MUCKAMORE ABBEY HOSPITAL INQUIRY

SITTING AT CORN EXCHANGE, CATHEDRAL QUARTER, BELFAST

HEARD BEFORE THE INQUIRY PANEL

ON WEDNESDAY, 5TH APRIL 2023 - DAY 33

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THE INQUIRY RESUMED ON WEDNESDAY, 5TH APRIL 2023, AS FOLLOWS

MS. BRIGGS: Good morning, Chair, members of the Panel. Today, you will be hearing evidence - firstly, from Dr. Petra Corr on behalf of the Northern Health and Social Care Trust. Her statement is in relation to Module 2, two discrete topics in that module, Panel, and I will read those into the record in due course. The reference of the statement is STM-87-1. 09:58

CHAIRPERSON: We've all got that, thank you.

MS. BRIGGS: There are no exhibits to that statement, Chair. And unless there's anything further at this stage, we can call the witness, Dr. Corr, please.

CHAIRPERSON: Please do. 09:58

DR. PETRA CORR, HAVING BEEN SWORN, GAVE EVIDENCE TO THE INQUIRY AS FOLLOWS:

CHAIRPERSON: Good morning, and welcome. Thank you very much for coming to assist the Inquiry and thank you for your statement. We met very briefly in the room from which you've just come. 09:59

Obviously, if you need a break at any stage, just let me know. And we'll break in about an hour anyway, because witnesses are normally the last person to say "I need a break"! So we'll try and stop after about an hour. And I don't think you'll be here all morning. 09:59

THE WITNESS: Thank you.

CHAIRPERSON: And I'll hand over to Ms. Briggs.

1 Q. MS. BRIGGS: Thank you, Chair. Dr. Corr, we've also met briefly this morning. My name is Sophie Briggs. I'm one of the counsel team to the Inquiry. We'll start with a few straightforward questions. You have provided a statement to the Inquiry on behalf of the Northern Health and Social Care Trust. It's dated 26th January 2023, isn't that right? 10:00

A. Yes. 10:00

2 Q. And you have a copy of that in front of you?

A. Yes.

3 Q. It's 14 pages long and it has no exhibits, isn't that right?

A. That's correct. 10:00

4 Q. And are you content to adopt the contents of that statement as the basis of your evidence before the Inquiry?

A. Yes.

5 Q. I'm not going to read through that statement, but I will take you to certain places in it, okay? But I'm going to start by detailing the topics that you were asked to address in the statement. You were asked to address Module 2, which is Health Care Structures and Governance, isn't that right? 10:00 10:00

A. Yes.

6 Q. And you were asked to address specifically two areas - firstly, the interrelationship between trusts regarding patients admitted to Muckamore --

A. Yes.

7 Q. -- and also, provide an outline of provision for community-based services within the Northern Trust, isn't that right?

A. Yes. 10:01

8 Q. Okay. If we turn to the statement then, if that could be pulled up on screen, please, the first page? If we scroll down to section 1, please - okay, so that should be on your screen, Dr. Corr. Can I check it is?

A. It is, yes. 10:01

9 Q. Your qualifications and position are outlined there. It says there that you are a consultant clinical psychologist, isn't that right?

A. Yes, that's correct.

10 Q. Okay. And your position is as the Director of Mental Health, Learning Disability and Community Well-Being within the Northern Trust, isn't that right? 10:01

A. Yes.

11 Q. How long have you held that post?

A. I held the post as interim director since June 2020 and was substantively appointed into that post in July 2020 -- or, sorry, 2023. 2022, apologies! 10:01

12 Q. So you're fairly new within the post. It's really since 2020 that you've been an interim director, followed by the director post? 10:02

A. Yes.

13 Q. Is there a se duration for that post or is it just as long as the post holder wishes to be there?

A. No, it's as long as you wish to remain in post.

14 Q. And, presumably, because you are fairly new to the post, there might be matters on which you can't answer questions; would that be fair to say?

A. It could potentially be, yes.

15 Q. And, presumably, your predecessors to the post, for example, they may be able to assist the Inquiry if there are matters which arise which you can't assist the Inquiry with? 10:02

A. I'm sure.

16 Q. Prior, then, to your role as interim director, can you outline your experience and your posts that you held before that, please, for the Inquiry? 10:02

A. Yeah, surely. So as we've already noted, I am a clinical psychologist. I did my training in clinical psychology and qualified in September 1994. At that point I worked in Home First Community Trust, which is one of the Legacy Trusts that form the Northern Trust, and I worked within learning disability services and initially, for two years, within mental health services in parallel. However, I went on to then proceed to have my full career within learning disability services. 10:03 10:03

I worked in the Northern Trust in a clinical psychology job within community learning disability teams -- 10:03

CHAIRPERSON: Can you just take it a bit more slowly?

A. Sorry, apologies! So I worked within community learning disability teams over the first four years of my career and then moved into a post establishing a

specialist challenging behaviour service in the Northern Trust in the Home First area and was there until January 2003.

In 2003, I moved to a consultant clinical psychology post as head of psychological services for people with learning disability in the North and West Belfast Trust. I covered, at that stage, both hospital and community services - so that was Muckamore - and community services within North and West Belfast as Head of Psychological Services. 10:04 10:04

I then moved out of psychology into a general management post within learning disability services in Belfast Trust at the point of RPA when the Review of Public Administration amalgamated trusts and I worked in Belfast from March 2008 until April 2012 as a service manager for community assessment and treatment services within Belfast. 10:04

I then moved to the Northern Trust to a post as clinical director and head of psychological services for all services within the Northern Trust in April 2012 and remained in that post until July 2020, when I moved into the interim director post. 10:05

17 Q. MS. BRIGGS: Okay, thank you very much, Dr. Corr. So is it fair to say then, to simplify it, you've gone from the Northern Trust, or the Legacy Trust of the Northern Trust, to Belfast Trust, back into the

Northern Trust then through the lifetime of your career?

A. Yes.

18 Q. And as part of your time in the Belfast Trust, that would have involved experience with Muckamore? 10:05

A. Yes.

19 Q. Can I ask the size of the population that's covered by the Northern Health and Social Care Trust at present?

A. I don't have the precise details, but it's approximately 420,000. I can come back with detail on 10:05 that.

20 Q. Thank you, Dr. Corr.

A. But it's the largest of the population trusts in Northern Ireland.

21 Q. Okay. If we turn then to Section 3 of the statement - 10:05 it's internal page 2 - Section 3 there, that's you addressing the interrelationship between trusts regarding patients admitted to Muckamore. I'm going to ask you to read - I think it's the only time I'll ask you to read today, but can I ask you to read 3.1 and 10:06 the first three sentences of 3.2, please?

A.

"In 2007, the Legacy United Hospital Trust, Causeway Trust and Home First Community Trust merged to form the Northern Health and Social Care Trust. This statement 10:06 is made on behalf of the Northern Health and Social Care Trust.

Adults admitted to Muckamore Abbey Hospital from

Legacy, Causeway and Home First Trusts were managed through care management procedures. The process continued when the trusts were amalgamated to the Northern Health and Social Care Trust."

10:06

22 Q. And just the next sentence, please.

A.

"The care management procedure required the allocation of a named worker from the community learning disability team."

10:07

23 Q. So you refer there to the care management procedure. Can I ask is that a written down policy or procedure or how is that -- in reality, is it a written down document somewhere, or has it been in the past?

10:07

A. Yes, care management processes are largely used for the management of individuals who are supported by health and social care services. And it differentiates levels of provision and includes those individuals who are in funded placements and, I suppose, identifies responsibilities that trusts will have in terms of the review of those individuals and the ways of providing support to those individuals.

10:07

24 Q. And is it written down and provided to practitioners, per se?

10:07

A. There are processes within the services that would delineate the responsibility. So the operational policies within the teams would identify the roles of the named worker, for example, in relation to

individuals that they support.

25 Q. And would it be encompassed in a document that could be -- is it written down, for example? Could it be provided to the Inquiry over its various iterations? I assume it's changed over the years? 10:08

A. It will have changed. And, yes, it could be provided to the Inquiry if it was requested.

26 Q. And you've said in your evidence that the care management procedures were there at the time of the Legacy Trusts; can you say when the care management procedure first started? 10:08

A. No, I'm not sure when it started.

27 Q. For example, the Inquiry's Terms of Reference, the time frame of those goes back to 1999; would you be aware whether that was in place at that time? 10:08

A. I'm fairly sure that it was. I'm fairly sure that we've had care management processes in place throughout my entire professional career.

28 Q. And it continues to date then, it's fair to say,

A. Mmm. Yes. 10:09

29 Q. Are you aware of whether that care management procedure applies to other trusts or is it unique to the Northern Health and Social Care Trust?

A. No, all trusts follow care management processes.

30 Q. And would they be the same across the trusts? 10:09

A. Largely.

31 Q. Can you say, for example, what differences there might be in the context of the evidence you're giving today, for example, in the context of learning disability

individuals and those with severe mental health needs?

A. I would imagine that they're largely similar across trusts. They would be very -- there could be slight differences in terminology. Some trusts used key worker, some trusts use named worker. But the core principles are largely the same. 10:09

32 Q. Okay, thank you very much, Dr. Corr. You go on to say then:

"A community named worker is the most involved professional aligned to the service user, often a registered nurse or a social worker." 10:10

Would that individual require to be specialised in learning disability or mental health, for example? 10:10

A. So, the training pathways of social workers and nurses and occupational therapists are somewhat different. Nurses would typically be registrants who are on the particular part of the registration in relation to learning disability nursing. So when we would appoint community learning disability nurses, they would have specific skills, expertise and training in relation to learning disability services. So their training pathway through their qualification will have been in relation to learning disability services in the main. 10:10 10:10

Social workers have more generic pathway and will develop skills and competencies, and will obviously have had placements as well and, potentially, those

placements may have been in learning disability services, but within social work there's a recognition of the competencies that cross specialisms. So it's less likely that they will have had a specific training in relation to learning disability. We do, however, recruit approved social workers and they have an additional qualification and training in relation to mental health and learning disability and, in particular, in relation to the application of the Mental Health Order and, more recently, the Mental Capacity Act. 10:11 10:11

Occupational therapists will have a generic training pathway and then will have specialist placements.

Clinical psychologists have a specialist -- or a generic pathway with a range of core specialisms and, until relatively recently, learning disability was a core specialism within clinical psychology training pathways. So I suppose what I'm saying is that there's a difference within the community learning disability teams in terms of the experience that individuals will have prior to coming into post. 10:11 10:12

33 Q. Thank you very much, Dr. Corr.

CHAIRPERSON: Could I just ask this: Presumably, you have the rotation scheme? 10:12

A. (Witness Nods).

CHAIRPERSON: -- in terms of training. And is LD a rotation?

A. So, again, that depends on the different training pathways. So within clinical psychology, learning disability was a core placement. Within LD nursing, it's obviously a full training pathway that's dedicated to learning disability services. Within the AHP professions, there is a rotation and learning disability can form part of that, but not necessarily required for all placements, as far as I'm aware.

CHAIRPERSON: And is LD sometimes coupled up with mental health? 10:12 10:13

A. There can be a bringing together of mental health and learning disability for, particularly, I suppose, for individuals who are not close to it. For those of us who work in the area, there's a very clear delineation between the two areas.

CHAIRPERSON: Sure. 10:13

A. But I think there's sometimes a simplification that leads to people presuming that learning disability and mental health are a similar field.

CHAIRPERSON: Yes, quite. Thank you very much. 10:13

34 Q. MS. BRIGGS: You go on to say, Dr. Corr, that:

"Care planning meetings were typically organised by MAH and the community named worker was invited to attend. There were a number of meetings, e.g. post admission, safeguarding, multidisciplinary and discharge meeting, routinely held regarding each patient." 10:13

Can I ask what period are you speaking to there? Are

you speaking to post 2007 since the Northern Trust was in place, or are you also speaking to pre 2007 when the Legal Trusts were in place?

A. This statement largely relates to post 2007. However, the practice pre 2007 would have been similar.

35 Q. Okay. Are you able to outline what the basic differences might have been, for example? Is that something you can assist the Inquiry with?

A. I suppose there was no, as far as I can recall or can identify, there was no specific process or procedure that was enshrined in policy or in procedural guidance around engagement with those individuals who were within hospital. We largely, both pre 2007 and post 2007, when an individual was admitted to hospital or had been living in hospital, as many individuals had up to that point, had had a sustained period in hospital, there would have been engagement, which would have been led by the hospital. So there would have been typically a ward round and the named individual would have been -- the named worker for the individual would have been invited to the ward round from time to time to give potentially an update or to appraise the ward team if there was focused work on resettlement of the work in relation to resettlement.

The hospital would equally have given an update on assessment and treatment for those individuals who were in periods of assessment and treatment. So there was joint working.

36 Q. Yes.
A. But it wasn't, as far as I can recall, set in a procedure and it would have varied potentially from one individual to another.
37 Q. And can I take from the evidence that you've given then that there wouldn't have been these formalised meetings with their various titles at the time; is that a fair summation? It would have been more informal contact in terms of ward round attendance by the named worker? 10:16
A. There were post admission meetings. So when an individual -- and sometimes there were pre admission meetings for when we were seeking planned admissions. So there would have been post admission meetings and there would have been preparation for discharge meetings and then multidisciplinary or ward rounds, depending upon the terminology used at the time. 10:16
38 Q. Thank you very much. If we go back to the post 2007, which is really what your statement is focusing on, in terms of the various types of meetings that you've talked about, the post admission, the safeguarding, multidisciplinary and discharge, are there any policies or guidance in place in terms of their frequency, the frequency of those meetings, for example? 10:17
A. I can't recall there being specific guidance around those particular meetings or any best practice that was enshrined in a document. 10:17
39 Q. And you say that they were typically organised by MAH; who else or what other entity might have been responsible for organising those meetings or might have

called such a meeting?

A. Community Trusts could have asked to attend, so we could have prompted and asked to attend on occasions. But, largely, when the individual was in the care of the other trust, which was either North and West Belfast or the Belfast Trust, the responsibility for -- the lead responsibility for care was at that stage passed to that trust. The medical responsibility was passed to the RMO within the hospital. So all care was coordinated and led through the Belfast Trust at that point in time. 10:17 10:18

40 Q. You said there that the Community Trust could have prompted such a meeting. What would have led to that, rather than MAH prompting a meeting?

A. On occasions, there could be families, for example, that we had high levels of involvement with prior to admission and it may be that the family may have brought an issue to the trust and we may have then sought, on behalf of the family and on behalf of the trust, a meeting to perhaps understand the particular treatment that was ongoing at the point in time or any issues that the family raised. 10:18 10:18

41 Q. Okay. And those various types of meetings, would minutes have been written down in respect of them, or did that vary between meeting? Or were there minutes at all? 10:19

A. My memory is that there were meetings with minutes. Ward rounds probably had action notes or notes that were recorded within files, as opposed to necessarily

detailed minutes, but the Belfast Trust would be better able to advise on that, as they would have had responsibility for those.

42 Q. Okay. You say there in your evidence that the community named worker would be invited to attend the meetings. Were they required to attend the meetings? 10:19

A. They were invited and the expectation would have been that they should attend. And certainly as a community trust, we would have expected our staff to attend unless there was a competing demand that made it impossible for them to be there. But in the spirit of ensuring that we were well cited on the progress of the individual's assessment and treatment, our expectation would have been that individual staff members would attend to be updated and to be part of the planning around any individual. 10:20 10:20

43 Q. Was there any process to ensure or check that attendance by a community named worker was at a sufficient level, for example?

A. No, I don't think there was a process. However, it would not have been atypical if there would have been an issue for the Belfast Trust or the North and West Belfast Trust in the pre RPA days to make contact to say that they would like the named worker to attend and that there hadn't been attendance, if that had been an issue. Typically, our staff were keen to attend and would have attended the ward rounds, and certainly when invited by consultant psychiatrists and the RMO we would have been keen to be part of the discussions. 10:20 10:21

44 Q. You go on later in that paragraph, if we could just scroll down a little bit on the screen -- it's the fifth line -- sixth line from the bottom and you said that:

"Northern health and social care professionals also had contact with their Belfast Health and Social Care Trust professional counterparts outside of these meetings to co-ordinate assessment, treatment and support, e.g. OT to OT, psychologist to psychologist." 10:21

Was there any formality to that contact? For example, was it specified how frequently that contact was to occur?

A. No, that would have been in an individual case by case basis and would have been recorded in case notes. So if there was a specific conversation around a specific individual, a patient, I, as a psychologist, for example, would have written a note in the case notes of the discussion with my colleague from the other trust. 10:22

45 Q. Do you think that's adequate, looking back on it now? Hindsight is a great thing, but do you think, for example, formalising the contact between Belfast Trust and Northern Trust or having requirements in respect of the community named worker being required to attend meetings, do you think, with hindsight, that might have been beneficial? 10:22

A. I think that the professional to professional discussions around individual clients were and are

appropriate, and the recording of that within the case files remains the most appropriate way and place to do that. I think that as we look back, engagement between the trust responsible for assessment and treatment and the trust ultimately responsible, the owning trust for the patient or from the trust of origin would best be proceduralised. And certainly if I was establishing a service today, I would be seeking clarity around attendance at meetings on a specified level.

46 Q. Okay. The last sentence in that paragraph then says: 10:23

"Incidents of concern occurring within MAH such as safeguarding were reviewed by the MAH team in keeping with policy."

10:23

Could you assist the Inquiry by, firstly, saying who are the MAH team?

A. So, Muckamore Abbey Hospital had a team of social workers, typically, and a multidisciplinary team, who would have had responsibility for the safeguarding 10:24 issues on the Muckamore site.

47 Q. And the policy reference, what policy is that?

A. So, there's been a series of different safeguarding policies over time. So, in 2006, the policy was in relation to safeguarding vulnerable adults. And that 10:24 was subsequently replaced in, I think, 2015 by a more updated policy in relation to safeguarding.

48 Q. Thank you, Dr. Corr. When you say "incidents of concern", can I ask how are those defined? Is that

wider than safeguarding incidents, for example?

A. No, that's probably predominantly safeguarding. So, safeguarding issues have a fairly -- should have a fairly broad definition in the first instance and there should be a refining then of what meets the threshold for ongoing review and further follow-up and joint protocol.

49 Q. Well, might incidents of concern include restraint, for example?

A. Incidents of concern that were reviewed through safeguarding would not necessarily have included restraint.

50 Q. What about other types of --

A. Restraint would have been considered as part of the treatment methodology that was offered within the Hospital and the management of challenging behaviour at a point in time.

51 Q. What about other types of incidents that might have been recorded on the Datix system? Would they have been encompassed within incidents of concern?

A. They could have been. It was largely the responsibility for the delivery of care in its totality, including the safeguarding and management of incidents was held by Belfast Trust as the responsible provider of care at that point in time.

52 Q. Okay. And, finally, just on that point, the incidents of concern, you say, were reviewed by the MAH team; was there any role for the community named worker or, indeed, the Northern Health and Social Care Trust in

that process?

A. The vast majority of safeguarding was dealt with through the Muckamore team. There would have been some levels of communication with the Northern Trust named worker and, depending upon the nature of the issues, that may or may not have been communicated to the Northern Trust. We were not always aware of all safeguarding issues that had occurred in relation to individuals who were our patients. 10:26

CHAIRPERSON: Can I just ask, in terms of these meetings, if your named worker from your trust goes along because a concern has been raised, what record would be kept in your trust? 10:27

A. We would keep a record in the named worker's file in relation to that patient. So that would be recorded in their file. 10:27

CHAIRPERSON: And would it then be up to the named worker to follow up the resolution of the concern that had been issued?

A. No, the issues were dealt with through Muckamore. So they had the lead responsibility in relation to cases. 10:27

CHAIRPERSON: I understand that. But, for instance, patients might move within Muckamore from ward to ward, but your named worker might have quite a good overview of what was happening with that patient -- 10:27

A. Mm-hmm.

CHAIRPERSON: Would anybody at your trust be, as it were, following up the general care of the patient and --

A. Yeah, certainly if our named -- sorry, apologies?

CHAIRPERSON: No, no.

A. If our named workers were aware of safeguarding incidents and of a patient moving from ward to ward, they would have ensured that they understood what the protection plans were that were in place for that individual. 10:28

CHAIRPERSON: And if there were continuing concerns, would that filter up to a level above the community key worker? 10:28

A. So, our named workers would have supervision arrangements in place and the expectation would be that if there were issues that were being raised in relation to a particular individual, that -- on a repeated basis, for example, or very serious concerns, that would be escalated to within supervision arrangements to that individual's supervisor. 10:28

CHAIRPERSON: And where would the record of that communication sit in your trust?

A. In all likelihood, that would sit within individual professional supervision files and records. 10:29

CHAIRPERSON: So those wouldn't be --

A. It may well have been, in some cases, also recorded into the patient's file that there was a discussion and supervision regarding -- 10:29

CHAIRPERSON: Right.

A. -- so an individual. And it could be updated within the individual patient file as well.

CHAIRPERSON: And since when were those all made

electronic and searchable?
A. The patient records?
CHAIRPERSON: Yes.
A. We aren't on electronic records. We're on paper records.
CHAIRPERSON: You're still on paper records?
A. Yes.
CHAIRPERSON: Now?
A. Mm-hmm.
CHAIRPERSON: So they're not really searchable? 10:29
A. No. They could be manually trawled.
CHAIRPERSON: Okay, thank you. Sorry to interrupt, Ms. Briggs.
53 Q. MS. BRIGGS: No problem at all, Chair. I'm going to move on. I'm going to ask a couple of general questions before we go back to the statement. In terms of funding when a patient transferred out of your trust and into the likes of Muckamore, how did that work? Which trust was responsible for the funding? 10:29
A. So, Muckamore was a centrally commissioned service with provision of beds for what was the Legacy Northern and Eastern Board patients - so that's what is now the Northern Trust, the Belfast Trust and the South Eastern Trust - with provision for PICU beds and forensic beds across the region. So there was no transfer of funding on a patient by patient basis. That was and always has been centrally commissioned on behalf of the Northern Trust and the Eastern -- sorry, the Northern Board and the Eastern Board, as was, and more generally now by 10:30 10:30

the SPPG.

54 Q. So that remains the position to date?

A. Yes.

55 Q. And is there data available on the numbers of patients who used Muckamore over the various years that came from the Northern Health and Social Care Trust? 10:31

A. There are records that Belfast hold and that could be pulled of the number of patients at various points in time.

56 Q. Would you have any idea of what those figures might be? 10:31

A. I have an awareness of figures at various points in time and I can give you some numbers, if it gives you...

57 Q. It would be very helpful, Dr. Corr, if you can, please.

A. And I can probably give you a fuller report, if required. So, in 2016, the Northern Trust had 35 patients within Muckamore. In 2017, it had 24. 2018, 24. 2019, 24. 2020, 21. 2021 -- sorry, apologies, the years and the numbers are starting to coalesce! -- 10:31

58 Q. You're all right! 10:32

A. -- we had 19 patients. In 2022, we had 17. In 2023, we currently have nine patients, two of whom are in treatment and seven are resettlement.

59 Q. Okay. So the first question is -- those figures go back to 2016 -- would there be figures available, I presume, for the pre 2016 period? 10:32

A. Yes, I can get those figures for you. I just didn't pull the entirety of the numbers.

60 Q. And, presumably, a number of those patients will be the

same patient. That just represents the number of patients in Muckamore rather than, for example, the number of new Northern Trust patients going into Muckamore who hadn't previously been there before?

A. Yes, there will be a core within that who are patients who have been there for a longer period of time. 10:32

61 Q. And would there be a breakdown available, for example, of the types of patients that those patients are -- for example, adults or children, learning disabled individuals, or individuals with severe mental health needs, would that kind of information be available? 10:33

A. So those individuals that I refer to will all be adults. Children stopped being admitted to Muckamore in 2010 when the Iveagh Unit was opened and Conacre was closed. They will all have a learning disability, because the only legal grounds to be in Muckamore is to have a learning disability -- and certainly if you're detained, a severe learning disability. And they will all be there because of a significant mental health or risk issue that leads to them being within the hospital. 10:33 10:33

62 Q. And on the topic of admission while we're there, who had the final decision regarding the admission of adult patients to Muckamore? Was it the Northern Health and Social Care Trust consultant or the consultant within MAH, i.e. within the Belfast Trust? 10:34

A. The admitting consultant always has the final determination on the allocation of a bed within the hospital. So it would be the admitting consultant in

the hospital. However, it's important to note that the Belfast Trust were, and the North and West Belfast Trust before that, were commissioned for psychiatry services to the Northern Trust areas as well and it was only in, I think, 2015 that the Northern Trust -- 2017, apologies, that we moved the psychiatry resource out of Belfast Trust into the Northern Trust. 10:34

63 Q. So, since 2017 then, the position has been that it would be the consultant within MAH, i.e. the Belfast Trust consultant, who would have the final say on admission of patients to Muckamore? 10:34

A. It has always been under the legislation the admitting consultant's responsibility to have the final determination around admission.

64 Q. Okay, thank you very much, Dr. Corr. I'm going to ask for internal page 3 to be pulled up, paragraph 3.3. You describe there how when the Northern Trust was formed, there was an existing project lead post for resettlement and you describe their role, which was to liaise with board staff, families and providers to seek appropriate accomodation for those patients within MAH who were classed as being delayed in their discharge or requiring resettlement. What would be the discipline of the individual who held that post? 10:35 10:35

A. That post has been held by a number of different individuals over the years. A number of those individuals that I can recall have been from a social work background. I think all that I can recall were from a social work background, but there may have been 10:35

another background. Typically, it will have been an individual who has a health and social care profession, and relevant experience in learning disability would be the shortlisting criteria for a post such as that.

65 Q. And do you know prior to 2007, i.e. before the Northern Health and Social Care Trust was established, did that post -- well, it existed, is your evidence. Do you know how long it existed for prior to 2007? 10:36

A. I'm sorry, I don't.

66 Q. If the Inquiry were interested in finding that information out, would you be able to assist the Inquiry to get that information for the Inquiry? 10:36

A. I could work to find it out. But I'm not sure where I would find that. But I could attempt to.

67 Q. Okay. And there might be individuals that you could point the Inquiry towards who might know that information? 10:37

A. There could be.

68 Q. You go on to say that the Northern Health and Social Care Trust progressed to establish a full resettlement team in 2014, which consisted of social work, nursing and OT. What prompted that change? 10:37

A. In 2014, we had, I suppose, been through a series of failed dates for the closure of resettlement beds within the hospital and the Inquiry will be aware that there had been an expectation that resettlement would have been complete on various occasions - so, 2002, 2011, 2015. There were a series of deadlines by which time we were to have completed resettlement. I 10:37

suppose, as a trust, we increasingly felt that there was a need for dedicated resource to support the development of community placements that would allow us to ensure that we implemented Equal Lives in its entirety and that we moved away from a model of hospital-based assessment and treatment into community-based care. So, therefore, we felt that we needed a multidisciplinary resource that would dedicate itself to the development of placements.

69 Q. Thank you very much, Dr. Corr. You go on to say: 10:38

"This team had regular contact with MAH staff through formal meetings, as described above..."

- and you've given evidence about that - 10:38

"...and contact through ward visits and telephone conversations with hospital multidisciplinary team members."

10:39

The question is much the same: Was there any formality to that contact -- written down, for example?

A. Yes, so the resettlement team would have held responsibility for the cases. They'd have been the named workers for the cases of those individuals who 10:39 were being resettled. So there's a full file for each of those individuals which will have detailed notes of all those discussions and all of those meetings. And any minuted meetings, the minutes of the meetings will

be held in those resettlement files for those individuals.

70 Q. Was there a required frequency of those meetings, for example?

A. I'm not sure that there was a required frequency, but there was custom and practice that there would have been -- there's a journey to resettlement and as the individual's resettlement is coming to fruition, there's obviously an increased frequency in meetings. There's a planning stage at the beginning where there's high levels of assessment information being gathered, and that would have been gathered by our Challenging Behaviour Services, as they were known at that point in time, in collaboration with the Hospital and those would have formed the core focus at that point in time. And that would have been followed up then by multidisciplinary meetings and ward rounds. 10:39 10:40 10:40

71 Q. You mentioned in your evidence -- I think you said of those meetings that were minuted -- were all meetings minuted or just some? 10:40

A. Meetings, typically, are minuted. Discussions around individual care is recorded within the file as part of the clinical care. Sorry, there's a subtle difference between discussions and --

72 Q. Perhaps you might expand on that a little bit for the Inquiry, please? 10:40

A. It's probably challenging to explain, but the provision of care and the assessment of individuals obviously requires a meeting of people, but that doesn't

necessarily make it a meeting. So assessments require individuals to meet together to discuss patients, and that's part of the clinical care of that individual. A formal meeting, I suppose, I would understand to be a pulling together of a group of individuals at a point in time with a key focus and a purpose to a meeting. And that's where I would expect there to be a recorded minute of a meeting.

73 Q. Okay, thank you very much, Dr. Corr. If we could look down to paragraph 3.4, please, you say there: 10:41

"In 2015 the Northern Health and Social Care Trust initiated Muckamore admission and discharge meetings, which were a formal interface meeting to discuss the progress of patients who had been admitted to hospital." 10:41

Again, can you assist the Inquiry by speaking to the frequency of those meetings?

A. I can check. My memory is that they were either bimonthly or quarterly. They could potentially have been quarterly. I established those meetings when I returned to the trust. I need to check whether it's 2013 or 2015 - I have a record of 2013, but I can check that and come back to the Inquiry and whether the 3.4 is a typo there at -- whether it was 2013 those meetings commenced, or 2015. 10:42 10:42

74 Q. Thank you, Dr. Corr. Did they relate to one patient or multiple patients?

A. They related to multiple patients. So there was two processes within the Hospital at that point; there was a resettlement population, who were being dealt with through resettlement processes, and then there was another population who were at that point in time being admitted for assessment and treatment. And the point of those meetings was for us to better understand why individuals were being admitted to hospital; was it an appropriate admission; could there have been something alternative done in the community which would have better met their needs and would have led to us not having to admit the individual to hospital; and what were the appropriate pathways out of hospital and how could we ensure that the admission was timely and focused and that we were in a position to effect a timely discharge. I suppose it was an attempt to not create another resettlement population. 10:43 10:43 10:43

75 Q. And your evidence was that you established those meetings. Is there - there may not be - a written down guidance or policy document as to the establishment of those meetings, what the purpose of them is, and how frequently they're to be conducted, for example? 10:43

A. I can check if there was terms of reference. We have terms of reference for a number of meetings, but I cannot recall at this point whether there was. But I can check and provide that for the Inquiry if it is available. 10:44

76 Q. Thank you, Dr. Corr. And would incidents that had occurred in relation to patients be raised at these

meetings -- for example, serious adverse incidents and the like?

A. Each patient was discussed, so each patient who had been admitted over the period of time. So I think it was quarterly meetings. So each patient who had been admitted over that quarter was discussed. The reason for the admission was discussed and their treatment and care within the hospital was discussed. Safeguarding incidents may have been raised, but that was not the point of the meeting. The point of the meeting was much more to focus on the assessment and treatment and the planning for discharge. Safeguarding would have been dealt with through those other discussions that we've already mentioned. 10:44 10:44

77 Q. But, presumably, the matter of safeguarding was fairly integral to the admission and discharge of a patient and, for example, a patient that was being discharged, if there had been a safeguarding incident, that might be something that was particularly important to those at the meeting? 10:45 10:45

A. It's obviously an important part of an individual's experience. It's not necessarily integral to assessment and treatment or planning for discharge. Obviously, if there had been a very significant safeguarding issue, it would be important to understand the impact that that had on the individual and their experience of their time within the hospital and to plan for that upon their discharge. But it wouldn't have been a focus of those meetings. The meeting was 10:45

really to understand the mental health issues that led to the admission or the environmental context that was challenging for that individual, to enable us to make changes in that environment or in the person's community-based treatment that would allow us to better meet their needs and reduce the likelihood of future admissions. 10:46

CHAIRPERSON: Yeah, I suppose you need to understand what issues have arisen with a patient to understand better how to resettle them in an appropriate environment? 10:46

A. Yes. So you would want to understand how the patient had been while on the ward and what their experience was. So, I suppose, for example, if a patient had been assaulted by other patients on a repeated basis, that would have been part of the narrative that was discussed during those meetings. 10:46

CHAIRPERSON: So it's not the safeguarding incident per se, as it were; it's how it might affect the speed and -- 10:46

A. That person's well-being and mental health in subsequent resettlement or discharge.

CHAIRPERSON: Yes.

A. I suppose it was an individual meeting, but it allowed us to pull things from that to help us to think about the gaps in community services that we needed to develop as a trust to allow us to create appropriate service provision to better meet the needs of the population of the Northern Trust. 10:46

78 Q. MS. BRIGGS: Okay, Dr. Corr, I'm going to move on to paragraph 3.5:

"Members of Northern Health and Social Care Trust senior management team also attended regional adult resettlement meetings held by MAH within the Hospital. The focus of these meetings was to review the progress of all trusts in relation to resettlement and delayed discharge and to support discharge." 10:47

Can you speak to what comparisons were made between the various trusts at these meetings?

A. I'm not sure it's helpful to describe it as "comparisons". I think the discussion was more an understanding of progress against the performance targets for the PTL list, for the complex discharges, for resettlement patients, and to understand progress. So there was a performance element in relation to that and there was also then a planning element, because obviously there was a level of co-ordination from time to time -- so it was quite a strategic meeting, is my understanding from the former director, that would have allowed for discussion around some individuals who, from across trusts, were going to a similar scheme. So there could have been potentially a supported living scheme which met the needs of individuals from different trusts. So, as a result of that, there was a need for co-ordination and oversight. So there was a performance element, but there was also a strategic 10:47 10:48 10:48

planning and supportive and developmental element to that meeting, is my understanding.

CHAIRPERSON: Can I just ask this: In terms of resettlement, were there boundaries of each trust strictly defined? So just by way of a bad example, if there was a particular patient who was the responsibility of another trust and they needed particular services for resettlement and you had a space available, would that patient ever be considered for, as it were, crossing the boundary and coming into your trust for resettlement? 10:48 10:49

A. There was quite a lot. The Northern Trust obviously -- Muckamore sits within the Northern Trust geographically.

CHAIRPERSON: Quite. 10:49

A. So there was quite a lot of individuals from other trusts who were resettled into our area. And there was, as often occurs, in the surrounding district too hospitals, there was a number of, in the first instance, nursing homes and then, more laterally, supported living systems developed in the proximity to the hospital geographically. So, as a result, we often would have been the net recipient of individuals from other trusts. So individuals would have been placed by other trusts in our geographical locality because we had service provision for those individuals. 10:49 10:50

CHAIRPERSON: And then sorry to be so venal about it, but who would pay for that resettlement?

A. So the resettlement would have been paid for by the

owning trust. So the individual's trust of origin.
CHAIRPERSON: Yes.
A. And then there was an agreement and discussion around the transfer.
CHAIRPERSON: So presumably -- 10:50
A. That was never a barrier -- finance was never a barrier to placement progress.
CHAIRPERSON: But that's, presumably, the sort of issue that might be discussed at these meetings?
A. Absolutely. And subsequent transfer of responsibility 10:50
for -- so key working of the individual then, if the trust was geographically far away, would have then transferred potentially to the Northern Trust over a period of time. So we would have taken responsibility
for provision of some of the local services, which had 10:50
an impact, obviously, on our service delivery.
DR. MAXWELL: I just wanted to clarify that. So the originating trust would pay the independent care home provider?
A. Yes. 10:51
DR. MAXWELL: But they wouldn't pay you for your psychology, community nursing, OT. So you were bearing the cost of that patient without any transfer from the originating trust?
A. Yeah. 10:51
DR. MAXWELL: So it was a cost burden for the Northern Trust?
A. Yeah. There was slightly different arrangements in different professions. So, for example, in psychology,

there was a case by case basis where we would have an agreement around supporting individuals in different trusts because there was a bit of flow -- effectively, there was a little bit of flow across. So we tried to work in a collaborative way as much as possible. But there were certainly some trusts who would have experienced potentially more burden because of the geographical development of, for example, nursing homes in their area. So there's an over-provision of nursing home placements within the Northern Trust area, so, as a result of that, we have often been net recipients and we would have had some discussions with commissioners and the board in relation to that, with varying degrees of success. 10:51 10:52

CHAIRPERSON: Yes. 10:52

79 Q. MS. BRIGGS: Just on the topic of progress on resettlement, because that's the words you've used in your statement, were there any comparisons done or league tables or factors that might have meant that one trust was doing better than another? 10:52

A. There certainly were tables produced which identified - and still are - of the progress against the various targets that there have been at various points in time.

80 Q. And where would those be?

A. The various iterations of performance management at the board would have centrally held those and Belfast would also have held, through medical records, a table of who from each trust had been discharged over a period of time. 10:52

81 Q. If we go to paragraph 3.6 then:

"Members of the senior management team also attended performance management meetings held by the Department of Health, Social Services and Public Safety to review progress against priorities for action targets." 10:53

For the lay person, or for the uninitiated, what is a priorities for action target?

A. So, within the health and social care's commissioning arrangements of services and the Department of Health's strategic outline for how we deliver our services, there's an expectation that we meet certain standards, and one of those ways of describing the standards are priorities for action. So it's merely a way of saying that, for example, no one should live in hospital beyond 2002, or no one should live in hospital beyond 2011 or December 2019. So the target has been that no one should live in hospital, should have an address in hospital, and that we should be progressing toward that target. So it's really a way of just describing that target. 10:53 10:54 10:54

82 Q. At those meetings, what, if anything, was discussed in relation to Muckamore?

A. So, those meetings would have reviewed the progress of individual trusts in relation to resettlement and, as I said, would also have taken a strategic approach, looking at the development of services. They would have been chaired by the board and would have taken a 10:54

strategic approach to the development of community based services, alongside really understanding progress against those resettlement targets.

83 Q. Would Muckamore have been discussed?

A. Muckamore, obviously, was the hospital that we were talking about resettling from, so it wouldn't have been possible to have the meeting without discussing Muckamore. 10:55

84 Q. In terms of how the hospital was performing or how it was perceived by those within it, incidents of safeguarding and the like? 10:55

A. No, the focus in relation to that was the performance of the Community Trust in bringing individuals out of the hospital, as opposed to the functioning of what happened within the hospital predominantly. 10:55

85 Q. I'm going to ask you a couple more questions on this section of your statement, but they're more general questions. Was there any reluctance to transfer in to Muckamore by families within the Northern Trust before 2017, in particular, when allegations about Muckamore came to light? 10:56

A. I don't think we can presume that families are a homogenous group. So there are some families who -- there's a long history in learning disability from the early days of a view that individuals with a learning disability were best cared for in a hospital, and many families were told that at an early stage. And it's important to contextualise our current service delivery in that frame, in that many families were told that 10:56

that was the best thing that they could do for their child and, in good faith, they did that.

Over time, there has been a move towards an understanding of care within the community. And as a result of that, some families have had real difficulty in finding themselves in a position where they can't care for their relative at home and that they have to seek an admission to hospital, and many families have worked through very significant difficulties and challenges before they're willing to. So I don't think we can describe the group as a homogenous group; there's varying experiences depending upon the families' views of their role, their responsibilities and the period of assessment and treatment. 10:57

CHAIRPERSON: I think the question may have been more focused on whether there were known to be or thought to be issues around Muckamore itself, as opposed to the admission to a hospital.

A. Sorry, I missed you there. There was -- 10:58

CHAIRPERSON: -- where there were issues or thought to be issues around Muckamore itself prior to 2017 that might make a family reluctant to have their relative admitted to it.

A. There were, obviously, there were a number of previous safeguarding issues across the hospital at various points in time. And we do know that -- professionally, we know that institutions are at greater risk of challenging experiences for individuals. Whether that 10:58

has been fully understood for families before this level of wide scale investigation into Muckamore, it would be difficult for me to know. In the main, my experience was that when families felt that it was recommended that there was a period of time in hospital for assessment and treatment for an individual, that they typically felt that that was the best thing to do and they proceeded with that professional advice.

CHAIRPERSON: Yes.

A. I think they looked to professionals for --

CHAIRPERSON: For guidance

A. -- guidance.

CHAIRPERSON: Absolutely.

A. -- around what was appropriate.

CHAIRPERSON: Thank you.

86 Q. MS. BRIGGS: And just to follow up on that, was there a learning disability hospital within the Northern Trust between 1999 and 2021 that was available to patients other - Muckamore was in the Belfast Trust - was there anything within the Northern Trust?

A. No, so the North and West Belfast Trust, in the first instance, and more recently Belfast Trust, are commissioned for the provision of beds for people with a learning disability for the three trusts: The Northern, Belfast and South Eastern, and the regional provision of PICU and forensic beds. So, no, we don't have a hospital in the Northern Trust, because we don't need one because it's commissioned through Belfast.

MS. BRIGGS: Okay. It was at this point, Chair, I was

going to move on to Section 4, but it might be best to take a break?

CHAIRPERSON: Yes, absolutely. So we'll stop there for about 15 minutes. Hopefully, you'll be given a cup of tea or coffee or whatever it is that you want. And we'll try and sit again at twenty-five past. Okay, thank you very much, indeed. 11:00

SHORT ADJOURNMENT

11:00

THE INQUIRY RESUMED, AS FOLLOWS, AFTER THE SHORT ADJOURNMENT

CHAIRPERSON: Thank you very much.

MS. BRIGGS: Chair, I'm going to ask for the fourth page of the statement to be pulled up at this stage. 11:21

CHAIRPERSON: Yes.

87 Q. MS. BRIGGS: Can we just scroll down to Section 4? Thank you very much. This is the other half of your evidence. It's about an outline of provision for community-based services -- that's within the Northern Trust. And you divide, very helpfully, your statement into a number of sections in that regard. So I'm going to start with the section here which is "Community Teams" at Section 4.1. Your evidence as regards community teams starts and it focuses on the post 2007 position as regards community teams, and you were very clear that your evidence is on behalf of the Northern Trust and that's when the Northern Trust was 11:21 11:21

established was in 2007. But can you assist the Inquiry at all regarding the position with community teams before 2007?

A. So, the community teams prior to 2007 would have reflected the split between the two trusts. So Home First would have had community teams for Antrim and Ballymena, for Magherafelt and Cookstown, and for Larne, Carrick and Newtownabbey, so divided over three sectors. And then Causeway as a separate trust would have had a community team for the Causeway Trust. 11:22

88 Q. Okay. And would the community teams, would they have looked roughly the same as what they did after 2007, or would there have been any big differences or noticeable differences between the teams?

A. My memory is that there was a slight variance between how the two trusts operated, but I'm not sure at what point it changed. So there would have been initially separate professional lines of management as opposed to multidisciplinary management in the Home First area; and the Causeway area, there was a Legacy team leader for that team who had multidisciplinary line management responsibility for the whole team. So nuances of difference. 11:22 11:23

89 Q. Okay. You say in your evidence that there were three clinical psychologists, one per team, across the three community teams. And later in your evidence, at the next paragraph, you say there were four clinical psychologists across the four teams. Why was that? Was that a deliberate choice or was there a shortage of 11:23

clinical psychologists in learning disability?

A. Clinical psychologists within learning disability were based within the teams and then, when we moved to a position of having four teams, there was a need to expand the level of clinical psychology provision and there was additional funding identified as a result of investment in community infrastructure, which allowed for the development of clinical psychology services, which are fairly core to the development of community assessment and treatment services. 11:24

90 Q. Was one psychologist per team deemed sufficient or was it simply due to the numbers available to the trust?

A. Within the overall workforce, there's limited numbers of clinical psychologists because of limited numbers of training places. Certainly had we had more funding for clinical psychology and had we had more clinical psychologists available, I would have no doubt that we could have used them and employed them gainfully. However, I think every professional grouping would be in a position to say that. We could say that about nurses, about social workers, about OTs. 11:24 11:25

DR. MAXWELL: Could I just ask, has there ever been a workforce skill mix review? You know, forget about supply -- a patient needs-based workforce skills review? 11:25

A. There's a workforce review underway on learning disability now as we speak. So there's a current workforce review that's being led by the Department of Health, and it's predominantly focusing on a mapping of

what current provision looks like. And I would presume that it will move to the next stage, which will be then to identify what the level of provision should be. But, no, within Northern Ireland, within my memory, there hasn't been a scoping of what the service should look like.

DR. MAXWELL: And can I ask have any of the professional groups set standards? So, for example, we know the Royal College of Physicians will set standards about the number of consultant physicians per population. Is there any professional organisation within psychology that has set that sort of standard?

A. I think my memory is that the BPS, at a very early point in my career, that there was guidance around the number of clinical psychologists within district health authorities. But I couldn't tell you what the recommendation is. But I think in the 1990s there was potentially a guidance document produced by the BPS to that effect.

DR. MAXWELL: Thank you.

91 Q. MS. BRIGGS: Across the previous paragraph, 4.1.1 and 4.1.2, you speak to the number of service users in the trust at various times for the uninitiated. The definition of "service user", would that be those using community services within domestic or supported living arrangements, or would it also include hospital patients, such as patients within MAH?

A. So, service users, as I have used it, refers to all those individuals with a learning disability who were

the responsibility of the Northern Trust, whether they lived at home with family and were open to us as an individual known to us, or whether they were placed in nursing supported living, residential care, or, in fact, were in hospital for assessment and treatment. 11:27

92 Q. So it would include individuals --

A. And resettlement.

93 Q. -- who were in Muckamore?

A. Yes.

94 Q. Okay. If we could go to 4.1.3, please? If we could scroll down just a little bit further, please? Thank you. Within that section, you go into some depth about the arrangements for children. The second last paragraph, you talk about the Home First Community Trust establishing the Children's Challenging Behaviour Service, subsequently renamed the Dual Agency Behaviour Support Service, and that was in 2005. What kind of staff were in that service? For example, did it include psychologists? 11:27 11:28

A. So, at that point in time the service was led, and continues to be led, by a consultant clinical psychologist. And in the original development of that service, there were two, if my memory serves me right, nurses -- I think it was two nurses who were learning disability registrants who had additional training and expertise. And if I recall accurately, I think they had attended the Tizard training in behaviour analysis and positive behaviour support as it's now known. 11:28 11:29

95 Q. And you said that the service was led by consultant

clinical psychologists. They would have been providing services as part of the service then; they would have been providing psychology services to children --

A. Yes.

96 Q. -- who had engaged with the service? 11:29

A. Yes, and oversight and supervision and support for the rest of the team.

97 Q. Thank you, Dr. Corr. And then the last sentence of that paragraph:

11:29

"The interface between children's services and Muckamore ended in 2010, as Iveagh (assessment and treatment service for children with learning disabilities) was opened by the Belfast Health and Social Care Trust and no further children were admitted 11:30 to Muckamore."

Previously, children were admitted to Conacre ward, isn't that right?

A. Yes. 11:30

98 Q. Where do children now from the Northern Health and Social Care Trust go to? Can they access Iveagh or is that just for Belfast residents?

A. No, Iveagh is commissioned in the same way as Conacre had been and includes residents of the Northern Trust. 11:30

99 Q. Thank you very much. If we go on to 4.1.4 then -- I think there are two 4.1.4s. I think the one that I would like to look at is the first of those. Bear with me, I'm just going to check. Okay, it is the first

one. You've written there:

"In December 2017, the Northern Health and Social Care Trust took over managerial responsibility for psychiatry services for the Northern Health and Social Care Trust population from the Belfast Health and Social Care Trust."

Does that refer to psychiatry services in the community and in the community teams, rather than at Muckamore? 11:31

A. Yes, so Muckamore -- Belfast continued to have responsibility for all services on Muckamore site, including psychiatry and all other professions. At that point in time, Belfast, and prior to December 2017, Belfast provided psychiatry service for community 11:31 services in the Northern Trust, Belfast Trust and South Eastern, and we made a determination that we would like to move our psychiatry service in-house to the Northern Trust. And for about a year -- it took about a year and a half, if I recall correctly, to put 11:32 the arrangements in place to identify the resource that was dedicated to the Northern Trust and then to make the arrangements to bring those individuals across to the Northern Trust from the Belfast Trust.

100 Q. Thank you very much, Dr. Corr. If we then go to the 11:32 graph at 4.1.5, please? This is a graph, if I've read it correctly, that shows the cases open to community teams within the Northern Trust. Firstly, can I ask what is meant by cases open to community teams? Could

that be patients that were previously at Muckamore or patients who had never been in a hospital setting? Could it include patients who had never been admitted to a hospital?

A. The greatest majority of those individuals that are numbered there will never have been to Muckamore or any hospital -- for people with learning disabilities specifically. 11:33

101 Q. And it also would include resettled patients from the likes of Muckamore, is that right? 11:33

A. Yes, it details all individuals who are known to the Northern Trust.

102 Q. And you can see from the graph that there's a fairly steady increase right through until 2018, when it levels off, it plateaus. Is there any reason for that? 11:33

A. The graph starts shortly after Equal Lives was published and, over this period of time, there was a change in our thinking regarding learning disability services from a medical model to more of a biopsychosocial model. And during the phase of the medical model, the predominant treatment of choice and service offered would have been admission to hospital. And under the Mental Health Order, the admission to hospital is predominantly for individuals with a severe learning disability. Equal Lives, however, offered a more inclusive and accurate definition of learning disability, to include those individuals who also have a mild learning disability - so, people who have a significant impairment of intellectual and social 11:33 11:34

functioning, as opposed to just those who have a severe impairment - and, therefore, reflects approximately 2.2% of the population, as opposed to 0.5% of the population.

11:34

So, over time, community teams became more open to accepting and seeing that their responsibility went beyond those with a severe learning disability. And as a result of that, we started to receive referrals for individuals for psychometric assessment to establish eligibility for services for those individuals who didn't have a severe learning disability but did have a mild learning disability.

11:35

So I think it's likely that the growing numbers were a reflection of the policy change, as stated in Equal Lives, influencing practice and increasing numbers of people with a mild learning disability becoming known to services.

11:35

103 Q. And what about the plateau from 2018 through to 2021, is there any explanation for that?

A. I think what we tend to see is that there's a cohort of individuals with a mild learning disability who come to services, but the vast majority of people with a mild learning disability are never known to services. In fact, many of them don't know that they have a mild learning disability. So the proportion of individuals that we see with a mild learning disability who become known to services are typically those who experience

11:35

difficulty and challenges, maybe who've come into contact with forensic services, with PSNI or with Court Services; individuals who, maybe, have issues in relation to childcare. And there's a proportion of the mild learning disability population that we see and I think the plateau probably relates to that. So we still are dealing with a very small proportion of individuals with a learning disability from the northern area. There are many more individuals who have a mild learning disability in the Northern Trust catchment area who don't know they have a mild learning disability or who don't need to avail of specialist learning disability services because their needs are met, typically through universal services, which is entirely appropriate and entirely in line with the Equal Lives vision. But if they were to need services, they could be assessed and they could come in and receive services and additional supports. 11:36 11:36 11:36

CHAIRPERSON: Can I just -- so sorry, Dr. Maxwell -- go on. 11:36

DR. MAXWELL: So you've said Equal Lives would -- you suggested that 2.2% of the population would have a mild LD condition or disability and that 0.5% have severe. So you seem to be suggesting that Muckamore would be dealing with people with a severe disability. I can't do the maths, because I'm not good enough for it -- what proportion of that 2.2% of the Northern Trust population are actually under the care or open to community teams? 11:37

A. Typically, what you find - I'm not going to do the maths myself either at this point, but I think it's slightly above --

DR. MAXWELL: Anybody else can volunteer!

A. I think it's slightly above 0.5% of the population are reflected there in the numbers that are open to us, and that's reasonably typical, actually, when you look across services -- we tend to know many of the individuals with a severe learning disability. There's many, actually, who are cared for by their families and we don't know them until, sadly, parents pass away. And we know a very small proportion of those who have a mild learning disability, in my experience. 11:37 11:38

DR. MAXWELL: But, as you pointed out, not everybody with a mild learning disability needs to be under the care of a community team. 11:38

A. Absolutely.

DR. MAXWELL: And so it's actually quite hard to know what the optimum number who should be receiving support is. So it would be hard to plan for it, I assume? 11:38

A. And it's very contextually defined. So in areas of higher levels of deprivation and poverty, you would expect to see potentially slightly more individuals presenting to services and requiring additional supports. In areas where universal services have developed well to meet the needs of individuals with a learning disability, then, actually, many individuals will not need to avail of specialist learning disability services. So it's also a reflection of the 11:38

maturity and development of universal services, as well as issues to do with --

DR. MAXWELL: So coming back to the plateau, you're clearly not seeing everybody with a learning disability in the geographic area -- 11:39

A. No.

DR. MAXWELL: And, I suppose, my question, which is a bit unfair but I'm going to ask it anyhow, do you think you're meeting the people who need support at the moment, or is there something about lack of resources 11:39 which has meant you've reached the capacity you can manage and that's why there's a plateau?

A. I don't think the plateau reflects our capacity so much because demand comes regardless of whether we have capacity -- because we have access to the services via 11:39 primary care and via GPs, and GPs are strong advocates, in my experience, for their patients and they often build strong relationships with individuals with a learning disability and their families. So they will advise us if there's something that is required in 11:40 terms of a service need. I think it's probably more a reflection of is that the level that we're at is the level of individuals who require adjustments and additional supports in relation to their learning disability. 11:40

DR. MAXWELL: Thank you.

CHAIRPERSON: And, I suppose, a much more basic question from me, but the 0.5% that you're referring to who have a severe learning disability, first of all,

are we just dealing with your trust in terms of that percentage figure?

A. No, that's fairly standard across prevalence figures for learning disability across countries.

CHAIRPERSON: And dealing with that cadre of patient, are some of those, in community settings, is there a level of severity, as it were, of disability that your trust would simply not be able to cater for in a community setting? 11:40

A. No, we meet the needs of all individuals, whether they have profound and multiple learning disabilities, severe learning disabilities, or mild learning disabilities. So we would work to provide specialist support to any of those individuals within a community setting. 11:41

CHAIRPERSON: That's very helpful. Thank you.

104 Q. MS. BRIGGS: Dr. Corr, I'm going to move to 4.1.6, which is further on the next page. You describe there where you state that: 11:41

"Following the establishment of the Safeguarding Board, Northern Ireland being established in 2012, the Northern Trust created an adult safeguarding lead post in 2013. In 2014, the Northern Health and Social Care Trust Learning Disability Services created three senior practitioner roles, with the responsibility of Designated Adult Protection Officers (DAPOs) increasing to four senior practitioners in 2018. These senior practitioners had involvement in all safeguarding 11:42

referrals within the Trust. Safeguarding within MAH was carried out by MAH safeguarding team."

Regarding safeguarding within MAH, which you say was carried out by the MAH safeguarding team, was there any role for the DAPOs or the Northern Trust in that process? 11:42

A. The responsibility for safeguarding for issues that occurred within Muckamore rested with the Belfast Trust. In some cases, there would have been discussion with named workers and there could have been discussion subsequent to that with DAPOs or with the safeguarding team within the Northern Trust. 11:43

105 Q. There could have been? Does that mean that there might not have been at times, or it would have varied in some way? 11:43

A. It was varied. It was led by Belfast Trust and we would not necessarily have been core to those determinations and discussions.

106 Q. If we move on to Section 4.2 then, Community Assessment and Treatment Services, you say there: 11:43

"From 2004, Adult Challenging Behaviour Services provided a dedicated peripatetic service for adults with a learning disability who also displayed challenging behaviour. Their remit was to provide an in-reach service to prevent placement breakdown, admissions to inpatient services and to provide support to carers." 11:43

And you also say towards the end of that paragraph that the team was subsequently renamed as the Positive Behaviour Support Service in 2014. Did that team provide any services within Muckamore?

A. The team would have reached in to Muckamore to do assessments in preparation for resettlement and for discharges, and also would have been working with individuals who were potentially subsequently admitted during the period of time that Muckamore accepted admissions. So the team could have been working with an individual who ended up being admitted to Muckamore for assessment and treatment. So, yes, the team would have reached in and out. 11:44 11:44

107 Q. And that would have been in relation to Northern Health and Social Care Trust, patients who had come from the Northern Trust? 11:45

A. Yeah.

108 Q. If we go to 4.2.2, it's over the page, and you say there:

11:45

"Northern Health and Social Care Trust LD services recognise that not all admissions to MAH were in relation to service users with challenging behaviour. Admissions also occurred due to severe mental health needs or forensic issues." 11:45

In relation to those patients with mental health needs or forensic issues, can I ask were the care management procedures the same in terms of, for example, the

appointment of a named worker from within the Northern Trust?

A. Yes, they were the same.

109 Q. At 4.2.4 then, you talk about the Community Treatment Services facility and the Intensive Support Service. You say there that: 11:46

"This service provided service users open to community treatment services greater levels of hands-on support in line with their needs at the time. The Intensive Support Service provides support to service users in a variety of settings, including the service user's own home or day care setting." 11:46

Has there been any assessment of the effectiveness of that service? 11:46

A. Yes, the service, since it was established, has completed routine outcomes measurement of all individuals. So every individual who receives a service from that team has a number of measures of their challenging behaviour of care burden, of quality of life carried out at the beginning of the involvement of the service, and that can be carried out at subsequent points in the way through, as well as at the point of discharge. So there's routine outcomes and measurements available for all individuals who have ever been open to the PBSS - in fact, it was commended by the RQIA review in 2016 for being the only service in Northern Ireland that had that level of outcomes 11:46 11:47

evaluation in place.

110 Q. And has there been an evaluation of the outcomes being positive in terms of the -- the outcomes that the service provides?

A. So there was an audit of admissions carried out at a point in time - I think it was 2018 - to look at the impact of the service on - in particular and of particular relevance to the Inquiry - to admissions to hospital. And what we found at that point in time was that individuals, the number of individuals who had been admitted to hospital over the period of the audit, which was 2013 to 2018, had reduced from 59 in 2013/14 to 40 in 2017/18, and that we also had a reduced number of repeated admissions. So what we would have identified at an earlier stage was that there was a number of individuals who had a revolving door in and out of the hospital. So in the first year, there was one individual who had nine admissions over the period of that year, and the goal of the service was to reduce admissions, to augment community infrastructure, and to enable individuals to be supported at home. And we found that by 2018, by the end of the audit, that, actually, we had a reduced number of revolving door admissions as well. 11:47 11:47 11:48 11:48

111 Q. Could that audit be provided to the Inquiry, if it's available? 11:48

A. Certainly.

112 Q. If we go to Section 4.3 then, it's Day Services and Day Opportunities and it's internal page 10. For the lay

person, can you describe what the difference is between day services and day opportunities?

A. So, day services are divided largely into two models of provision to simplistically sort of separate them. One of them is a building space provision, which is adult centres, and those are typically a building in each town that provides for the needs of those with more severe or complex learning disabilities and additional needs. There'll be a higher level of staffing and support, so we'll be potentially offering a support level of one staff member for every three individuals. And some individuals may have one-to-one or two-to-one staffing to meet their needs. So those will largely be buildings based, with the majority of therapeutic intervention, care, activity, training and support occurring within that building, obviously with outreach into the community. 11:49 11:49 11:49

Day opportunities are often provided by partner organisations on our behalf and are typically for those with mild learning disabilities. It's very much in keeping with the direction of Equal Lives, with the support on development of individuals, opportunity for vocational, leisure and, I suppose, more meaningful opportunities to engage in their local community. 11:50 11:50

113 Q. Okay, thank you very much. There's a graph just down the page here at 4.3.2 and it details the day services provision to service users over the various years and it divides it up into day care services and day

opportunity sessions. Were those whole day sessions or short sessions - for example, one to two-hour sessions?

A. No, they're full days.

114 Q. And I think if you look at 2021, for example, it adds to about, if my maths is right, 1,400 sessions. Is that per day or per week? 11:51

A. That's individuals who are in receipt of services.

115 Q. So an individual, for example, might be in receipt of a daily service, and another individual might be in receipt of a weekly service; is that a fair summation? 11:51

A. So, individuals will have assessed needs and their assessed need could be for a five-day service, it could be a for a three-day a week service, and they could have a different package of care -- they could have a hybrid model involving several different types of supports; they may have direct payments on top of day opportunities. 11:51

116 Q. Okay.

A. It's very much individually tailored.

117 Q. Thank you very much. If we go to page 11 then, it's Section 4.4, Accomodation and Respite. And if we go down to 4.4.8, if I can get the page reference... It's page 12. I think you'd referenced earlier in your evidence about nursing home placements within the Northern Trust being large. I think there are a large number of these when you look at the graph. It's over 200. 11:51 11:52

A. (Witness Nods).

118 Q. Can you tell us a bit more about these -- for example,

the typical size of placements?

A. So, the model of service delivery and learning disability in the 1940s, 1950s, 1960s and 1970s was largely hospital care. There was then a move to de-institutionalisation throughout the 1980s and 1990s and some delay, obviously - well, not obviously, but some delay, unfortunately, in Northern Ireland in that progressing. The first phases of de-institutionalisation were typically into nursing care and very often what you found was a full ward closed and there was a creation of a nursing home within a town or area. And quite often there would have been staff who would have moved from that nursing home who knew the patients well and were very attuned to their needs and supported that group of patients. So it could have been quite a large nursing home -- it could have been, maybe, 20 to 30 individuals who would have previously been together in a ward. 11:52 11:52 11:53

Over time, the model has changed and been influenced by policy context and we've moved to more a model of supporting living service, individualised tailored care. Some individuals require different models of care and continue to require nursing care. Some individuals require residential support. So, I suppose, nursing home placements are largely -- are often a legacy of some of the former de-institutionalisation efforts. However, some - and, increasingly, they're tailored to meet nursing needs 11:53 11:53

and, obviously, the population of people with learning disabilities do have additional physical health needs - I mean, we know through "Death by indifference" and the confidential inquiry into the premature deaths of people with learning disabilities that, actually, there are complexities in individuals' health presentations and those can be best met by appropriate provision of care through nursing care. So it's important and helpful to have nursing placements for those individuals who need it. But many other individuals can have their needs met through supported living. 11:54 11:54

119 Q. And the nursing home placements themselves, presumably they do vary then in terms of size and the number of service users within the individual settings?

A. Yes. So there will be a broad range of nursing provision across the trust. 11:54

120 Q. Section 4.5 then is Support Services. It starts on page 13. There are two tables you have presented us with here. The first one is on the screen now. It's in relation to domiciliary packages of care. You can see there in 2021 that there's about 130 users, is that fair to say? 11:55

A. Mm-hmm, yes.

121 Q. And the second table that you've provided then just further down on the next page is in relation to direct payments. And you can see there by comparison in 2021 there's about 240 users. How do domiciliary packages of care, of which there are more using it, differ from the -- sorry, domiciliary packages of care, of which 11:55

there is less using it, differ to direct payments, in which we can see more service users? What's the difference between the two?

A. So a domiciliary package of care is largely to support a person within their placement. So it can be assistance with getting up and dressed in the morning and managing some day-to-day tasks. Direct payments have a flexibility and can be to meet a range of needs. It may be that individuals decide not to engage in certain services and can use self-directed support or direct payments to create an alternative package of care for themselves. Often carers find it a more flexible way. 11:55 11:56

CHAIRPERSON: I know this is obvious, but does it do what it says on the tin in terms of a direct payment? Is it a direct payment to, as it were, the family looking after the individual? 11:56

A. Yes.

CHAIRPERSON: And they then decide how they're going to --

A. They manage it. There's obviously a governance arrangement around how we ensure that there's appropriate oversight of what's provided and that it's meeting an assessed health and social care need. But, yes, it's largely to afford the family and the individual more flexibility in what supports they avail of. It's enshrined in the Equal Lives perspective of family-led care. 11:56 11:56

122 Q. MS. BRIGGS: Thank you very much, Dr. Corr. If we

could just very briefly go back to the first of those two graphs and scroll up a little bit further to the text at 4.5.1? You've said there:

"Domiciliary care packages historically and presently are delivered through both Northern Health and Social Care Trust statutory and private providers." 11:57

What is the split between the private packages and the Northern Trust? 11:57

A. I'm afraid I don't know that.

123 Q. Okay. Could that information be provided to the Inquiry if it's of interest?

A. We could certainly provide the split between statutory and private providers across all packages of care. And I think we probably could provide specifically for learning disability. But, yes, I'm happy to make efforts to do that. 11:57

CHAIRPERSON: Thank you.

124 Q. MS. BRIGGS: Thank you, Dr. Corr, that would be of assistance. What are the advantages and disadvantages when the private is compared with the statutory provided? 11:58

A. I think there's strength in both. I mean, I think the statutory provision and private provision both actually should be connected in to the team who support the individual and the named worker and the family and, regardless of who the provider is, they should be meeting the assessed need. I don't think that there 11:58

should be a difference in whether there's a statutory provider or a private provider. It's much more about a mixed economy and trying to mobilise as many resources as we can.

125 Q. And, finally, if we go to the graph again at 4.5.2, that shows the number of direct payments in place, but not the financial cost. Would that data be available for the Inquiry? 11:58

A. Yes.

126 Q. That would be of great assistance if you could provide that in due course, Dr. Corr. Given that -- well, if we start with more learning disabled individuals were, perhaps, being resettled as time went on - the more difficult cases, if we put it that way - would that have led to an increase in costs? 11:59 11:59

A. Not necessarily in relation to costs for direct payments. It will have led to an increase in costs for placements because individuals with more complex needs and higher levels of staffing needs and need for more bespoke packages will have a requirement for higher levels of support within their service. So placements are much more expensive. 11:59

127 Q. Do the direct payments roughly stay the same then, dependent on the individual and one with a higher need and one with a lesser need? 12:00

A. I'm not sure if I'm understanding you correctly, but there's a set rate for a direct payment and, depending upon the hours of assessed need, the costs are obviously multiplied so...

CHAIRPERSON: Does it follow - this is my ignorance, I'm afraid = but does it follow that for those with higher, much higher needs, direct payments are less likely to be suitable, as it were, because they're less likely actually to be remaining at home? 12:00

A. Yes. There's some very complex - I mean, there's exceptions to every generalisation - there's some very complex individuals who remain at home and the family are supported through direct payments. But, in my experience, the majority of individuals who are highly 12:00 complex tend to end up in placements with care provided and, as a result of that, it's less likely to be a direct payment.

CHAIRPERSON: Thank you.

MS. BRIGGS: Okay, Dr. Corr, that's all the questions 12:01 that I have for you. I'm looking to the Panel to see whether there's anything further...

CHAIRPERSON: No.

DR. MAXWELL: Yes, so just following on from that conversation, it appears that most of the residential 12:01 and nursing care placements provided by the independent or third sector -- you, as a trust, provide some supported living and all the other sort of support for people in their own home -- we've heard from a lot of witnesses that as the resettlement programme 12:01 progresses, the patients who are still in Muckamore are becoming increasingly complex. And we've also heard from some of the families that they've been offered placements in care homes that they weren't happy with

or that failed - there seemed to be quite a number of people who have tried and come back. So my question is, given that for the patients who are left have very complex needs, is there an appetite in Northern Ireland in the independent and third sector to provide what is a very high risk, expensive service? You talked about having more care home places within your geography than in other areas, but are they the right sort and are providers interested in doing these very high risk, complex patients? 12:02

A. So I'll try and answer the multiple parts of that in relation to -- we have nine individuals within the trust who are currently still within the hospital and we have plans in place for -- and two of those are still in assessment and treatment -- so we have plans in place for all seven. So I would say that there is an appetite. 12:03

None of it -- it's very rarely that there's a sort of off the peg placement. It's very much, and has been over recent years, about the development of bespoke placements to meet individual needs, and that can very often mean building a service literally from the founds up. So we have built in partnership with providers bespoke apartments, placements, services around individual need that are very much about ensuring that we best meet the needs of those individuals who, indeed, have very complex -- and have had difficult experiences and failed placements and I can understand 12:03

families' reticence and anxiety about placements.

DR. MAXWELL: So I understand the capital spend and getting the right environment, but most of the staff in these places are care workers, rather than people with a professional qualification -- 12:04

A. (Witness Nods).

DR. MAXWELL: Is there difficulty in getting the care workers with the right skills to work with these complex patients, even if you've built the building?

A. I think that's the core to success, is getting the 12:04 appropriately -- it's important to get good buildings, but, actually, strong staff teams are the core to success, and I think strong staff teams who have strong values. So I think everything starts from the values. And if we get staff with the right values, we can 12:04 actually train and support them in the development of skills. And the trusts typically work in partnership with providers. We increasingly look for individual providers who have positive behaviour support as their framework and we use our community treatment services 12:05 to reach in to those individuals and to support those individual placements. So we'd be involved in the training of staff, the partnership around each individual. So we would develop the care plan or positive behaviour support service or the Promote 12:05 service, who work with individuals with mental health needs, would develop the plan and the training, and the providers from the community or voluntary or private sector would work with us around getting to know that

individual -- and work with Muckamore around getting to know that individual, building up their skills and expertise before we develop the pathway for resettlement.

DR. MAXWELL: So that sounds like a much more expensive placement than, say, a placement of an old person in a residential care home. What ballpark figure would that sort of placement cost? You may not be able to answer that. 12:05

A. I mean, I couldn't give one answer because there's a different answer for each person. 12:06

DR. MAXWELL: Yes.

A. So each person that we are providing services to have a different package of care cost.

DR. MAXWELL: But the idea of the range of costs? 12:06

A. It could be, on a weekly basis, you could be looking at four or five thousand pounds per week for some placements for individuals who have very complex needs and high levels of staffing and support needs.

DR. MAXWELL: Thank you. 12:06

A. But it's important.

MS. BRIGGS: Dr. Corr, thank you very much for coming to the Inquiry and giving your evidence today. That is all the questions for you.

CHAIRPERSON: Dr. Corr, thank you very much, indeed, for your statement. And thank you very much for bearing with us and for assisting the Inquiry. So thank you very much for your attendance. 12:06

What I think we'll do because you -- I know you've got a legal team here, so you may want to speak briefly to them. But rather than stop early for lunch, I think we'll just stop for five minutes now and we'll try and start the next witness and see how far we get. But, Dr. Corr, thank you very much. 12:07

THE WITNESS: Thank you.

CHAIRPERSON: Just five minutes.

SHORT ADJOURNMENT 12:07

THE INQUIRY RESUMED, AS FOLLOWS, AFTER THE SHORT ADJOURNMENT

CHAIRPERSON: Thank you very much. 12:15

MR. McEVOY: Good afternoon, Chair, Panel. So your next witness today is Ms. Jan McGall, who's giving evidence on behalf of the Southern Health and Social Care Trust. If she could be called, please. 12:16

MS. JAN MCGALL, HAVING BEEN SWORN, GAVE EVIDENCE TO THE INQUIRY AS FOLLOWS:

CHAIRPERSON: Good afternoon. Thank you. We met very briefly in the room this morning. I'm afraid you've been sitting around outside for a while. Have you been watching the proceedings? 12:16

THE WITNESS: Yes.

CHAIRPERSON: Good. Okay. Well, you're very welcome.

Thank you your statement. I'm going to hand you over to Mr. McEvoy.

THE WITNESS: Okay. Thank you, Chair.

128 Q. MR. McEVOY: Thank you, Ms. McGall. We also met briefly earlier today. As you know, my name's Mark McEvoy and I'm one of the Inquiry counsel. You have kindly provided to the Inquiry a statement of 18 pages and an exhibit of one page and it's dated 23rd January 2023. Do you wish to adopt that statement as your evidence to the Inquiry? 12:17

A. I do, thank you.

129 Q. Now, if we can bring up just the first -- to start off first things first with the first page, please, you, just by way of background, tell us about your qualifications. By training, you are an occupational therapist? 12:17

A. That's correct.

130 Q. And then, currently, your position is that of Director of Mental Health and Disability within the Southern Health and Social Care Trust, and you've held that position since last March? 12:17

A. Yes.

131 Q. So just over a year?

A. That's correct.

132 Q. We'll just call it the Southern Trust, I think, for brevity's sake if that's all right? 12:17

A. Yes.

133 Q. Could you tell us just before you took up your position last March, what you did prior to that?

A. Yes, so the majority of my clinical career as an occupational therapist from qualifying, I worked in mental health services in the -- formerly, the South Eastern, eh, Southeast Belfast and then the Mater Hospital Trust, which laterally became the Belfast Health and Social Care Trust, and I worked in a range of mental health jobs, clinical remit, in that trust. I took up management roles then in and around 2014 in mental health services and I worked in management roles in mental health services up until 2019. And from August 2019 until February 2020 I went to Muckamore Abbey Hospital as a senior improvement lead, predominantly to stabilise the management structure in Muckamore at that time and, with others, to address the RQIA improvement notices that had been issued to Muckamore Abbey. 12:18 12:18 12:18

I left the Belfast Trust in February 2020, moving to the Southern Trust, where I took up position as the Assistant Director of Mental Health Services in the Southern Trust. And then, as you say, from March 2022, I have been the Director of Mental Health and Disability, including learning disability services, in the Southern Trust. 12:19

134 Q. Okay. So from that answer, we can gather then that you do have first-hand experience of Muckamore Abbey Hospital? 12:19

A. I have.

135 Q. But as I'm sure you're aware, your role here today is

to answer questions, where appropriate, on behalf of the Southern Trust?

A. That's correct.

136 Q. So it may be that we'll hear from you in due course, but today the focus is on the Southern Trust and relationships then into Muckamore. 12:19

A. (Witness Nods).

137 Q. Picking up just on that trajectory and particularly the fact that you have sort of ascended from an assistant role, you have - maybe now is a good time to deal with it - provided an organogram, which is the very last page, page 19 - it's the one exhibit to which I referred. This document, it appears to be dated 2007, is that right, you have it open in front of you? 12:19

A. I do, yes. 12:20

138 Q. Are you currently sitting at the top of this particular tree then?

A. So this exhibit was provided because this was the first year of the Southern Health and Social Care Trust coming into existence. 12:20

139 Q. Yes.

A. And this was the structure at that time. It has changed somewhat and that is reflected in the statement of evidence that I have given.

140 Q. Yes. 12:20

A. Because the Assistant Director of Physical and Sensory Disability and the Assistant Director of Learning Disability was a merged post, post 2007. So this was at a point in time. It is slightly different now.

141 Q. All right. So, currently, we have two assistant directors then below the director?

A. We have three. We have an assistant director for mental health; an assistant director for disability, which includes learning disability services; and we have our new assistant director for inpatient mental health and disability services. 12:21

142 Q. Right.

A. Because I am responsible for the Bluestone Unit, which includes adult mental health, learning disability and dementia in patient beds and -- 12:21

143 Q. The panel may not be aware, but where is the Bluestone Unit based then?

A. So the Bluestone Unit is on the Craigavon Hospital site and it is for the population of the Southern Health and Social Care Trust. 12:21

144 Q. At this particular time, this is going back to 2007, as you say?

A. Yes.

145 Q. There's quite a lot of responsibility sitting under the Assistant Director for Learning Disability. On the left-hand side, we can see Hospital and Acute Services and below that then the Longstone Hospital -- 12:21

A. (Witness Nods).

146 Q. What's the current status just of the Longstone Hospital? 12:21

A. So the Longstone Hospital was the former learning disability unit for the Southern Board. It closed in 2013, Autumn of 2013, and all of those patients would

have been resettled. Dorsy Ward, which is on the Bluestone Unit at Craigavon Area Hospital is the current assessment and treatment inpatient bed facility for individuals with a severe learning disability for the population of the Southern Trust. It's a ten-bedded unit. 12:22

147 Q. Now, I appreciate you have detailed the development of this in the period, this particular chart, in the time since. But can you give us a rough idea of where, if at all, respectively psychology and psychiatry would sit within this framework? 12:22

A. Yes, so psychology and psychiatry, as you will note in my statement, sat as part of the growing multidisciplinary team, both managerially and clinically. So within each of these community services, hospital services, there would have been jobbing psychiatrists and psychologists involved as part of that multidisciplinary team. And then their line management structure as a divisional medical director or the directorate - medical directors they'd be known at that time - and the lead psychologist would have sat alongside the assistant directors in the managerial structure. 12:22 12:23

148 Q. All right. So just returning then just to the body of your statement and, in particular, Section 2, which is where you pick up on the first of the themes that you were asked to address by the Inquiry, which is that of interrelationships between the trusts regarding patients admitted to Muckamore. And that is the second 12:23

page of your statement then, so it's 0852. At the very outset of the first paragraph, 2.1, on that page, you describe having taken or having undertaken a review of available patient records and documents and to outline the interrelationship between the Southern Health and Social Care Trust, the Southern Trust, and Muckamore Abbey Hospital in relation to patients admitted to the facility. Can I ask you about the methodology involved in that review? How did you go about it? 12:24

A. So the Southern Trust has provided disclosure to the Inquiry of the 28 patients between the period of the Inquiry's Terms of Reference, 1999 to June 2021. So those patient records -- 12:24

CHAIRPERSON: 1999, did you say?

A. Yes. 12:24

CHAIRPERSON: Yes, sorry, I heard '89.

A. Sorry, December 1999 to June 2021. So that information has been provided to the Inquiry. So I subsequently reviewed each of those patient records to determine, you know, was there interface with Muckamore Abbey Hospital, what was the nature of that, and that is where I -- 12:24

149 Q. MR. McEVOY: Okay, so you sat down with that finite number of patient files --

A. Yes. 12:25

150 Q. And it's your own work?

A. It's my own work.

151 Q. So it's what sometimes one hears referred to as a desktop review?

A. It was, yes, because I obviously wasn't in post at that time, so it's not my own memory of it, but I have reviewed documents that have been made available to me, yeah.

152 Q. In the course of that review, did you speak to or have any discussion with regard to what you were talking or looking at in the course of that review, did you speak to anybody else who might have been contemporaneously in post? 12:25

A. Yes, so some of the managerial staff that remain in employment of the Southern Trust at present would have been involved from the creation of the Southern Trust in the resettlement of patients from Longstone and in the development of community services. So, where they were available, I was able to clarify any questions that I had with them. 12:25 12:25

153 Q. At the end of the first paragraph, you say that:

"A review of available patient records indicate that admissions were in four broad categories, as follows: Admission of a child to the Specialist Children's Ward..." 12:26

- which is Category (a) -

12:26

"(b) Transfer of an individual admitted as a child to an adult ward in Muckamore Abbey Hospital when aged 18 years;

(C) Admission of an individual whose behaviour needs

exceeded what was available in Longstone learning disability hospital;

(d) Admission of an individual with forensic criminal convictions."

12:26

Can you clarify for the Inquiry whether those four categories deal with individual patients or are they categories of patient?

A. So when I reviewed the records made available to me, which predated the creation of the Southern Trust because, obviously, the Terms of Reference were from 1999 and we still do have those patient records, that is the type of individuals that would have went to Muckamore.

12:26

154 Q. So that's the type of individuals --

12:27

A. Type of individuals.

155 Q. So those are patterns, essentially?

A. Yes.

156 Q. All right, thank you. So it may be, as you pointed out, that the materials have been provided to the Inquiry and it may be that we'll revert to you in due course about those particular case records in more detail. But as I'm sure you can gather from what you were asked to do today and what you've done, the task in hand is really to get an idea of the structures that are in place or were in place in relation to these patients.

12:27

12:27

So at 2.3 of your statement you tell us then that in

the case records you were looking at in relation to admissions to Muckamore Abbey Hospital indicate the presence of clinical discussions on the appropriateness of admission between referring and accepting consultant psychiatrists and, at times, other members of the multidisciplinary management team. 12:28

Now, on that question of clinical discussions, is there a structure which governs those discussions and the basis for them taking place? 12:28

A. From evidence made available to me, there isn't a templated format. But what I noted was the consultant psychiatrist from within the Southern Trust discussing the clinical case with the potential receiving psychiatrist in Muckamore Abbey and they documented discussion about the clinical presentation of the patient, the risk profile, the rationale for admission, and the potential outcomes or product of the admission is detailed in the clinical notes of the patient. So it isn't a set pro forma, but it was more like a clinical discussion/rationale for admission with what was expected to be achieved, and then the outcome of that clinical discussion. 12:28 12:28

157 Q. Okay. So there's no pro forma. There's no, therefore, overarching policy or procedure which dictates when such meetings ought to occur? 12:29

A. No. From what I have read, it looked as if that the needs of the individual that was determined could no longer be met within the available services in the

Southern Trust for reasons outlined above -- and then Muckamore Abbey, as you're aware, was regionally commissioned to provide Psychiatric Intensive Care Unit, the PICU, or the forensic -- or and the forensic unit. So in the clinical records, it looks as if the needs have been established not to be able to be met locally in the Southern Trust area, and then there was a clinician to clinician discussion to make the referral. There was a clinical documented discussion on that referral and then an outcome whether the patient was accepted for admission or not. 12:29 12:30

158 Q. All right. But the Inquiry can take it then that these discussions took place on a more ad hoc basis as opposed to --

A. Yes, patient by patient need basis. 12:30

159 Q. Then you go on to say there is evidence in the records, most specifically in relation to individuals admitted with forensic issues or history, of inter-trust, but also referred to as multiagency case discussions and corporate meetings to discuss risk update and assessment, planning for home leave, changes in clinical placement -- for example, ward moves or consideration of an extra contractual referral to facilities outside of Northern Ireland, changes in clinical presentation and when preparing for discharge. 12:30 12:30

Again, is there a structure or a policy or both? What's the means for indicating when such meetings should take place?

A. So the majority of the records that I reviewed in this timescale were individuals admitted to the Forensic Unit. So there would have been, if individuals were on licence or that was their disposal route from court, there would have been a requirement for regularity of meeting. I can't specify today what that was, but I can go back and check what that was. 12:31

160 Q. That might be helpful.

A. On other occasions then it was when there was a change in the presentation of the patient. So obviously they were admitted to the unit for a purpose. If that was achieved, if there was a deterioration, or if there was a change prepared or planned for the clinical care, then both the Community Trust, the Southern Trust and Muckamore would have come together to discuss that. So that would have been more ad hoc. And there would have at least been an annual review by the key worker in the Southern Trust of the patients placed in Muckamore Abbey. 12:31 12:31

161 Q. So those patients with maybe forensic issues or history may have had a requirement stipulated, but you're prepared to go back and look at that for us? 12:31

A. I can check that out, yes.

162 Q. Thank you.

A. What was also noted was that if, you know, the individual was availing of a period of pass or leave from the ward, obviously some of them may have been bound by, you know, restrictions to access. So there was inter-trust meetings to prepare for that period of 12:32

leave to ensure that it's safe -- that any considerations in relation to licensing was considered and that the family was prepared and it was appropriate for the place of leave to take place.

163 Q. Your final point in that paragraph is in relation to you noting evidence of family involvement in those meetings. Was that, the family involvement, was that a noted requirement? 12:32

A. The clinical records that I reviewed note that Mum and Dad or sister were present at the multidisciplinary meeting on that time. Again, it was more likely to relate to periods of pass home to said individuals or when preparing for discharge. So there was continued input of family if they were remain involved in the person's care. 12:32 12:33

164 Q. So it could be that family involvement is dictated more by the particular case rather than --

A. Yes.

165 Q. -- by a policy or process?

A. We would also always, if there is family remaining involved, encourage their involvement. And I think that triangle of care between patient, professional and family has become stronger as the time has gone on. But where there was family involvement, their needs were always considered. 12:33 12:33

166 Q. This is based on your historical review and --

A. Yes, and if you carry on to the next paragraph, you can see that there's evidence in some of the case notes that the Southern Trust staff would have continued to

engage with the families in the Southern Trust area, even though their relative was in Muckamore Abbey, and would have undertaken carer's assessments and carer reviews.

167 Q. We'll come on to that in just a moment. On the next paragraph, though, at the outset you say there evidence of joint meetings to discuss, plan and review care. I suppose, for clarity, between whom were the joint meetings? 12:33

A. Between the Muckamore Abbey treating team and the Southern Trust community team. 12:34

168 Q. All right. And, once again - you'll notice a theme to these questions - but was there a procedure or policy or any other sort of formal or semi-formal structure which dictated or mandated what should happen in terms of those meetings taking place? 12:34

A. No, not -- no formatted procedure or planning. It was obviously related to the change in the patient's presentation or changing level of care requirement. Under the code and quality care guidance, there is more emphasis placed on, you know, involvement of all professionals in a category of care. And you'll see strength and risk assessment most particularly in those individuals with a forensic need. 12:34

169 Q. Again, as you know, we are trying to establish structure here and the degree or absence of it that there might have been in place at this particular time. 12:34

So then you say just about halfway down that same

paragraph:

"Clinical records in some cases note that community learning disability staff from the Legacy Southern Trust in-reached to review and meet with individuals..."

- I think that was the point you were making a moment ago - 12:35

"...whilst they were an inpatient in Muckamore Abbey Hospital, usually for the purposes of an update on the assessment of clinical need, risk assessment and preparation for discharge." 12:35

Just for the lay person, can you tell us what in-reach actually means?

A. Okay, so I suppose we need to remember that the majority of Southern Trust patients were treated locally. So there's a small number of patients in Muckamore. But where there were patients placed from the Southern Trust in Muckamore Abbey Hospital, I did see evidence of in-reach from community professionals to the hospital and that assessment of clinical need is usually in preparation for discharge. So, you know, how is the mental state? What are the patterns of challenging behaviours? Are there any specific issues that need to be considered in planning for discharge? You know, what is the current means of communication 12:35 12:36

with the individual? What is their wants and requests and likes for discharge? Are there any physical health conditions that have developed during the period of time of the admission that need to be factored in? So all of that range of clinical need would be taken into account. 12:36

CHAIRPERSON: Sorry, when you refer to community professionals, what does that cover?

A. So that would cover the staff of the Southern Health and Social Care Trust, who would have been responsible for placing the patient in Muckamore Abbey. 12:36

CHAIRPERSON: I understand that. But what sort of beast is it? What sort of --

A. Oh, apologies. So it would have been a member of the multidisciplinary team. So it could have been a learning disability nurse or a social worker in the main. 12:36

CHAIRPERSON: Right. Or an OT or...

A. OTs predominantly weren't case managers. They would have been providing assessment and intervention on a patient by patient basis. So that the predominant staffing group would have been learning disability nurses, social workers and clinical psychology, most particularly for those with a forensic history. 12:37

CHAIRPERSON: Thank you. 12:37

170 Q. MR. McEVOY: Now, at 2.5, which is the next paragraph then, you refer to finding evidence or seeing evidence of inter-trust working to support the resettlement of individuals from Muckamore Abbey Hospital in line with

the regional resettlement process, with Southern Trust successfully supporting the resettlement of six individuals. Now, first, in that sentence, can you tell us the time period over which those six individuals were resettled? 12:37

A. So my understanding, it would have been -- the records I reviewed were from December 1999 to June 2021. I do not think we have had an admission to Muckamore Abbey from around 2013, but I can double-check that and come back to the Inquiry. 12:38

171 Q. Well, just in terms of the period, and that's obviously quite a long time, can you locate for us over that period of time when those six individuals --

A. I need to come back to you on those dates, yeah.

172 Q. Very good. You have commented that their resettlement was successful. Can you give us an indication of the methodology that you used to conclude that the resettlement was successful? 12:38

A. So the successfulness of the resettlement was that the individuals now are not currently living in a hospital as their permanent address. They have been resettled or they were resettled into a range of supported living and/or bespoke placement. So they were able to lead a full and equal life, you know, outside of the hospital environment in that, in my understanding, they didn't require re-admission to Muckamore Abbey Hospital. So that in itself was a successful outcome. 12:38 12:39

173 Q. Well, did it include evidence of getting feedback from the individuals that they felt that they had been

successfully supported to resettlement?

A. So I can't speak to the six individuals in totality, but, in general terms, yes, the majority of people who have been resettled, both from Muckamore Abbey Hospital to the Southern Trust, but also our own resettled 12:39
population from Longstone, feedback about the difference in the quality of their life they experience outside of a hospital environment -- obviously there's a period of adjustment to that, especially if you had lived a very long time in a hospital environment, but 12:39
the world opens up, opportunities are greater than there would have been as an inpatient in a hospital ward. There's freedom of movement. You have your own tenancy. You can engage in activities that are of interest to you. You can spend your day as you wish to 12:40
do. You have opportunity to engage with your family. So there has been feedback gathered in various means through independent advocacy and other groups as to what resettlement has meant to individuals who have been resettled -- 12:40

174 Q. I'm going to come onto the advocacy question in a second but just in terms of establishing whether or not there was a structure for getting the feedback into your trust and then maybe that conveying on to Muckamore, or vice versa for that matter, was there a 12:40
structure in place in order to do that from the patients themselves?

A. There wasn't a prescribed structure. But there was, you know, regular satisfaction surveys or, you know,

social stories about life beyond resettlement that were gathered. But it wasn't a prescribed structure.

175 Q. Would it be unfair to describe that as empirical or anecdotal feedback, as opposed to formally gathered feedback? 12:41

A. I suppose it's not anecdotal when it comes from the patient because it's their life experience.

176 Q. Yeah.

A. But if you're asking me about formalised feedback, it would have been data. It would have been, you know, 12:41 seven patients resettled, seven patients remaining in the community post resettlement. So we would have counted facts and figures. That more qualitative stuff would have been on a more ad hoc basis.

177 Q. All right. At the end of paragraph 2.5 then, you 12:41 describe Southern Trust commissioned Advocacy and you describe it as being a strong feature in supporting individuals in the resettlement process. Can you tell us something about this Southern Trust commissioned advocacy, what shape it took and how it was funded and 12:41 so forth?

A. Yes. So when the Southern Trust was going through the process of resettling individuals from Longstone, they were very clear to seek the views of the patients being resettled and to have individuals to support and 12:42 advocate for them if they weren't able to do it on their own behalf. So the trust commissioned Advocacy - it's currently Disability Action - and whilst they're commissioned from the trust and we pay them through a

service level agreement, they are independent of the trust. They hold their own mind and their own views and their role is to bring forth the wishes, the needs, the views of the patient to the trust and work for the benefit of the individual being resettled. 12:42

178 Q. And, again, how were you able to gauge from your review that this was a strong feature? What enables you to tell the Inquiry that?

A. Because they were -- the advocate was part of the -- documented as in attendance at the case discussions at 12:43 the core group meetings and there was evidence of advocates bringing forth issues that needed to be addressed by the trusts on behalf of the patient. And that still continues today.

179 Q. At 2.6 then you say that: 12:43

"There is evidence of the attendance of Southern Trust senior managers at regional meetings focusing on resettlement both from Muckamore Abbey Hospital and Longstone Learning Disability Hospital in a Southern 12:43 Trust area. There is reference in correspondence to adherence of the Southern Trust to resettlement targets set by the Department of Health and the Social Care Board."

12:43

Can you tell us, first of all, I suppose, picking up on the second sentence first, about those targets? You make reference to correspondence about adherence to the targets. Does the correspondence go so far as to tell

us whether the targets are being met?

A. Yes, so obviously the Equal Lives document said that resettlement should be concluded by 2011. Having reviewed information made available to me, the Health and Social Care Board and the Department of Health had set resettlement targets to be achieved, and then that was monitored through a performance management structure and there are available minutes of attendance at those meetings to say "In this quarter, we have resettled ten patients" or four patients or zero patients, dependent on how the performance was. 12:44 12:44

180 Q. All right. Just before I move on then to the next section, did you notice in the course of your review whether there was any reluctance in any of the material that you looked at on the part of families to have - and this is - I'm not talking about case specific circumstances, but any reluctance of families to have their relatives admitted to Muckamore prior to 2017? 12:45

A. I suppose, back to my earlier point, the majority of individuals from the Southern Trust were admitted locally to Longstone Hospital. So it was smaller numbers than perhaps other trusts were admitted to Muckamore. I think there was nothing in the evidence that I reviewed that demonstrated significant family concern. The concern was more about the individual and the deterioration that was requiring hospital admission, as opposed to the location of that hospital admission. 12:45 12:45

181 Q. The same question but on a slightly different context:

Did you notice any reluctance on the part of clinical staff to see a patient admitted to Muckamore out of the Southern Trust?

A. I suppose the preference would be that we were able to treat our Southern Trust patients within our own services and close to their own homes because it keeps the family networks - it's quite a journey from, you know, Keady to Muckamore. So there was nothing that I had reviewed in the evidence that the clinical team were reluctant to admit to Muckamore based on the quality of care that was provided there, no. What they had got was to the stage where they had exhausted all options within the Southern Trust to meet patient need, or the decision was taken out of their hand if it was a forensic patient and that was the regionally commissioned unit. 12:46 12:46 12:46

182 Q. Again just focusing on this question of structures in place between the Southern Trust and Muckamore, when the revelations came out in 2017 which led to the establishment of this Inquiry, did it trigger any investigation within the Southern Trust into anything that might have happened at Longstone, do you know? 12:46

A. I wasn't present in the Southern Trust in 2017, so --

183 Q. You didn't see anything in the course of your review?

A. No. 12:47

184 Q. And, again, just in terms of your own trust's dealings with Muckamore, did the revelations cause any revision of your practices and procedures with Muckamore?

A. I suppose, I am responsible today for a learning

disability inpatient unit and whilst we still await the findings and recommendations of the Inquiry, there have been a number of reports along the way in relation to Muckamore and others and we take that learning and make changes to make sure care continues to be safe. I think, today, times are different than they were back in 1999. I know, today, we have a weekly overview of incidences across a range of units, including the Dorsy Learning Disability Inpatient Unit, which looks at the monitoring of restrictive interventions, the review of Datixes for incidents. There is a strong feature in safeguarding. There is a strong feature in having a skilled, supported workforce to meet patient need and we are very mindful that, at times, jobs can be difficult and we have to support our staff both in training and in psychological safety to be able to do their jobs well. So, I suppose, today, practice is very focused on ensuring our staff are well skilled and supported to deliver quality good care to the patients in our care. The governance systems are more robust in trying to pick up trends and identify issues that come out through incidences and --

12:47 12:48 12:48 12:48

185 Q. Just pausing there, so the training and the psychological supports that are in place for staff, you say that those have been -- I mean, it's my word but I took from what you were saying, expanded or developed in the time since the revelations came to light?

12:49

A. I think we're learning every day, but, yes, there is a strong focus on having staff who are trained in

positive behaviour support to understand how to respond at times of difficulty. You know, we're always advancing our staff in trying to reduce restrictive interventions and there is a process of work across both mental health and learning disability services regionally to do that. I know in the Southern Trust we have introduced calm boxes, things to try and de-escalate situations before restrictive intervention is required and that's working with the patient to understand what their triggers may be, what helps settle things down. 12:49 12:49

So we continued to try and develop better ways of working that are more conducive for recovery from that period of illness and, you know, continued the function and the lives of the individuals. So I do think there is learning already in place from the reports that have come out to date in relation to Muckamore Abbey. 12:50

DR. MAXWELL: Can I just ask, obviously it's -- it can be quite difficult for staff managing people with very complex needs -- do all the staff on your inpatient unit have regular clinical supervision? 12:50

A. Yes.

DR. MAXWELL: So the health care assistants, the nurses? 12:50

A. There is obviously a prescribed supervision structure for nursing staff and psychologists, medics --

DR. MAXWELL: Does it include the health care assistant, who are often the ones who are involved in

the direct contact?

A. Yes. So what we have introduced is daily safety huddles where there is -- that involves all the members of staff --

DR. MAXWELL: That's not supervision; that's a safety huddle. 12:50

A. Yes, that happens on a daily basis. And then there is supervision of health care assistants in place, which would look at their training, any areas of development for themselves, and reflection on their practice. 12:51

DR. MAXWELL: That sounds like appraisal rather than clinical supervision, though. And to sound like my learned colleagues, is there a policy in that?

A. We will have a supervision policy and I can provide that to the -- 12:51

DR. MAXWELL: That would be useful.

A. And, I suppose, this is the Southern Trust today. It is not Muckamore at that time.

DR. MAXWELL: Yes.

A. In the Southern Trust today, we also have facilitated sessions with psychology, the likes of Balint and debrief, which could form a version of clinical supervision. 12:51

DR. MAXWELL: Yes, that would be useful to have, thank you 12:51

CHAIRPERSON: Sorry, was the express used "balance" or "Balint"?

A. Balint.

CHAIRPERSON: As in Balint groups?

A. Yes. Our clinical psychologist facilitates group discussion sessions for Dorsy staff where they have the opportunity to reflect on incidences of concern or difficulties in their practice or issues that they wish to bring up. 12:52

CHAIRPERSON: And just in terms, for the lay person hearing, I think I do understand how supervision works -- it's not as a lay person might understand supervision. Can you just explain how supervision works? 12:52

A. So for a professional staff, it is a requirement of their registration. Supervision, we would have both operational and clinical professional supervision. So it can encompass the range of that your training is up to date; that you're continuing your professional 12:52 development to be able to do your job well; that you're working - you know, there are issues within your role that you're able to fulfil or if there are any issues that they're not; and then that the kind of clinical element of the supervision can be a reflection about, 12:52 you know, how does it feel to be caring for that patient, how have you managed in dealing with that, is there anything that we can help you think through or provide training on, or support.

CHAIRPERSON: And can you give us some clue as to how 12:53 often - I mean, supervision in some practices happens every two weeks or every month - can you give us some clue --

A. Well, I would say that the safety huddles that happen

on a daily basis are ad hoc supervision because there's guidance issued and opportunity for discussion on case. I will come back to you as to how per profession regular supervision is.

CHAIRPERSON: I think that would be helpful because it is a sort of sign, I think, of good practice. 12:53

A. It is.

CHAIRPERSON: And I think it would be interesting to know. And finally this -- and I don't mean this rudely in any way, but in every inquiry that I have been involved with, I've heard witnesses saying, "Well, we're learning all the time", but could you say there was a step change, as it were, in your practices since the revelations came out in 2017? 12:53

A. Yes. There is a step change. 12:54

CHAIRPERSON: And that would be demonstrable?

A. I think it would be demonstrable both in the psyche of the staff , but also in the way we work. You know, we have changed our processes, we have strengthened our governance. Now, I think there is still a way to go. You know, I am assured care is safe today, but that's not to say it's completed. 12:54

CHAIRPERSON: No, quite.

A. I think it's an ongoing -- I mean, Dorsy is constantly in my mind to ensure that care is safe and in, you know, the minds and practices of my team. But, yes, there is a step change in being aware of the needs of individuals who can't always communicate themselves and to ensure that our staff are involved, not isolated; 12:54

that we listen, that we monitor trends, that we look at data and we try to investigate as fairly as needs be as things arise, yeah.

CHAIRPERSON: Thank you. Sorry to interrupt.

186 Q. MR. McEVOY: That's quite all right, Chair. So it neatly takes us on to the second aspect of your statement or the second topic, rather, that you were asked to address, which is the outline of provision for community-based services, and it begins then at internal page 4. You have touched a little bit earlier, and there's no point in taking you through it again, just when I asked you about the organogram, about the development of management structures. But if I can take you just to the historical position, I suppose, as it was and begun at 3.31, which is at page 5, internal 5 - it's just below the heading "Community Services" and you're talking about the period from 1st April 2007 to March 2008. You indicate, of course, that this was a period of significant change for staff at management levels in the trust, with much activity centred on the establishment of new structures. And you talk about then how inpatient learning disability services were provided in Longstone. You then tell us that: 12:55 12:55 12:55 12:56 12:56

"Learning disability community services were provided by three locality based teams, Craigavon and Newry, which were multidisciplinary in nature, and Armagh, which was a social work team with access to a community

nursing team in this locality area. The directorate planned to develop multidisciplinary teams consisting of social work, nursing and allied health professions, with access to psychology and psychiatry across the three locality areas." 12:56

Now, out of that, the Inquiry would be interested to know why you have described the directorate and those teams then - this was their vision anyway - as having access to psychology and psychiatry? I mean, in other 12:57
words, were they not core functions? And I appreciate this was based on your historical review, but have you been able to determine that from what you read?

A. So, I mean, yeah, this is based on the Delegated Statutory Functions Report that would have been 12:57
submitted to the Health and Social Care Board. So my understanding is that at this stage of development in the 2007/2008 period, there was a variant practice across the Legacy Trusts. So, as you can see there, some had multidisciplinary teams, some didn't. And 12:57
there wasn't psychology and psychiatry aligned and available to be aligned to each of those. So my reading of the report was --

187 Q. Just pausing there, sorry, when you say not available, what do you mean? 12:57

A. It wasn't commissioned. There was no one in post. It wasn't a resource that had a multidisciplinary team of X number of social workers, nurses, and a psychiatrist and a psychologist.

188 Q. Was there a reason for that?
A. I don't --
189 Q. I appreciate again you're looking at this from a --
A. Backwards, yeah.
190 Q. -- review perspective, but was there an explanation why? 12:58
A. I guessed it would be helpful to look at how services were commissioned pre 2007 and --
191 Q. So do you think the commissioning materials might provide the answer to why psychology and psychiatry might not have been factors in the equation? 12:58
A. Yes, I think that's probably the best place to get that evidence. My understanding of the reports that were made available to me was that it was the intention of the new Southern Trust to develop multidisciplinary teams that initially had access to available psychiatry -- 12:58
192 Q. Yes, of course.
A. -- and psychology resource, with the ambition then that they would become core members of a multidisciplinary team as services developed. 12:58
193 Q. All right. In the next paragraph, you then move on to 2010/11. If I can take you, please, just to the top of page 6 --
CHAIRPERSON: I'm just going to pause for a moment, Mr. McEvoy. It's five past one. If you think you can finish this witness without rushing in any way by around 1:30, then we can sit on. If not, then we will need to take a break at some point. 12:59

MR. McEVOY: I think we're going to be able to cut through a bit of it. I think 1:30 or just a bit after might be a worthwhile target

CHAIRPERSON: Are you all right with that, if we do that? 12:59

A. That's fine.

CHAIRPERSON: It might suit everybody if we do do that, but I don't want anybody to feel rushed. And if you feel you can't do it justice, then just say so and we'll obviously break for lunch. 12:59

MR. McEVOY: Thank you, Chairman. I appreciate we've gone through a lot of paragraphs sort of line by line, but we're going to gather a bit of pace. There are some we can move on past so...

CHAIRPERSON: Okay. 12:59

194 Q. MR. McEVOY: -- so a bit more thematic now. But just picking up there at the top of page 6, please, Ms. McGall, just where you say:

"There was a focus of resources in the 2010/2011 year 13:00 on supporting hospital discharges as per directives from a Department of Health and Health and Social Care Board and it was the view of the trust that this was at the expense of service to carers in the community."

13:00

Can the Inquiry take it that you saw correspondence or an exchange in the course of your review which disclosed that view?

A. That is a verbatim lift from the Delegated Statutory

Functions Report that was submitted from the Southern Health and Social Care Trust to the Health and Social Care Board in that year.

CHAIRPERSON: Just keep your voice up, please, sorry.

A. Sorry, that is a verbatim lift from a statement that was included in the Delegated Statutory Functions Report of that year that was submitted from the Southern Health and Social Care Trust to the Health and Social Care Board. 13:00

195 Q. MR. McEVOY: So that is to say the HSCB as was would have been made aware of that specific concern? 13:01

A. Yes.

196 Q. Did you see it located anywhere else, the discussion, or a discussion, I should say, around that particular concern? 13:01

A. No.

197 Q. Did you see it transmitted to the Department?

A. Well, that Delegated Statutory Functions Report would have gone to the Health and Social Care Board. There was no further correspondence as to whether it went to the Department or that view was shared with the Department. I couldn't - I haven't located that in the paperwork. 13:01

198 Q. Would you, with your considerable experience - and I mean that in the most gentlemanly way possible - but would you have expected to have seen or would you expect to see correspondence between the HSCB and the Department discussing that concern? 13:01

A. The report that was made available to me didn't

evidence what those concerns were. But, you know, there were other fora that service priorities could have been discussed at. Health and Social Care Board officials sat on the Resettlement Programme Board for Longstone Hospital, which would have been an opportunity, I'm sure, to share those views. Obviously, the resettlement agenda was led by the Department, so there would have been director and assistant director level input to policy colleagues in and around that time. 13:02

So whilst I didn't see it in evidence, that could have been a fora where those issues could have been shared. But that statement in itself is a direct lift from the report that was shared with Health and Social Care Board as Commissioner. 13:02

199 Q. All right, the next logical question then is was there a response from the Health and Social Care Board to that? Did they directly address that?

A. Whether they directly addressed that or not, we did see funding come down in the forthcoming year for some development in community services. 13:02

200 Q. Can you recall - it's something you might need to go back and look at, but can you be more specific at the moment? Or, I mean, if it's something you need to take away -- 13:03

A. No, I mean, if you go on to paragraph 3.3.3, it notes sort of in the middle of that paragraph:

"The division supported the proposal for the creation of crisis response home treatment and the proposal for funding was submitted to commissioners in 2011/2012."

And it's my understanding we received around £60,000 then from Commissioners to begin the development of that service. 13:03

201 Q. So there could be a relationship then between the two?

A. There could.

202 Q. On the foregoing sentence, the next thing I was actually going to ask you about was the first that you described as having been established in terms of the Learning Disability Forensic Service, which aimed to support individuals with a forensic history to be resettled and live a safe and meaningful life in the community. Was that rolled out or, for want of a better word, copied by other trusts? 13:03

A. I guess that's for the evidence that follows me. My understanding is that there are forms of Learning Disability Forensic Services in most trusts. The structure of that, I'm not aware of as consistent across the province. But we have had a learning disability forensic team from that 2011 year. 13:04

203 Q. That's what I was just going to ask. Does that remain in place then? 13:04

A. It remains and has obviously grown and developed. We have a lead consultant clinical psychologist there. We have forensic practitioners and that team has grown in relation to the management of patients with differing

and more complex needs, yes.

204 Q. The team has grown. Have you got the funding to match the team?

A. Yes. Yes. And that is noted throughout, yes, where they developed both care that they provided, but also the size and difference to the team structure, yeah. 13:04

205 Q. Just before we leave this particular area, there's reference in this paragraph and the foregoing paragraph just to the question or the term of delayed discharges. What's your understanding of that from your perspective as a director of mental health and learning disability? 13:05

A. So delayed discharges is when the patient is medically fit for discharge. So there is no longer a requirement for a medically-led inpatient multidisciplinary team placement, but there hasn't been the ability to secure suitable, safe and effective plans for discharge. So from the point at which the patient no longer required inpatient care to the point at which they're placed, that period of time would have been the delay in their discharge. 13:05 13:06

206 Q. Moving down to paragraph 3.3.4 on page 6, you're dealing now with the period of 1st April 2012 to 31st March 2013:

"The division continued to progress the recommendations of a review of the care management provision of services and charging guidance." 13:06

And is that a reference number then - HSEE CCU 1/2010?

A. Yeah, so that is the 2010 care management guidance that we work to currently still in relation to the provision of care. So that is the named key worker, how care needs are assessed and how care needs are met. That is the guidance. 13:06

207 Q. Okay. Practically, what did that mean with persons with learning disabilities and their families, both in and out - if you can deal with both in and out of a hospital setting?

A. So in the community setting, that is the structure which you undertake your assessment of need. And then following that assessment of need, the services that are provided to support you. So that would allow you to be provided with a nursing or a residential placement, supported living placement, a domiciliary package of care, day centre, day care attendance, if you required the resource of an epilepsy specialist nurse. So that is the guidance that compositely looks at your assessed needs and then allows services to be provided in line with that. 13:07 13:07 13:07

And there are thresholds for care management or case management, but the majority of our learning disability patients, by the nature of their severe learning disability, would fall under, you know, case management guidance; therefore, they would have a nominated key worker responsible for the co-ordination of their care. 13:08

208 Q. All right, thank you. Over the page then to internal page 7, moving on down in that same paragraph, it's

really towards the end of it. You tell us -- this is about just over halfway through that top paragraph:

"A patient advocate was recruited in 2012/2013 to support the resettlements process." 13:08

A. So that's the same Advocacy --

209 Q. I just wanted to clarify is that the same service?

A. As we discussed, yes, this is when they came into post in that 2012/2013 year. 13:08

210 Q. All right, okay. And then you say that:

"The trust achieved resettlement of all long-stay individuals then from Longstone in autumn 2013." 13:08

A. That's correct.

211 Q. What was the position vis-a-vis Muckamore, or was there one at that particular time?

A. So my understanding was that we had a small number of patients still remaining in Muckamore from the Southern Trust area, but we haven't admitted anybody to Muckamore from that period of time. 13:09

212 Q. And that small number of patients, they're not mentioned. Why is that? Is that - and if I'm wrong - I'm surmising that that's because they're possibly being treated as Belfast Trust patients? 13:09

A. Inpatients, yes. And they're maybe just not mentioned because it wasn't mentioned in the Delegated Statutory Functions Report, which is where I took my evidence

from.

213 Q. Right.

A. Their details probably would have been provided in that first release of information to the Inquiry.

214 Q. Right. 13:09

A. But, I mean, if you need me to map across to the numbers at that time, I can do that and come back to the Inquiry.

215 Q. That would be helpful, thank you.

A. I know as it stands we have one individual - and 13:09 actually, I think if you go on down, it does tell you how many we resettled from Muckamore... I can come back with the details of that.

216 Q. That's fine, we'll follow up.

A. Yeah. 13:10

217 Q. I wanted just to move on, if I could, to - it's page 8, actually, and I'm moving on up to 3.36 on page 8. Now, between April 2014 and March 2015 you describe the directorate as continuing with a review of community services as part of an RQIA review. Were you able to 13:10 tell from your review what gave rise to that RQIA review? What triggered it, in other words?

A. It wasn't detailed in the Delegated Statutory Functions Report, but I know that that is a published review which was published in 2016. So the review was 13:11 monitoring the performance against the service framework for learning disability.

218 Q. And you have described it there as continuing with a review of community services as part of an RQIA review,

which tends to suggest, I suppose, to the uninitiated that that's something that you're doing in co-ordination or in tandem with the RQIA. Is that accurate?

A. It's maybe the way that is worded. I suppose, the RQIA -- there was the service framework for learning disability, which we would have had to have been measuring ourselves against to see how far our services had developed in line with Equal Lives and the strategic direction for learning disability services. My understanding is that RQIA then were undertaking a review across the region to monitor progress in relation to that. So we were -- Equal Lives and the service framework for learning disability was in place. Trusts were expected to organise and develop their services in line with that, and then RQIA was going to come in and check how far we had progressed. 13:11 13:11 13:12

219 Q. So the RQIA involvement in this circumstance wasn't triggered by a particular acute event or incident?

A. No, my understanding was they were just reviewing how far you'd got with the implementation of new strategy. 13:12

220 Q. Thank you. This then led, you tell us a little bit further down the same paragraph, to the forming of a basis for what's described as a case management model in which social workers and nurses in community teams would manage all aspects of a case, including those which would have fallen within care management teams. Can you just explain that for us in readily accessible lay person terms? 13:12

A. For what is quite a complex system!
221 Q. Yes.
A. So it relates back to the 2010 guidance I referred to on 3.3.4.
222 Q. Yeah. 13:13
A. And, historically, there would have been a care management team. So if I was a patient or an individual who required provision of social and health care needs, you would have went to that team and they would have found your placement, ensured your needs 13:13
were met in line with the assessment. So, rather than having a community learning disability team to keep going with the day-to-day stuff and a separate team to manage your social care requirements and your health needs, it was combined. So as it stands today, our 13:13
community learning disability team perform the function of case management; it's not a separate entity.
223 Q. Okay. And is that made up then of - it's a dual professional - it's social work and nurses working together? 13:13
A. Yes. Yes. Dependent on the person's needs. So if the person's in a nursing home, it's more likely that the case manager is a nurse.
224 Q. Right.
A. Whereas if it's a heavier social care provision - day 13:14
care, supported living - that individual could be a social worker.
225 Q. Does the model stipulate a need for the nurse to be mental health, learning disability or dual?

A. I'm not sure in relation to the policy guidance.
226 Q. I'm just thinking in terms of this particular model.
A. It would be expected that the nurses would be learning disability nurses. We sometimes have dual trained nurses, but the majority of nurses in learning disability teams will hold registration on the learning disability part of the NMC register. 13:14
227 Q. All right. Then you then tell us, in 2015, Northern Ireland Single Assessment Tool or NISAT, if I'm pronouncing that correctly -- 13:14
A. Yes.
228 Q. -- was implemented across the learning disability community teams?
A. And that is just an assessment --
229 Q. So how does this make things easier or complicate them, as the case might be? 13:14
A. That gives you a pro forma for assessment. So everybody gets exactly the same structured assessment.
230 Q. Okay. And when you say everybody, do you mean...
A. Everybody who has been referred to the community learning disability team. 13:15
231 Q. Regardless of their need and their setting?
A. Yes, that allows you to establish their level of need, yes.
232 Q. All right, okay. There's a very dense and helpfully very detailed paragraph at 3.7, Ms. McGall, but you talk in terms of April 2015 to 2016 about an expansion in the multidisciplinary teams, which I think is something you adverted to earlier in terms of 13:15

professional groups of staff, psychiatry, psychology, learning disability nursing, social work, occupational therapy, speech and language therapy and physiotherapy available to individuals as required.

Moving on down then, you talk about the developments with respect to the forensic learning disability team continuing to develop day opportunities, providing over 400 placements per week. You talk about continued investment by the division in the creation of an advocacy service. Just on that last point, is that an advocacy service which is intended to be different in character from the one you told us about earlier? 13:16

A. No, just more people. As opposed to an advocate, advocates plural. 13:16

233 Q. In September 2016 then, there's an adult disciplinary transition team established to assist young people and their carers and families at the point of transition from children and young people services to adult services. Again, a multidisciplinary team includes of social work, nursing, occupational therapy and speech and language therapy. 13:16

You say then the crisis response home treatment service continued to develop to provide safe and effective community-based care. Now, if you could just help us here because context is, perhaps, everything, but there is a missing word. 13:17

"The home treatment element of the service commenced in December 2015. Data analysis demonstrated a 60%..." --

A. Reduction!

234 Q. Thank you! 13:17

"...in admissions to inpatient learning disability beds then since establishment of this service."

CHAIRPERSON: Well, that should be a reduction, obviously, yes. 13:17

A. Reduction, apologies, yes. And, I suppose, all of those investments would have come from the Commissioner through a commissioning statement and then the services were developed in line with the available -- 13:17

235 Q. MR. McEVOY: Yes. And if that material - and I don't know this standing here now, but if that material hasn't been provided to the Inquiry, presumably it's something that we can receive, if necessary?

A. The commissioning statements? 13:17

236 Q. Yes. If necessary.

A. Yes, we can get that from either the board, yeah, or our teams, yeah.

237 Q. Can I then take you just to the -- there are two graphs just on page 11 then, 3.3.12. This is a summary of 13:17 data, just the first graph, which is the whole time equivalent staff and learning disability from 2009 to 2022. You've broken down, helpfully, within the bars each of the staff backgrounds and specialisms. Within

that, however, we don't see mention of psychology or - again, I know you'll have picked up that it's a recurring theme in my questions, but we don't see reference to psychology or psychiatry and I am wondering if you can provide the Inquiry with an answer as to why that should be so?

A. Yeah, I suppose this was data that the human resources department in the trust provided, obviously retrospectively. Organisationally and in practice, psychology and medical staff, psychiatrists, are part of the multidisciplinary team. Structurally, at times, their funding sits outside that of the multidisciplinary team. So if I was to ask for staffing or funding breakdown for a specific team, I would have to ask for the medical and psychology alignment separately to that. So I can provide that.

238 Q. Is that something that could be provided as well then?

A. Yes. Yes. So it's not that they're absent; it just isn't included the way our finance systems are organised.

DR. MAXWELL: Can I just ask about that? Because are those roles sometimes covering a number of divisions?

A. No, I mean, our consultant psychiatrists are aligned to a community team and they also currently --

DR. MAXWELL: Full-time equivalent --

A. -- whole time equivalent will follow their patient into the inpatient unit and back out again. And the same for psychology, they are aligned to a team or potentially two teams. But they're not across many

different services, no.

DR. MAXWELL: Thank you.

239 Q. MR. McEVOY: Now, the next graph then - and there are two related graphs, so if you can sort of keep your finger on that page, on page 11, but also then turn to 15, you'll see two further graphs of sort of similar style. The first one at 3.3.13 deals with individuals in receipt of social care. 3.5.4 and 3.5.5 deal with supported living placements and nursing and residential placements respectively. Really I'm asking this question sort of dealing with how this approaches the figures behind each graph, but at the outset of your statement you told us that the population covered by the Southern Trust is in the order of about 327,000? 13:20 13:20

A. That was at 2007. I think, currently, it's around about 380,000 - it's slightly grown up. 13:20

240 Q. But the question is more around comparative, a comparative analysis of sort of those headings and that trend compared to, say, for example, Belfast Trust. Would you expect to see similar trends in Belfast Trust? Would you see expect to see similar trends in Belfast Trust or would you expect to see different trends? In either case, is there a reason why? 13:21

A. Well, I don't know the case load sizes or individuals in receipt of social care in Belfast Trust. 13:21

241 Q. It's a bigger trust, of course?

A. It is a bigger trust. So there'll be the general prevalence of a learning disability in the population.

242 Q. Well, that's where I was going. Would there be a

greater prevalence in - would you expect to see a greater prevalence in Belfast? Would it be --

A. Well, you know, there are more areas of higher socioeconomic deprivation in Belfast and we potentially see a higher level of learning disability in that population. It can also be about people reaching out for services. So in a more rural area, sometimes families dealt with things themselves and cared for the person without the requirement of statutory services. That may be the case in Belfast, I don't know. But I would have said that that kind of steady 2,000 individuals would probably be very similar to the Northern Trust. It's a slightly bigger population geographical area, but probably comparable to their figures. 13:21 13:22 13:22

CHAIRPERSON: Can I just ask you do accept the Belfast Trust is bigger, do you? Because we keep - we've heard different figures and the figure I've got in my mind was 340,000, which is smaller than yours.

A. Yeah, I would have thought Belfast Trust -- their staffing level is definitely much greater than the Southern Trust. 13:22

CHAIRPERSON: Right.

A. At the point in time they had around 22,000 staff in the Belfast Trust, the Southern Trust have 14,000. 13:22

CHAIRPERSON: I was just basing it on the population covered --

A. The population size I think is smaller than other trust areas.

CHAIRPERSON: Ah!

A. I think the Northern Trust is the biggest population at present.

CHAIRPERSON: Well, that's what we heard this morning.

A. Yeah. But, again, it's inner city -- 13:23

CHAIRPERSON: So you're basing on staffing, in fact, not the population covered in terms of Belfast being a bigger trust than yours?

A. Yes, on staffing.

CHAIRPERSON: Yes. It may not matter, but I just want to understand. 13:23

A. Yes, staffing levels are higher.

243 Q. MR. McEVOY: There are, across those three same graphs, again the sort of same question applies to all three and maybe you can deal with them respectively -- just on that one at 3.3.19 there is a bit of a dip. It's broadly - it sort of goes up and down a little bit and then seems to dip down from 2018/2019 to 2019/2020. 13:23

A. 3.5.5 are you talking about?

244 Q. Sorry, 3.3.13 - just the first graph. 13:24

A. Oh, yes.

245 Q. There is a little bit of a dip there. Can you help us with why that would be?

A. I can't, I'm afraid. I gathered this information from, as I say, the DSF reports and year on year they just provided a raw data figure. There was no analysis behind it. 13:24

246 Q. That's fine. Again then, turning to page 15, there is a graph which seems to go up sort of quite

significantly from 12/13 to 12/14/15 -- sorry, to 2014/2015. It flat lines a little bit before tailing off then, and then tailing off completely between 2017 and 2019. Again, can you help us with why that would be? 13:24

A. Yeah, so that sharp increase between 2012 and 2014 would have correlated with the resettlement of Longstone. So that would have been about the development of new supported living arrangements and placements as a resettlement from the long-stay 13:25 population in Longstone. So through my prose, you will see that there was new schemes coming on board. So that would have allowed for that significant increase. From there, it is relatively steady. There has been no new capital investment or structural growth in 13:25 supported living facilities. So the placement numbers have stayed reasonably steady and what usually would happen is either the person's needs exceed that that can be provided in supported living and they move on to, perhaps, nursing care or they die and then that 13:25 leaves a vacancy for someone else coming along.

247 Q. Then on 3.5.5, we can see there's a - in terms of individuals placed in a nursing or residential placement and, again, it's drawn from the same source, I think, Ms. McGall. But there's an up tick from 11 to 13:25 12 and then there's a slow decline from 12/13 down to 17/18; a bit of an up tick again before it tails off - up to 2018/2019 and then it tails off again to 2019/2020. Is there a reason for that?

A. I would be also suggesting that that would track some of the resettlements. So some of the patients resettled earlier from Longstone were, perhaps, older, whose needs would be more better met in residential and nursing. So that was probably the 11/12 period we were moving people out. I don't know the reason for the 17/18 spike. Again, it was lifted from raw data. I can try and find out from staff who may be around at that time, but I'm not sure we would have --

248 Q. That's something you can come back to us on? 13:26

A. If I'm able to, yes.

MR. McEVOY: Well, those are my questions, Ms. McGall. It may be the panel have some, but those are mine. So, thank you.

DR. MAXWELL: Yes, I've just got one question. So on page 6 when you're talking about 2011 to 2012, the end of the paragraph notes that in the Delegated Statutory Functions Report there was concern about individuals under 18 being admitted to the Adult Interim Assessment Inpatient Unit. Do you know if that was just a general concern about having children and young people in adult service, or was it about the quality of care they were receiving? 13:27 13:27

A. I think it was about having children and young people in adult services. 13:27

DR. MAXWELL: So that might stress the capacity in Iveagh wasn't sufficient?

A. I am not exactly sure when Iveagh opened --

DR. MAXWELL: I think 2010, we're told.

A. Okay, so whether it was a capacity issue or it wasn't available, you know, between the closure of Muckamore and the creation of Iveagh.

DR. MAXWELL: Do you have any concerns about the capacity to treat children and young people under 18 currently? 13:28

A. I don't have responsibility for children and young people. That sits with a different director. But it is not my understanding that there are major concerns at present requiring learning disability inpatient provision for the under 18s, no. 13:28

DR. MAXWELL: Thank you.

PROF. MURPHY: I had one question about your day care graph --

A. Okay. 13:28

PROF. MURPHY: -- which is on page 14. It's a very minor thing, but what's plotted here? Is it number of people or number of sessions or... There's no label on your vertical axis.

A. It will be placements available. Apologies. 13:28

PROF. MURPHY: So, effectively, people?

A. Yes.

PROF. MURPHY: Thank you.

CHAIRPERSON: I just want to understand a bit more about Longstone - is it Longstone? 13:29

A. Longstone, yes.

CHAIRPERSON: Longstone. By 2014, there are no long-term learning disability patients left?

A. That's correct. Autumn 2013 was the --

CHAIRPERSON: Did it have a secure facility, Longstone, or not? Did it have a secure ward?

A. No, Muckamore Abbey provided the regional psychiatric intensive care, RPIC facility.

CHAIRPERSON: And so when you talk about this at 3.3.5, when the crisis team became involved, if they needed to admit a patient, that admission would probably be to Muckamore? 13:29

A. No, that would have been to the newly commissioned assessment and treatment unit in the Southern Trust, which is now the Dorsy Ward. 13:29

CHAIRPERSON: Ah, is it the ten beds that you spoke about?

A. Yes.

CHAIRPERSON: And did you find ten beds was sufficient for your purposes as a trust? 13:30

A. Well, we currently have ten beds. And, yes, it is sufficient because we have been growing the crisis response home treatment element. So we're trying to intervene early, provide support at the person's own home address. And I am hopeful that, actually, with the further development of the community assessment and rehabilitation service, the CARS model, which will hopefully come out in the further strategic plan for learning disability, that, actually, we can take cognisance of that bed number going forth. 13:30 13:30

CHAIRPERSON: And in terms of that ten-bed facility, what would be your longest term patient there?

A. So we do have two patients that are greater than one

year in their admission in Dorsy Ward at present.
CHAIRPERSON: How much greater, do you know?
A. One individual is there probably around two and a half to three years, but he's had periods of deterioration in his mental state, so he hasn't been a delayed discharge for that period of time -- 13:31
CHAIRPERSON: Right.
A. But his duration of --
CHAIRPERSON: Is he a delayed discharge now?
A. He is a delayed discharge now, yeah, for the last year, although there are plans in place for his movement on. 13:31
CHAIRPERSON: Sorry, say that again?
A. There are plans in place for his discharge and that is imminent.
CHAIRPERSON: And would that be to a facility within your trust? 13:31
A. Yes.
CHAIRPERSON: Right.
A. Yes. But what we have seen over the duration of Dorsy is that, with attention, we can, you know, admit patients for a period of assessment and treatment and successfully discharge them within an appropriate timeframe. 13:31
CHAIRPERSON: And obviously this morning we were hearing about the Northern Trust and just to cross-refer, as it were, do you occasionally refer your patients who are within your trust to the Northern Trust for resettlement? 13:31
A. Occasionally. And also we would take patients from

other trusts to the Southern Trust area from the Northern Trust, from South Eastern Trust, the Western trust and from Belfast. And I think, actually, one of the patients that was resettled from Muckamore, as I referred to, was actually a South Eastern Trust patient resettled from Muckamore Abbey and placed in the Southern Trust area. 13:32

CHAIRPERSON: And that was simply because at that point you happened to have an accommodation that would work -- 13:32

A. A vacancy that met their assessed need, yeah.

CHAIRPERSON: I think that is all that I want to ask. Can I thank you very much for your statement and for the assistance you've given to the Inquiry this afternoon. We expected to get you away a bit earlier than this, but it's been very valuable evidence to the Inquiry, so thank you very much. 13:33

THE WITNESS: Thank you. Thank you for your time.

CHAIRPERSON: We are next sitting on Tuesday, 18th April -- I think everybody got an e-mail. We're not sitting on 17th, so we'll next meet on Tuesday, 18th April, when I think we're hearing from the South Eastern Trust, from Ms. Lyn Preece, and Ms. Elizabeth Brady of the Western Health Social Care Trust. And can I wish everybody a happy Easter and a good break. 13:33

MR. McGOWAN: Chair, I wonder could I flag just one issue before we break?

CHAIRPERSON: Yes, of course.

MR. McGOWAN: It was just at the beginning of the

evidence sessions in March, there was an indication given that with respect to the evidence of some of the witnesses, given the breadth of the issues to be covered, that an opportunity would be given to the core participants to submit further issues and questions for consideration, and I think the indication had been given that a note would be circulated to the core participants setting out the proposed way forward. It was just to say that we are keen to receive that so that we can -- 13:34

CHAIRPERSON: I thought that had been done, in fact.

MS. RICHARDSON: I'll check.

CHAIRPERSON: No, we can check that. But thank you for raising it, and that will happen.

MR. McGOWAN: Just to say, given the breadth of the issues covered, we were hopeful that consideration would be given to that facility being considered for the other witnesses as well that have given evidence. 13:34

CHAIRPERSON: Yes, sure. Thank you.

MR. McEVOY: Thank you, Chair. I should just make the point that all core participants will be aware that there is a mechanism by which questions can be submitted to Inquiry counsel for consideration and -- 13:34

CHAIRPERSON: There is. Yes, I think the point is and I think Mr. Doran mentioned at the beginning of this whole session that if there were issues that people wanted to raise that arose from the evidence, then they would be able to do so. It doesn't necessarily mean a witness will have to come back. It may be that it 13:34

could be done potentially by correspondence. But I think that facility was offered and we must, of course, follow that up.

MR. McEVOY: Thank you

CHAIRPERSON: All right, thank you for raising that. 13:35
Thank you again and we'll meet after Easter.

THE INQUIRY WAS THEN ADJOURNED UNTIL TUESDAY, 18TH APRIL 2023 AT 10:00