Independent Review of the Management of Brandon

Easy Read Executive Summary

This document uses different names to protect the people and the places named in this report

National Independent Review Panel

Version as of 26th November 2021

Introduction to the Easy Read Executive Summary

NIRP stands for:

National Independent Review Panel.

We were set up in 2017 to look into serious things that happen in HSE social care services.

Our job is to write a report on people with disability who have been harmed in HSE disability services.

We look to see if the serious things that happened could be managed in a better way so that these things will not happen again.

In 2018 the HSE asked us to look into serious incidents that happened in a residential service for people with intellectual disability.

The residential service is called Stillwater services.

The serious incidents happened between 2003 and 2011.

A whistle blower is someone who tells when something wrong is happening to people.

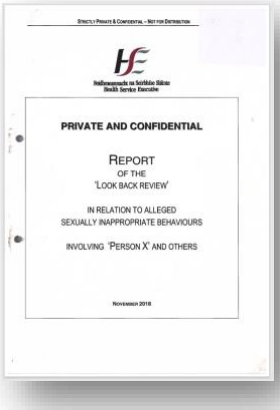
A whistle blower told a politician in 2016 that there were bad things happening to residents in Stillwater services.

The politician told the manager of the disability service that this was happening.

One of the people with intellectual disability who lived in Stillwater services was behaving in a sexually harmful way to other residents who lived there.

This is also called sexual abuse.

The person who was doing this has been given the name Brandon.


PRIVATE AND CONFIDENTIAL

REPORT
OF THE
'LOOK BACK REVIEW'

IN RELATION TO ALLEGED
SEXUALLY INAPPROPRIATE BEHAVIOURS

INVOLVING 'PERSON X' AND OTHERS

A report was written on what was happening in Stillwater services.

This report is called the Look Back Review 2018.

The Look Back Review 2018 report said that Brandon had sexually abused other residents of Stillwater services between 2003 and 2011.

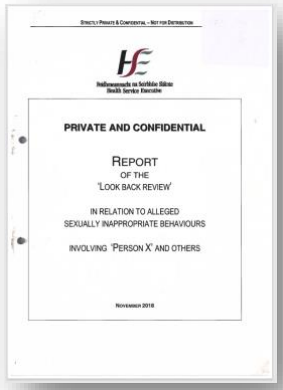
Terms of Reference – the reasons why we wrote the report

We wanted to review how the place where Brandon lived was being managed. We looked at:

- Management
- Staffing
- Policies and how records were kept
- If the residents who lived made choices for themselves about their care.
- If the residents family were involved in supporting their family member in making these choices.

We looked at the HSE plans to deal with:

- Protection and support for residents affected by Brandon's behaviour
- Communication with families
- Communication with the HSE and others who were involved in Stillwater services.
- Assessment and care planning relating to Brandon's care.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We looked at recommendations in the Look Back Review 2018 report to see if they were put in place.

Health Information and Quality Authority
An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

We looked at the Health Information and Quality Authority inspection reports.

They are known as HIQA.

HIQA make sure that health and social care services give a good quality service and protect the rights of people with disabilities.

We looked at their reports on Stillwater services and the recommendations they made.

We wanted to find out things we believe needed further review and examination.

We wanted to find opportunities for learning from what we found in this review.


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National Independent Review Panel
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We had to give a report to the HSE's National Director, Quality Assurance and Verification team about what we found out and our recommendations for improvement of disability services.

Methodology – how we got the information for the report.

The years for the review on Stillwater services were from:

January 2003 to December 2018.

The review was about finding out what went wrong and how we can learn to do things better.

The John Smith Unit

We looked at the John Smith Unit. It had 3 wards in a community hospital. It was opened in 1983.

The John Smith Unit became a part of Stillwater services in 2005.

The John Smith unit shared a community hospital site with other wards which is a nursing home to older people.

The John Smith Unit closed in 2020.

Stillwater services

Stillwater services was set up in 2007 and is made up of 7 houses.

Stillwater is a residential and day care service for adults with intellectual disability.

Stillwater is across the road from where the John Smith Unit was.

Profile and Behaviour of Brandon

The person whose behaviour harmed others is Brandon.

Brandon went to the John Smith Unit in 1991.

Brandon was transferred to Stillwater services in 2008.

Brandon went in to a nursing home in 2016.

Brandon died in the nursing home in April 2020.

Brandon behaved in a sexually inappropriate way. This is called sexual abuse.

This was harmful to others.

Brandon had a mild to moderate intellectual disability.

Brandon had Bipolar Affective Disorder.

Brandon also had Frontal Lobe Syndrome. A senior forensic clinical psychologist said that Brandon's sexually

harmful behaviour was related to this condition.

We noted from Brandon's records that his harmful sexual behaviour towards other residents are documented from 28th January 1997.

There were 3 more records of sexually harmful behaviour towards residents in Brandon's records up until December 2002.

This is important because it shows that management knew about Brandon's harmful sexual behaviour in the past.

From 2003 there are many recorded incidences of sexual abuse by Brandon against other residents.

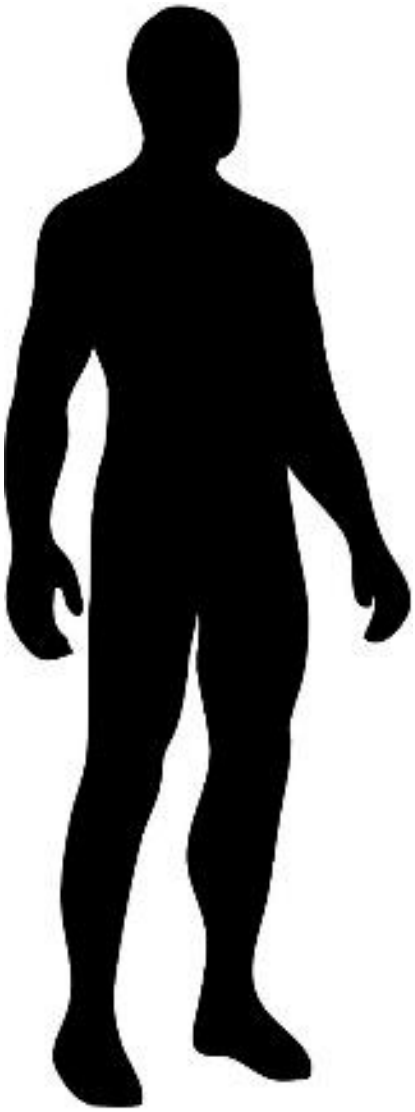
On the 16th January 2003 Brandon was seen by staff touching another resident in a sexually harmful way.

Brandon often focused on residents who were very vulnerable.

Brandon touched his penis often.

This is called masturbation.

Brandon did a lot of things that were sexually harmful to others.



Brandon showed and touched his penis in front of others.

Brandon did this very often in the sitting rooms and corridors where he lived and on regular bus trips.

When Brandon masturbated he would shout bad words at staff and at other residents.

Brandon would touch other residents in a sexual way outside their clothing.

Brandon also touched the genitals which are the penis and vagina areas of other residents inside their clothing.

Brandon would try to go into other residents bedrooms during the night.

Brandon did go in to other residents bedrooms at night.

Brandon would pick on very vulnerable residents.

Brandon was also aggressive to other residents and staff by shouting and hitting out.

There are 18 residents who we believe were sexually abused by Brandon between January 2003 to November 2011.

There are no other records from November 2011 of Brandon sexually abusing a named resident.

There are other reports on record that say Brandon kept behaving in a sexually harmful way to other residents until he moved to a nursing home in May 2016.

Management strategies for Brandon's behaviours – how Brandon was managed.

Brandon was moved 9 times in the 15 year period of this review.

Each time Brandon was moved this protected the residents and staff from Brandon's harmful behaviours.

When Brandon was moved to a different house this gave him access to other residents who became new victims of his sexually harmful behaviour.

Brandon moved in to house 2 in Stillwater on 22 December 2011 to live by himself away from other residents.

The number of records of Brandon's sexually harmful behaviour reduced a lot when he lived on his own.

When Brandon moved to house 2 this stopped Brandon harming other residents because he lived on his own.

This was a good way to manage Brandon.

On the 5th September 2013 Brandon was moved back to house 1 to live with the residents he had harmed before.

This was not a good way to manage Brandon.

Communication with families

The families of the 18 people who were sexually abused by Brandon were not told of the assaults at the time.

All family members have now been told of the abuse.

Senior staff from the HSE have said sorry to the families of the people who were abused by Brandon.

We spoke to 2 residents who could speak for themselves.

They were both assaulted by Brandon.

They no longer live at Stillwater services.

They said their time there was not happy.

One of them said they were afraid of Brandon they did not want to go back to Stillwater services in the future.

We met with family members of residents who were abused by Brandon.

Some family members could not be located.

We wanted to let the families know the HSE had asked us to look into the reports of sexual abuse by Brandon at Stillwater.

We told families that we would write a report and share it with them.

The families were happy to talk to us.

They were happy we were looking into what had happened in Stillwater services.

They want to know why Brandon was able to cause harm for so long.

Many families were worried about the stigma of abuse and had not told other family members.

These families did not want a report published because of this.

All the families said they were very sad and angry at what had happened to their loved one at Stillwater services.

The families wanted to know that this would not happen again.

One family said that they wanted a report published to make sure that everyone knew what had happened and that this would help stop this abuse happening again and protect residents in disability services.

Reports to An Garda Síochána

The HSE told us that Stillwater services contacted An Garda Síochána 4 times about Brandon.

The first report was by a nurse manager to a Garda Sergeant in June 2011.

There was no HSE follow up of this report made to An Garda Síochána.

The second report to An Garda Síochána was in March 2017 by a service manager.

This report was not written down anywhere but the service manager told us what she remembered at the time.

She told the Garda that there was a Look Back Review about sexual abuse at Stillwater services.

The Garda asked if there was anything she could do.

The manager told the Garda that she would give her the Look Back Review when it was done.

The third report to An Garda Síochána was in December 2018.

A service manager met with the Garda liaison officer. This Garda works with the staff and people who live in Stillwater services. The service manager told her about the “Look Back Review” 2018 report.

The Garda liaison officer said she would tell her supervisor about this report.

The fourth report was in 2019 when An Garda Síochána told the HSE that they were investigating Brandon’s harmful sexual behaviour.

On 26th February 2020 An Garda Síochána wrote us a letter and said;

“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 on 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

The HSE have a Safeguarding Vulnerable Adults Policy 2014.

In 2016 safeguarding and protection teams were set up.

These teams did not exist before 2016.

We found that sometimes management in Stillwater services did not take safeguarding advice from the safeguarding and protection teams seriously.

We saw a report on a review of safeguarding arrangements.

This review said there was some good safeguarding arrangements.

This review also said there were some arrangements that were not so good.

The HSE put a plan in place to make safeguarding better.

The HSE told us that this plan helped their services to get registered with HIQA.

HIQA

HIQA were not set up to inspect disability services until November 2013.

Our review of Stillwater services is from 2003 to 2016.

Brandon's sexual abuse of residents in Stillwater services were recorded before 2011.

HIQA started to inspect Stillwater services from January 2014.

HIQA inspectors found when abuse was reported to management in Stillwater services that it was not handled very well.

Since 2016 HIQA have done many inspections in Stillwater services.

HIQA say that Stillwater services now meet the right standards to keep their registration.

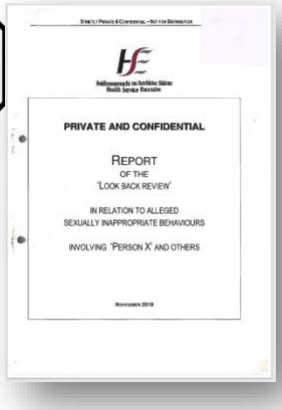
Key Findings – the main things we found out from our review of Stillwater services

We found out that many residents in Stillwater services were sexually abused by Brandon.

This happened for a long time when Brandon lived there until 2016.

We found out that staff knew Brandon was sexually abusing residents in Stillwater services.

A whistle-blower told a politician what was happening in Stillwater services.



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The Look Back Review 2018 happened which looked at the number of people and times where Brandon sexually abused people he lived with.

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We were asked by the HSE to look at how Stillwater services were managed and to find out how the sexual abuse by Brandon went on for so long.

We wanted to find out why management did not do anything to stop Brandon from abusing residents.

We found a number of reasons why Brandon was able to sexually abuse residents for so long.

How residents lived like they were in a hospital was not good in the John Smith Unit and in the Stillwater Services.

Residents were called patients.

Where they lived were called wards.

Residents did not have a choice where they lived or who they lived with.

Residents depended on staff to protect them.

Residents had no power to protect themselves from Brandon.

Staff had almost no power to protect residents.

Staff reported the abuse to the management at the time but nothing was done about it.

We found that the lack of senior management and leadership in Stillwater services let the situation get worse over time.

Management deciding to move Brandon many times made things worse.

This was not a good way to manage Brandon.

Brandon lived in Stillwater services for 20 years.

Brandon never had an assessment of his needs carried out for him.

No one thought that Brandon might need a specialised placement that would support his needs better.

We found that there were a lot of policies but staff had not been properly trained on how to use them.

Based on research we believe that it is now time for disability services in this area to change how they provide care to people with disabilities.

We believe a social inclusion model in disability care is a better way to provide care to people with disabilities.

This means having a rights based approach to person centred care and community integration.

Allowing people with disabilities to make choices for themselves.

The management structures and how things are done in disability services need to change.

The HSE has told us that they have started to make changes.

Recommendations – what we think should happen about what we found in Stillwater services

A group should be set up who will redesign disability services.

This group should design services on a social and human rights based approach to services for people with disabilities.

This group should report to the national director for community operations in the HSE.

The group should have an independent chairperson who has the right skills to develop intellectual disability services.

There should be people with intellectual disability and family members from disability services on this group.

This document was proof read by independent advocates who have intellectual disability.

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