Independent Review of the Management of Brandon

The National Independent Review Panel – Brandon Report for Publication

This report has been pseudonymised

to protect the identity of the residents and the service

National Independent Review Panel

Version as of 26th November 2021

Introduction

The National Independent Review Panel (NIRP) was established by the HSE in 2017 to review the most serious incidents within the HSE and HSE funded disability services. The NIRP examine circumstances related to people with a disability where there are major concerns about how the services involved managed the care of an individual or group of individuals. The NIRP seek to determine what the relevant services and individuals involved in the case might have done differently that could have prevented the significant harm or improved the quality of life for the person/s concerned. The purpose of a review is therefore to ensure that lessons can be learned from the case and that those lessons can be applied to future cases to prevent similar situations from occurring again.

On the 4th December 2018 the Health Service Executive (HSE) commissioned the National Independent Review Panel (NIRP) to complete a review into serious incidents of concern which took place between 2003 and 2016 in "Stillwater services". These services are directly provided HSE residential and day care services for adults with intellectual disability.

Prior to this commission a Look Back Review (2018) into these incidents had been conducted by an external expert. On 31st October 2016 a public representative had brought concerns regarding the regular occurrence of sexual assaults to the attention of the general manager for disability services in the Community Health Organisation (CHO). On 5th December 2016, as a result of these concerns, the Chief Officer in the CHO commissioned a Look Back Review. These concerns had been raised with a public representative by an individual who the public representative referred to as a "whistle blower".

The Look Back Review (2018) report identified 108 occurrences of sexually inappropriate behaviours by one resident of Stillwater services, referred to in this report as 'Brandon', towards other named residents of the facility between the years 2003 - 2011.

Terms of Reference

1. Review the adequacy of the governance arrangements pertaining to the facility where Brandon resided to ensure fitness for purpose:
    - Leadership, culture and management of the facility (both internal and external) and decision making processes
    - Monitoring, oversight and quality assurance by the HSE of the facility
    - Staffing: including, job descriptions recruitment processes, resources qualifications, skill mix, training, supervision and support
    - Operating policies and procedures including admission and discharge criteria, risk management, whistle blowing, reporting of adverse and untoward incidents
    - Wider safeguarding policies
    - User participation and involvement in decision making including advocacy
    - Family participation and involvement in decision making
    - Records and record keeping.

2. Review and examine the response from HSE management (both local and at CHO levels) since the concerns were brought to their attention, particularly in relation to the HSE plan to deal with:
    - Protection and support for residents affected by Brandon's behaviour
    - Communication with families
    - Communication with the HSE Regional and National management regulatory bodies and other key stakeholders
    - Assessment and care planning relating to Brandon.

3. Review the consideration of and the implementation of the recommendations contained in the "Look Back Review (2018)" report.

4. Review the consideration of and the implementation of recommendations from any Health Information and Quality Authority (HIQA) inspection reports.

5. Identify any issues which the review team believe require further review and examination

6. Identify opportunities for learning arising from the findings of the review.

7. Provide a report to the HSE's National Director, Quality Assurance and Verification with conclusions and recommendations for improvement.

Methodology

The timeframe for this review is from January 2003 to December 2018. The review focused on Stillwater services, which is a HSE residential and day care service for adults with intellectual disability.

The review process focused on a systems analysis to review what went wrong, identify failings in the system and highlight key learning. In that context the NIRP does not attribute blame or culpability to individuals. The purpose of the report is not to establish whether abuse has occurred or to what extent. The expertise to establish whether an abusive incident occurred rests with the HSE. The Look Back Review (2018) had already established a baseline of incidents as recorded in Stillwater service files.

John Smith Unit

The John Smith unit, which became part of Stillwater services in 2005, was a three ward complex within a local community hospital situated on the outskirts of the town. The unit was opened in 1983 as a residential facility for people with intellectual disability, who, in line with national policy at the time were relocated to there, primarily but not exclusively from large mental health institutions. The John Smith unit shared the community hospital site with a number of other units which mainly provide nursing home services to older people. The John Smith Unit closed in Spring 2020.

Stillwater complex

The Stillwater complex, which also became part of Stillwater services in 2005, is comprised of seven houses and is a residential and day care service for adults, both men and women, with an intellectual disability in the mild to severe range. The Stillwater complex which is just across the road from the John Smith unit, was first opened for residents in 2005.

Profile and behaviour of Brandon (Deceased)

The person whose behaviour is the focus of this review (Brandon) was admitted the John Smith unit in 1991 and subsequently transferred to the Stillwater complex in 2008 where he remained until his discharge to a local nursing home in 2016. Brandon passed away in the nursing home in April 2020.

Brandon was a gentleman with a diagnosis of mild – moderate intellectual disability and Bipolar Affective Disorder. Brandon also had an additional diagnosis of Frontal Lobe Syndrome to which a senior forensic clinical psychologist directly attributed Brandon's sexually inappropriate behaviour.
The first recorded incident of sexual assault by Brandon, noted on the files viewed by the NIRP is dated 28th January 1997, when Brandon was found by staff to have his hands on the genitals of another resident. The records from 28th January 1997 to 3rd December 2002 note a further three incidents of inappropriate sexual behaviour. Although the terms of reference of this review are confined to look at incidents between 2003 and 2018, these earlier records suggest that this sexualised behaviour had been on-going and known to managers of the service prior to 2003.

From 2003 onwards the number of incidents of Brandon's sexually inappropriate behaviours increased. The first recorded incident in 2003 occurred on 16th January 2003 when Brandon was observed to be touching another resident "inappropriately". In the period 2003 to 2011 Brandon engaged in a vast number of highly abusive and sexually intrusive behaviours. Evidence available on file would suggest that Brandon regularly targeted particular individuals and was able to identify particularly vulnerable residents whom he pursued relentlessly. The range of inappropriate sexual behaviour by Brandon included:

- Exposing himself and masturbating in the presence of others. This behaviour was very frequent and occurred in the sitting rooms and corridors of his shared accommodation and on regular bus trips
- Almost nightly prolonged, masturbation which was often accompanied by verbal obscenities being shouted at staff and other residents
- Sexual touching and attempted touching of other residents outside their clothing
- Touching the genital and intimate areas of other residents inside their clothing
- Attempting to and succeeding to enter the bedrooms of residents whom he had previously targeted, during the night
- Targeting particularly vulnerable residents
- Verbal and physical aggression to other residents and staff.

The NIRP review team have identified eighteen residents who it is believed were sexually assaulted by Brandon in the period January 2003 to November 2011. From November 2011 onwards, there are no further written reports of Brandon assaulting a named individual. However, there are a number of reports on file to suggest that Brandon continued to engage in inappropriate behaviour,

including sexual touching of other residents, publicly exposing his genitals or masturbating in public until his move to a private nursing home in May 2016.

Management strategies for Brandon's behaviours

A common management strategy employed to deal with Brandon's sexually assaultive behaviour was to move him around various wards. Brandon was moved a total of nine times in the fifteen year period of this review. While each of these moves provided some respite to the staff and residents from the ward Brandon was vacating, unfortunately they also gave him access to other residents many of whom became new victims of his abusive behaviour.

On the 22nd December 2011 Brandon was moved to house 2, in the Stillwater complex to live by himself away from other vulnerable residents. While this move resulted in a sharp reduction in the number of sexual assaults recorded, unfortunately, on 5th September 2013 he was moved back again to house 1 to live with the residents he had previously assaulted.

Brandon's move to house 2 appears to be the only successful strategy employed in the management of Brandon in that it did provide some protection, albeit short term, to other residents.

Communication with families

Throughout the period under review eighteen known victims of Brandon's sexual assaults have been identified. There is no evidence that any of the families of these residents were informed at the time of these assaults. All family members have now been informed of the abuse and have been issued an apology by senior staff from the CHO.

During the course of this review the NIRP met with two individuals assaulted by Brandon, who have capacity to make their own decisions. Neither of these individuals continue to reside in Stillwater services and describe their time there as not particularly happy. One of the individual's expressed a fear of Brandon and a desire not to return to Stillwater services in the future.

The NIRP have also met with a number of family members of those affected by Brandon. There were a small number of individuals affected by Brandon's behaviour where it has not been possible to locate an appropriate next of kin to engage with. The first objective of the NIRP's engagement was to ensure that individuals and families were made aware that the HSE had commissioned the

NIRP to complete a review in Stillwater services. The second objective was to share with the individuals and families the main findings and recommendations of the review.

The review panel found that families were open to being engaged with and for the most part were glad to have been eventually told what had happened to their relatives in Stillwater services. They were also happy to learn that an independent (NIRP) review had been commissioned which they hoped would get to the truth of why this behaviour by Brandon was able to continue for so long. All of the families expressed their sadness and at times anger at what had happened in Stillwater services and sought some assurance that this would not happen again. Many of the families who met with the NIRP were concerned about the shame and stigma associated with sexual abuse and had indicated that for this reason they had not shared the disclosure of abuse with extended family. These families were particularly keen that the report should not come into the public domain. There was however one family who expressed the wish to have the anonymised report published, to ensure openness and transparency for the future protection of all residents of disability services.

Reports to An Garda Síochána (AGS)

The CHO have reported to the NIRP four occasions of contact between Stillwater services and An Garda Síochána (AGS) in relation to Brandon.

The NIRP found that the first report to An Garda Síochána relating to the sexual assaults was made June 2011 when a nurse manager met with a Garda sergeant in the local station, the NIRP however found no evidence of any HSE follow up on this report.

The second occasion occurred in March 2017. This is an undocumented recollection by service manager (2) which was described in a letter dated 13th July 2020 from the HSE to the NIRP:

"I informed her that there was a look back review being completed by an independent team into alleged historical abuse of a sexual nature within the centre. She asked me whether there was anything she needed to do at that time. I informed her that a copy of the final report would be given to the Gardaí. No notes were taken by her or me as I was just informing her of the review."

An Garda Síochána were again contacted in December 2018 when a service manager met with the Garda Liaison to Stillwater services and briefed her on the outcome of the "Look Back Review"

(2018). A copy of the report was given to the Garda liaison officer at this time who advised that she would be escalating this information to senior Gardaí.

In April 2019 An Garda Síochána confirmed to the HSE that they are completing an investigation regarding Brandon. An Garda Síochána also replied to the NIRP in a letter dated 26th February 2020:

"There is currently an on-going Garda investigation into allegations of abuse of patients at Stillwater… and also into the alleged withholding of information on the sexual abuse of patients by staff employed by the HSE. It is expected that a file in these matters will be submitted in the coming weeks which will in turn be forwarded to the Director of Public Prosecutions for direction…..as this is an on-going investigation An Garda Síochána are unable to comment any further at this point".

Reports to the Safeguarding and Protection Team

As part of the HSE's 'Safeguarding Vulnerable Adults Policy' (2014), Safeguarding and Protection Teams (SPTs) were established nationwide in January 2016 in each of the HSE's nine CHO areas. SPTs therefore, did not exist for most of the period under this present review, nonetheless their role in Stillwater services after the whistle-blower raised concerns with the public representative is very illuminating in terms of the culture and attitude towards safeguarding concerns displayed by the management of this facility. The NIRP found evidence that the HSE on occasions disregarded the advice and guidance offered by the safeguarding and protection team in terms of how serious safeguarding concerns should be dealt with. The NIRP were given access to a report by an external expert in safeguarding which was commissioned by the HSE in 2016 to undertake a review of Safeguarding arrangements across the designated Centres. This review demonstrated some evidence of effective safeguarding arrangements but also highlighted areas of concern. An action plan was developed to address the recommendations of the report throughout the CHO with the view to further strengthening safeguarding within the Service. The HSE have informed the NIRP that these improvements assisted the service in obtaining full registration with HIQA.

HIQA

The Health Information and Quality Authority (HIQA) was established under the Health Act 2007. HIQA is an independent authority established to regulate health and social care services in Ireland. For most of the period of this review HIQA did not have a remit or legal authority to inspect disability services in Ireland. This legislative requirement began in November 2013. While the NIRP believe Brandon continued to pose a threat to residents living in Stillwater services until his move to the

nursing home in 2016 all of the recorded incidents of inappropriate behaviour by Brandon towards others took place in Stillwater services prior to 2011. This timeframe preceded HIQA's legal authority to inspect residential centres for people with a disability. The NIRP did, however, note that HIQA inspections carried out since July 2014 found serious deficiencies in the care provided to the Stillwater residents including *"significant risks to the safety and welfare of the residents in the centre"*. At that time, HIQA also identified *"serious failings in the governance and management of Stillwater services",* citing failures to report and investigate allegations of abuse. *"Inspectors identified several allegations of abuse that had not been appropriately reported to management or when reported, had not been properly investigated in accordance with national safeguarding policies or procedures".* Since 2016 HIQA have completed regular inspections and have recognised the improvements within the service. Stillwater centres now meet the necessary standards to maintain their registration.

Key Findings

A number of residents in Stillwater services were subject to sustained sexual abuse by another resident, Brandon, over a prolonged period of time during his residency (Brandon was discharged from this facility on the 9th May, 2016). It is clear from the evidence reviewed that this occurred with the full knowledge of staff and management of the facility at that time. It was eventually brought to light by the actions of a 'whistle-blower' who approached a public representative on 7th October 2016, who in turn brought it to the attention of the general manager in the county's disability services. This resulted in a look back review being conducted to establish the facts and the extent of Brandon's behaviour. The NIRP were subsequently commissioned to review the governance arrangements in the facility and understand why this situation had continued over a period of years without any effective action being taken by the management, during Brandon's residency, to stop and prevent these highly traumatic assaults.

The NIRP found that there were a number of contributing factors which led to this situation continuing for so long.

The review panel believe the most significant contributing factor was the clinical environment of the John Smith unit which was subsequently recreated within the Stillwater complex. This environment promoted a medical model approach which largely reflects how people are cared for in a hospital environment where residents are viewed as patients who are ill and in need of treatment. When most of the residents were eventually relocated to the Stillwater complex (2005-2008) this culture of hospital care continued with the houses in Stillwater being described as wards and the people

with disabilities living there as patients. The review team found the practice within this complex to be outdated and having all the characteristics of an institutionalised, congregated setting.

The fact that each resident in Stillwater services does not live in a rights based environment where they can make real decisions about where they live and who they live with, means residents are completely dependent on staff in the service to protect them. This lack of control or choice rendered residents powerless to protect themselves from Brandon or to avoid his unwanted sexual advances.

Staff too, experienced this powerlessness as they regularly reported incidents to the director of nursing at that time, in the expectation that something would change which it never did. Staff with whom the NIRP met described an environment where *'people were and still are very fearful of coming forward (the staff member) described a legacy of bullying where people were shouted down and sometimes bullied out of their jobs.'* The review team did, however, find some evidence that many of the staff working in Stillwater services did their best to manage a very difficult but ultimately unmanageable situation. This difficult working environment undoubtedly contributed to high levels of absenteeism and a reliance on agency staff which in itself contributed to Brandon's on-going mismanagement.

The NIRP also found that a lack of external management oversight and leadership from the HSE also allowed this situation to worsen over time. It appears to the review team that the leadership in disability services in this particular unit was embedded within an old system and culture which lacks the vision, knowledge, skills and expertise to design and manage a modern person centred service for people with intellectual disabilities.

The service strategy of moving Brandon from place to place in an attempt to manage his behaviour only served to make the situation worse as it simply created new opportunities for Brandon to abuse new victims. Unfortunately at no time during Brandon's twenty years in this service was a holistic assessment of his needs conducted or an alternative, more specialised placement considered for him.

The review team found an abundance of policies and procedures within the service but found little evidence that staff had been properly trained on how to use or implement them. Basic guidance on such practices as informing families when their loved were harmed were rarely adhered to at that time.

Based on the latest international evidence from research and international best practice the review team believe that it is now time for disability services in this area to move to a social inclusion model in disability care provision. A model which embodies a human rights based approach to person centred care and community integration. A move to such a model would mean a greater emphasis on person centred care where the rights of people with intellectual disabilities are protected as they become empowered to exercise choice and control over their lives. This would require a change in management structures, working practices and most important of all culture. The HSE has informed the NIRP that they have commenced this process of change.

Recommendations

The review panel recommends:

The establishment of a strategic working group tasked with developing a new vision for disability services in this area in line with national policy. This working group should be charged with re-designing disability services in this area and developing a road map for achieving this new vision.

This strategic working group should design services based on a social and human rights based model of service provision for people with disability.

The review panel recommends that this working group should have a strategic reporting relationship to the national director for community operations in the HSE.

It is recommended that the working group should have an independent chair, who has expertise in the development and delivery of intellectual disability services, able to challenge the old order and hold the membership to account for affecting change.

It is also recommended that the membership of this working group should include service users and family members from disability services.