where the brothers should live following disposal. However they did acknowledge that in the event of STOs being imposed by the court, the brothers had limited social functioning and would not be able to live independently of their main carers.

7.5.17 RQIA found that WHSCT also considered that the court might issue hospital orders in respect of the two brothers. The Director of Adult Mental Health and Disability Services wrote to the HSC Board seeking commissioner support, particularly if hospital orders were required for the onward care of the brothers.

7.5.18 Following the ruling of the court in relation to fitness to plead, the Public Prosecution Service secured an independent opinion from an consultant forensic psychiatrist on the options available to the judge in the McDermott case. Further to the submission of this report as written evidence at the disposal hearing, the judge questioned the consultant psychiatrist with specialist interest on learning disability from the WHSCT on the option outlined in that report. He agreed with the opinion outlined in the report that a STO was the only option practically available to the court.

7.5.19 The outcome of the hearing was that the judge imposed STOs for each brother for two years. In line with the WHSCT's expectations, the social worker assigned to the brothers' case was asked in court if she would act as the supervising officer in respect of the STOs. SOPOs were also imposed on the brothers for life.

7.5.20 WHSCT's actions in relation to the STOs are considered in the next section of this report. The lead agency for the management and oversight of a SOPO is the PSNI. The WHSCT has no legal obligation in respect of SOPOs. The WHSCT has maintained active communication with the relevant PSNI Public Protection Unit (PPU) since the SOPOs were imposed.

Liaison with PSNI

7.5.21 From an examination of the documentation submitted by the WHSCT, RQIA found evidence that the WHSCT engaged effectively with

colleagues from PSNI in relation to this case. Examples of joint working included:

- Prompt responses to the provision of appropriate adults when requested.
- Liaison and referral with PSNI on child protection issues in accordance with Cooperating to Safeguard policies and procedures.
- Jointly attending meetings with representatives of the Donagh community.
- Liaison about the potential for referral of the brothers back to the LAPPP for a reconsideration of their classification.
- Establishment of a multiagency core group by WHSCT with active participation of PSNI colleagues.

Conclusion

7.5.22 RQIA was satisfied that WHSCT staff attending court were fully aware of their respective roles and the implications of the range of disposal options that might arise as a result of the judge's ruling.

7.5.23 RQIA has concluded that WHSCT fulfilled its responsibilities in relation to the criminal justice system. The WHSCT provided an appropriate adult service when requested. The WHSCT responded appropriately to a court direction to prepare a report to set out its views in relation to disposal. WHSCT staff maintained effective working arrangements at operational level with colleagues from PSNI.

7.6 Responsibilities in Relation to Supervision and Treatment Orders (STOs)

7.6.1 On 18 June 2010, at a disposal hearing at Omagh Crown Court, the judge determined that James Francis and Owen Roe McDermott would each be made subject to a STO. During the court hearing the judge asked a WHSCT social worker present in court if she was willing to act as the supervising officer for the two brothers, and she agreed to carry out this function. In his judgment, the judge stated that:

"I am obliged to explain to you the effect of these orders:

- The order will last for two years. I would have preferred to make the order for longer but legislation does not allow for any longer period.
- There will be a requirement that you shall submit during this period to treatment by or under the direction of a medical practitioner.
- There will be a requirement that you reside at an address approved by your supervising officer.
- The Magistrates' Court can amend the provisions of the order, but cannot extend it beyond two years."

Background Information on STOs

7.6.2 STOs were introduced in England in 1991. The orders could be applied as a possible disposal option in criminal proceedings where:

- a finding was found that the accused is not guilty by reason of insanity, or
- findings are recorded that the accused is unfit to be tried and that he did the act or made the omission charged against him.

7.6.3 In England, STOs were replaced by supervision orders in 2004. A Home Office circular(24/2005) described the purpose of the new order as being to enable support and treatment to be given to the defendant to prevent recurrence of the problem which led to the offending. There is no sanction for breach of a supervision order. The circular stated that, like the supervision and treatment order, the new order is non-punitive and intended solely to provide a framework for treatment.

7.6.4 In Scotland, STOs were introduced through legislation in 1995. In March 1998, the Scottish Office issued a guidance circular on STOs (SWSG4/98). The guidance stated that the orders were intended to fill a gap in the legislative provision for dealing in the community with people with mental health problems who had become criminally involved. The aim of the orders in Scotland was described as being to offer the right combination of medical treatment, oversight and support which would enable such persons to lead settled lives in the community. The guidance stated that court may vary or revoke an

STO but has no power to enforce it or to otherwise intervene in cases of non-compliance.

7.6.5 STOs were introduced to Northern Ireland through the Criminal Justice (Northern Ireland) Order 1996, which led to amendments to the Mental Health (Northern Ireland) Order 1986. The Criminal Justice (1996 Order) (Commencement No.2) Order (Northern Ireland) 1997 enabled the orders to be put in place from 1 January 1998. As in Scotland and England, STOs are available as a potential disposal option to the court in the circumstances set out in paragraph 7.6.2 above.

7.6.6 RQIA has asked DHSSPS if any specific guidance in relation to STOs has been issued to health and social care organisations in Northern Ireland and has been advised that no such guidance was issued.

7.6.7 In the absence of specific guidance, RQIA understands that the aim of issuing an STO in Northern Ireland broadly reflects the situation in England and Scotland. An STO is available as an option to the court when it is considered that absolute discharge, a hospital order or a guardianship order is not appropriate. The STO sets in place a framework for supervision and support for a person to ensure that he or she engages in treatment designed to prevent future offending. As in England and Scotland, in Northern Ireland there are no enforcement powers in relation to non compliance with an STO.

7.6.8 RQIA has noted that there are differences in the wording of the legislation between Northern Ireland, Scotland and England which mean that guidance cannot be applied directly between jurisdictions. In particular the legislation in Northern Ireland does enable the court to specify a hospital as a place of residence whereas in Scotland this was specifically excluded in the original legislation. In England the new supervision order cannot require a patient to be admitted to hospital against his will.

7.6.9 The legislation on STOs enables the court to include "Optional requirements as to residence" in the wording of an STO. In terms of the residence element of the order RQIA understands that supervision in respect of approval of residence relates to the appropriateness of the address to ensure engagement with treatment.

7.6.10 RQIA has been provided by NICTS with information about the number of STOs issued in Northern Ireland since May 2006.

- There have been 11 orders since May 2006, one each in 2006 and 2007, none in 2008, five in 2009 and four in 2010.
- Social workers have been assigned as supervising officers in eight of the 11 cases.
- A probation officer was assigned as supervising officer in three cases.

Actions of WHSCT in relation to the STOs

7.6.11 RQIA was advised, during discussions with WHSCT staff involved in the management of the McDermott brothers case, that the WHSCT had some previous experience of situations where STOs have been in place but this would not be a common occurrence. The Adult Learning Disability team had experienced one previous case, some years previously, where a WHSCT social worker had been the designated supervising officer.

7.6.12 RQIA met with the supervising officer and she explained that she understood her role under the STOs was to provide supervision of the brothers to ensure that they engaged in treatment.

7.6.13 The designated supervising officer had been the assigned social worker to the family before the disposal hearing and therefore had a good understanding of the family circumstances. In the period after the disposal hearing on 18 June 2010, the supervising officer visited the family.

7.6.14 By 28 June 2010, there was clear evidence of rising concern in the Donagh community about the return of the McDermott brothers to their family home, after the conclusion of the court case. In the period up to 5 July 2010, RQIA found that there was a lack of understanding within WHSCT about its duties and powers in relation to the STOs. It was perceived that the issue of the STOs may have resulted in the WHSCT having taken on a greater public protection responsibility in supervising the brothers through agreeing to provide a supervising officer for the STOs.

7.6.15 On 28th June 2010 a meeting was convened by DHSSPS which considered a series of actions to be taken forward, following the court decisions. The WHSCT convened a multidisciplinary meeting on 29 June 2010 to develop an action plan. The action plan included that daily visits by social services should commence to the McDermott home. It was also agreed that contact should be made with the McDermott family with regard to a possible voluntary admission of the two brothers to hospital. This action was then taken forward by the supervising officer. The family agreed to consider the proposal but expressed concern about the possibility of the brothers not being released from hospital.

7.6.16 On 1 July 2010, a solicitor wrote a letter on behalf of the WHSCT to the solicitors acting for the McDermott brothers. It advised that it was the view of the WHSCT that the welfare and treatment of the brothers would be best served at that point in time by their accommodation in the safe environment of a learning disability unit. The view of the WHSCT was also that the brothers would be accommodated on a voluntary basis. The letter confirmed that there was no intention to

seek the detention of the brothers under the Mental Health (Northern Ireland) Order 1986. A response was requested by the following day.

7.6.17 On 2 July 2010, WHSCT plans were in place for the brothers to be admitted to a hospital on a voluntary basis. However, a member of the McDermott family intervened and cited the terms of the STOs as giving the brothers the right to remain at home. Following this intervention by a family member, the solicitor acting on behalf of the WHSCT, wrote to the solicitor acting for the McDermott brothers. The letter gave notice that by virtue of the terms of the STOs imposed upon the brothers, the supervising officer had determined that, with immediate effect, the brothers were to reside at a named hospital. The letter stated that if the brothers failed to comply with this direction they would be in breach of the terms of the STOs.

7.6.18 RQIA found during discussions with senior officers of WHSCT that, advice from senior counsel on 5 July 2010, confirmed that the letter issued on 2 July 2010 was based on a false assumption that the duty of the supervising officer to approve the place of residence in the STOs gave the supervising officer powers to require the brothers to be admitted to hospital.

7.6.19 On 2 July 2010, the solicitors acting for the McDermott brothers sought leave to apply for a judicial review of the decisions made on 2 July 2010 by the supervising officer and the WHSCT in respect of the two brothers. The hearing did not proceed, as copies of STOs were not available. Discussions did take place between legal representatives at the High Court which provided greater clarity around the role and responsibility of the WHSCT in relation to the STOs. In particular, the issuing of the STOs did not alter the public protection arrangements in relation to PPANI, with PSNI as the lead agency for the case, and also for the SOPOs which had been issued.

7.6.20 The WHSCT then carried out its roles in relation to the STOs, with the understanding that the responsibility of the WHSCT was to monitor and supervise both men in regard to their compliance with the STOs, in the context of its therapeutic interventions as a health and social care agency. It was agreed that weekly supervision visits would take place on an unannounced basis rather than daily.

Conclusion

7.6.21 RQIA found that, during the early period after the disposal hearing, there was a lack of clarity as to the trust's duties and powers in relation to the STOs which had been imposed by the judge. This lack of clarity led to two actions which, in retrospect, were not fully appropriate. These were the introduction of daily supervision visits and the issuing of a direction to the brothers to be admitted to hospital.

7.6.22 RQIA found that following the admission of the brothers to hospital on a voluntary basis, the supervising officer continued to exercise her responsibilities in relation to the STOs up to 30 September 2010, the endpoint for this review. She maintained contact with the brothers in hospital and also with family members in Donagh.

Recommendations

7.6.21 A review of the experience of trusts in relation to supervision and treatment orders should be carried out across Northern Ireland to identify learning points which can be shared across HSC organisations. This review should inform the development of guidance for issue to HSC organisations on the exercise of responsibilities in relation to supervision and treatment orders.

7.6.22 The legislation in relation to supervision and treatment orders should be reviewed at an appropriate time, by the relevant Departments, in light of changes made in other parts of the UK.

7.7 Governance, Including Coordination and Communication

7.7.1 The responsibilities of the WHSCT in relation to its discharge of statutory duties and duty of care to its population are complex. A number of key governance and accountability issues arise in respect of:

- child protection
- public protection
- the protection of vulnerable adults
- duties under the Mental Health (Northern Ireland) Order 1986
- duties under human rights and equality legislation
- requirements to work cooperatively with other agencies

This section of the report examines the way in which the WHSCT managed the circumstances of this case as it emerged, considering whether the WHSCT discharged its duties and responsibilities in line with legislation and policy. These considerations are examined under:

- governance and risk management
- coordination of the WHSCT actions
- communication with the community, politicians and the media

Governance and Risk Management

7.7.2 From an examination of the records and in speaking with staff within the WHSCT, RQIA found that the management of the events in the early stages was appropriate across all programmes of care. As reported in section 7.1, following referral from the PSNI to the Gateway team and into the public protection arrangements, a robust and coordinated approach was taken by the relevant personnel. A similar approach was taken by staff working within the Adult Learning Disability team who assumed responsibility for the care of the brothers when they had been assessed as having a learning disability. It is evident that risks were managed at an appropriate level within the WHSCT.

7.7.3 As soon as issues began to emerge in respect of the disposal of the brothers in the community, the WHSCT's Senior Management team took corporate responsibility for issues as they emerged. It was evident from meetings with members of the Senior Management team and the Chairman of the WHSCT that the issues and concerns in relation to this case were shared and discussed at the highest levels within the organisation. In line with its accountability arrangements, the WHSCT also maintained continuous and open lines of communication with the HSC Board and the DHSSPS.

Coordination of the WHSCT Actions

7.7.4 In the period leading up to the disposal hearing on 18 June 2010, clinical and managerial staff contributed, through multidisciplinary processes, to the development of a report, which the WHSCT submitted in response to a direction from the court.

7.7.5 Following the disposal hearing, the WHSCT responded to the growing concerns about the return of the brothers to Donagh by developing an immediate action plan and later a comprehensive care plan.

7.7.6 The WHSCT recognised the need for a coordinated multiagency response in this case after the disposal hearing. The WHSCT established a strategic group and an operational core group. The core group, with representation from PSNI, has made an effective contribution to ensuring appropriate coordination of actions in relation to the case. The core group continues and appears to have been effective in dealing with complex areas of supervision and treatment; child protection; adult safeguarding; and ensuring effective links to public protection arrangements.

7.7.7 In planning for the potential, and then actual, admission of the brothers to hospital, meetings between key WHSCT staff were held to ensure that respite and treatment could be provided without compromise to either the rights or safety of the other hospital patients, or the McDermott brothers.

Communication

7.7.8 RQIA acknowledges the importance of communication to stakeholders by trusts on matters of public interest. Three main strands of communication were considered in relation to this case. They included:

- communication with the wider Donagh community
- communication with the media
- communication with the Northern Ireland Assembly, through the answering of Assembly Questions and attendance at evidence sessions of Northern Ireland Assembly committees

7.7.9 As a result of community dissatisfaction following the return of both brothers to their home in Donagh, senior WHSCT staff attended a series of meetings with representatives of the Donagh community, including a public meeting. These meetings were held on 5 July 2010, 19 July 2010 and 14 September 2010. The meetings were facilitated by local political representatives and the Donagh Community Forum. The WHSCT stated the meetings were held to provide clarity on the legal obligations and its duties in respect of the case; to provide advice on services; and to maintain effective lines of communication. However, the survivors and representatives of the community advised RQIA that they considered that the WHSCT could have been more

proactive in responding to the emerging concerns. Following the meeting held on 14 September 2010, a joint statement was issued on behalf of all who attended, with a commitment to ongoing engagement.

7.7.10 WHSCT provided information to inform responses to a set of 26 questions posed by the representatives of the Donagh community to the Minister of Justice and the Minister for Health, Social Services and Public Safety.

7.7.11 On 9 September 2010, the WHSCT Chief Executive, at the request of the DHSSPS, attended a meeting of the Northern Ireland Assembly Committee for Health, Social Services and Public Safety.

7.7.12 In the period from 1 June 2010 to 30 September 2010, the WHSCT dealt with an unprecedented 117 press enquiries about the case. The WHSCT's communication department managed the enquiries in line with WHSCT procedures.

Conclusion

7.7.13 The management of the McDermott case has been complex for WHSCT and has required sensitive handling and communication. The WHSCT has had to ensure that it upholds its duties under the Mental Health (Northern Ireland) Order 1986 and its obligations to protect children and vulnerable adults. It must be recognised that the WHSCT, in its communication with the community and in other public forums, must maintain its legal duty of confidentiality for those in its care.

7.7.14 RQIA considers that within the governance arrangements, risks were managed at appropriate levels within the WHSCT. Issues and concerns in relation to the case were shared and discussed at the WHSCT's Senior Management team and the WHSCT Board. The WHSCT maintained continuous and open lines of communication with the HSC Board and DHSSPS.

7.7.15 A key outstanding issue remains the strongly held view of survivors and the Donagh community that the WHSCT had failed to communicate with them effectively on this case. RQIA recognises that the WHSCT met with the Donagh community and that it was mindful of its duty of confidentiality and the limitations of the powers available to it under the STOs. There is evidence from the outcome of the joint meeting held on 14 September 2010 that the community and the WHSCT both recognise the need for continuing dialogue. Through this dialogue, RQIA considers that a greater understanding can be achieved as to how to manage communication more effectively in the future.

Recommendation

7.7.16 The WHSCT should work with partner organisations to maintain proactive and meaningful engagement with the Donagh

community in matters relating to this case, ensuring at all times that it maintains its legal duty of confidentiality to those in its care.

8.0 Conclusions and Recommendations

8.1 In examining the detail of the WHSCT's involvement of this case, RQIA acknowledges that the issues being dealt with were complex. It is evident that the WHSCT has duties that span a range of statutory functions. These relate to the provision of care and protection of the population within its geographical boundary, and also a duty for the care and treatment of individuals identified to them as having a mental disorder or learning disability.

8.2 In ensuring that the terms of reference for this review have been properly addressed, RQIA examined in detail the full range of clinical and care records of the brothers; the full range of management communications and directives with the service; and, communication to and from other agencies and organisations associated with the case. This information was further validated through interviews with the range of WHSCT officers involved in the case.

8.3 Key to understanding the many complex issues arising out of the case, the views of survivors were also sought on their perceptions and experience of the care, support and communication from the WHSCT.

8.4 RQIA assessed that the WHSCT has met the requirements of relevant legislation and policy in its supervision, care and treatment of James Francis and Owen Roe McDermott, and its governance and management arrangements relevant to the case.

8.5 With regard to child protection, RQIA concluded that the WHSCT acted within the legislative framework governing child protection. In recognition of the distress caused to those associated with the case, the Gateway team discharged its statutory responsibilities around child protection in a sensitive and empathetic manner. This included a strategy for engagement with the community on strategies for child protection. A specific issue was identified in relation to the assessment of child protection risks in a relevant area of organised social activity. A recommendation has been made on how this should be addressed in the future.

8.6 One area for improvement was noted to have been the potential for vital communication to be lost due to difficulties in communication between social services and education during school holidays. As a result, a recommendation is made to address this issue on a regional basis.

8.7 RQIA considers that, in general, the WHSCT contributed appropriately to the PPANI arrangements in this case, through the work of the WHSCT's Principal Officer. An initial lack of awareness of the role of the new PPANI arrangements across the organisation did not impact on the response of the organisation to the PPANI process. A recognised need to ensure effective collaboration in this case after the

brothers were designated at Category 1 was subsequently addressed by the WHSCT establishing a multiagency core group.

8.8 From their initial assessment as having learning disabilities up to 30 September 2010, it was evident that the WHSCT provided the full range of care and treatment services to James Francis and Owen Roe McDermott, in keeping with their assessed needs.

8.9 RQIA recognised that the many issues surrounding this complex case have created significant difficulties in delivering care and treatment to the brothers and their immediate family. RQIA commends the professionalism and integrity of all staff involved in the care and treatment of the brothers, which was evidenced during this review.

8.10 It was evident that, during the early period after the disposal hearing, there was a lack of clarity within the WHSCT as to its duties and powers in relation to the STOs which had been imposed by the judge. This lack of clarity led to actions which, in retrospect, were not fully appropriate. This led to the WHSCT instigating daily supervision and the issuing of a direction to the brothers to be admitted to hospital. RQIA considers that neither of these actions was appropriate in the circumstances.

8.11 RQIA found that following the admission of the brothers to hospital on a voluntary basis, the supervising officer continued to exercise her responsibilities in relation to the STOs up to 30 September 2010, the endpoint for this review. She maintained contact with the brothers in hospital and also with family members in Donagh.

8.12 The WHSCT has a key responsibility for good governance, which includes effective communication with a wide range of relevant stakeholders. The management of the McDermott case has been complex for the WHSCT and has required sensitive handling and communication. The WHSCT has had to ensure it upholds its duties under the Mental Health (Northern Ireland) Order 1986 and its obligations to protect children and vulnerable adults. It must be recognised that the WHSCT in its communication with the community and in other public forums must maintain its legal duty of confidentiality for those in its care. RQIA considers that within the governance arrangements, risks were managed at appropriate levels within the WHSCT. Issues and concerns in relation to the case were shared and discussed at the WHSCT's Senior Management team and the WHSCT Board. The WHSCT maintained continuous and open lines of communication with the HSC Board and DHSSPS.

8.13 In assessing the actions of the WHSCT in relation to communication with the survivors of Donagh abuse, and the provision of services to support them, RQIA found that some of the survivors had strongly held negative views of the WHSCT's contributions to their individual care and support. There is a need to identify how all trusts, as part of a

multiagency response, can engage more proactively with survivors of sexual abuse, and ensure that there is clarity about how to access services.

8.14 RQIA recognises that when the WHSCT met with the Donagh community, it was mindful of its duty of confidentiality and the limitations of the powers available to it under the STOs.

8.15 It was evident that the WHSCT provided additional funding to NEXUS in relation to an increase in demand for its services from the Donagh area. NEXUS services were welcomed by those survivors who had accessed them, although the period for which services could be provided was considered to be too short. RQIA recognises that there were no specific referrals to WHSCT services from PSNI.

8.16 A recommendation has been made on developing effective, multiagency mechanisms to disseminate information about available services to survivors of sexual abuse as early as possible following disclosure of a complaint to PSNI.

8.17 RQIA examined the effectiveness of the WHSCT's engagement with other statutory organisations involved in the management of the case.

8.18 As outlined above RQIA considers that the WHSCT's specific engagement with other agencies, through the formal multiagency public protection processes under PPANI, was effective.

8.19 It was also evident that the WHSCT fulfilled its responsibilities in relation to the criminal justice system. It provided an appropriate adult service when requested and responded appropriately to a court direction to prepare a report to set out the WHSCT's views in relation to disposal. WHSCT staff maintained effective working arrangements at operational level with colleagues from PSNI.

8.20 During the course of the review, RQIA identified two other areas that require further consideration in the onward management of this and similar cases in the future.

8.21 As part of its work, RQIA met with members of the wider Donagh community who had organised themselves through the Donagh Community Forum. Some of the survivors of the abuse were also part of that forum. The community is recognised as a key stakeholder. The WHSCT met on three occasions following the disposal hearing to clarify issues and concerns held by the community. It was evident from RQIA's discussion with the community that there remains the strongly held view of survivors and the Donagh community that the WHSCT had failed to communicate with them effectively on this case. There is evidence from the outcome of the joint meeting held on 14 September 2010 that the community and the WHSCT both recognise the need for continuing dialogue. Through this dialogue, RQIA considers that a

greater understanding can be achieved as to how to manage communication more effectively in the future.

8.22 A further issue that arose through the course of the review was the wide ranging and different understandings of the working and management of STOs. This report aims to bring some clarity to the origins of these orders, noting that they were primarily aimed at providing supervision of care and treatment in a community setting.

8.23 It became increasingly clear to RQIA that there should be a detailed review of the experience of health and social care trusts in relation to STOs across Northern Ireland to identify learning points which can be shared across HSC organisations. The outcome of this review should inform the development of guidance for HSC organisations on the exercise of responsibilities in relation to STOs. RQIA was also of the opinion that as part of the development of new mental health and capacity legislation, consideration should be given to a review of how the use of STOs should be informed by the experience in the rest of the UK.

8.24 Having reviewed the actions of the WHSCT, RQIA concluded that the trust has discharged its statutory functions in respect of this case. In line with the terms of reference for this review, RQIA has identified a number of important learning points leading to the following recommendations.

Recommendations

1. The Regional Child Protection Committee should engage with the HSC trusts and with the education and library boards to consider amending the existing regional protocol to ensure that there is effective education service input into child protection processes at all times including school holiday periods.

2. The WHSCT should ensure that all relevant staff are aware of the PPANI arrangements and the roles and responsibilities of the WHSCT Principal Officer.

3. The WHSCT should ensure that its scoping of child protection risks takes account of all relevant areas to include areas of formal or informal social activity.

4. HSC organisations should review their arrangements to ensure that there are effective mechanisms to disseminate information about available services to survivors of sexual abuse and should work proactively with criminal justice agencies to ensure that advice and support is made available as early as possible following disclosure to the PSNI.

5. A review of the experience of trusts in relation to supervision and treatment orders should be carried out across Northern Ireland to identify learning points which can be shared across HSC organisations. This review should inform the development of guidance for issue to HSC organisations on the exercise of responsibilities in relation to supervision and treatment orders.

6. The legislation in relation to supervision and treatment orders should be reviewed at an appropriate time, by the relevant Departments, in light of changes made in other parts of the UK.

7. The WHSCT should work with partner organisations to maintain proactive and meaningful engagement with the Donagh community in matters relating to this case, ensuring at all times that it maintains its legal duty of confidentiality to those in its care

9.0 Appendix

Appendix 1 DHSSPS Letter to RQIA- McDermott Case Review (6 October 2010)

From the Permanent Secretary
and HSC Chief Executive

Dr Andrew McCormick

Department of
Health, Social Services
and Public Safety
www.dhsspsni.gov.uk

AN ROINN
Sláinte, Seirbhísí Sóisialta
agus Sábháilteachta Poiblí

MÄNNYSTRIE O
Poustie, Resydènter Heisin
an Fowk Siccar

Castle Buildings
Stormont Estate
BELFAST
BT4 3SQ

Tel: 028 90 520559
Fax: 028 90 520573
Email:
andrew.mccormick@dhsspsni.gov.uk

Glenn Houston
Chief Executive
Regulation Quality & Improvement Authority
9th Floor
Riverside Tower
5 Lanyon Place
BELFAST
BT1 3BT

Our Ref: AMCC 2666

Date: 6 October 2010

Dear Glenn

McDERMOTT CASE REVIEW

Following my letter to you, dated 30th September 2010, Minister McGimpsey, has agreed the attached Terms of Reference for the independent case review to be undertaken by RQIA.

I wish to draw to your attention the need to communicate with the survivors of abuse and the Donagh community throughout this process. In addition, and where appropriate to do so, liaison and engagement with the Criminal Justice Inspectorate is recommended.

Minister McGimpsey will expect an interim report on this case by 8th November 2010 with a date for the final report to be determined thereafter. The handling arrangements and general principles outlined in the joint protocol between RQIA and the Department apply in this independent review.

Yours

Andy

ANDREW McCORMICK

TERMS OF REFERENCE

On 30 September 2010, the Department of Health, Social Services and Public Safety commissioned an independent case review of the Western Health and Social Care Trust's duties and responsibilities in relation to the McDermott case (James Francis and Owen Roe). This commissioned Review, under Article 35(1) (b) of the HPSS (Quality, Improvement and Regulation) (NI) Order 2003, will cover the time period from the date of arrest of the brothers to 30 September 2010.

The terms of reference of the review are:

1. To describe the discharge of the Western Health and Social Care Trust's statutory duties, and responsibilities in regard to the supervision, care and treatment of James Francis and Owen Roe McDermott from the point at which they were arrested, in relation to offences pertaining to sexual abuse, to 30 September 2010.

2. To describe the actions of the Western Health and Social Care Trust in relation to communication with the survivors of Donagh abuse, and the provision of services to support them.

3. To review the Western Health and Social Care Trust's actions, including governance and management arrangements relating to the supervision, care and treatment of the brothers, taking account of the relevant legislation, policy and guidelines.

4. To examine the effectiveness of the Western Health and Social Care Trust's engagement with other statutory organisations involved in the management of the case, including public protection.

5. To consider other relevant matters that emerge during the course of the review.

6. To identify any learning from the case and make recommendations for health and social care organisations.

7. To identify any learning to further promote joint working with criminal justice agencies in the future management of such cases.

Timetable

Terms of Reference to be agreed	- 7 October 2010
Interim report to Minister McGimpsey	- 8 November 2010
Final report	- Date agreed following receipt of 1st report