MUCKAMORE ABBEY HOSPITAL INQUIRY

SITTING AT CORN EXCHANGE, CATHEDRAL QUARTER, BELFAST

HEARD BEFORE THE INQUIRY PANEL

ON MONDAY, 10TH JUNE 2024 - DAY 90

Gwen Malone Stenography Services certify the following to be a verbatim transcript of their stenographic notes in the above-named action.

GWEN MALONE STENOGRAPHY SERVICES

90

APPEARANCES

CHAIRPERSON:	MR. TOM KARK KC
INQUIRY PANEL:	MR. TOM KARK KC - CHAIRPERSON PROF. GLYNIS MURPHY DR. ELAINE MAXWELL
COUNSEL TO THE INQUIRY:	MR. SEAN DORAN KC MS. DENISE KILEY KC MR. MARK McEVOY BL MS. SHIRLEY TANG BL MS. SOPHIE BRIGGS BL MS. RACHEL BERGIN BL
INSTRUCTED BY:	MS. LORRAINE KEOWN SOLICITOR TO THE INQUIRY
SECRETARY TO THE INQUIRY:	MS. JACLYN RICHARDSON
ASSISTED BY:	MR. STEVEN MONTGOMERY
FOR ACTION FOR MUCKAMORE & SOCIETY OF PARENTS AND FRIENDS OF MUCKAMORE:	MS. MONYE ANYADIKE-DANES KC MR. AIDAN MCGOWAN BL MS. AMY KINNEY BL
INSTRUCTED BY:	PHOENIX LAW SOLICITORS
FOR GROUP 3:	MR. CONOR MAGUIRE KC MS. VICTORIA ROSS BL
INSTRUCTED BY:	MR. TOM ANDERSON O'REILLY STEWART SOLICITORS
FOR BELFAST HEALTH & SOCIAL CARE TRUST:	MR. JOSEPH AIKEN KC MS. ANNA MCLARNON BL MS. LAURA KING BL MS. SARAH SHARMAN BL MS. SARAH MINFORD BL MS. BETH MCMULLAN BL
INSTRUCTED BY:	DIRECTORATE OF LEGAL SERVICES

FOR DEPARTMENT OF HEALTH:	MR. ANDREW MCGUINNESS BL MS. EMMA TREMLETT BL
INSTRUCTED BY:	MS. CLAIRE DEMELAS MS. TUTU OGLE DEPARTMENTAL SOLICITORS OFFICE
FOR RQIA:	MR. MICHAEL NEESON BL MR. DANIEL LYTTLE BL
INSTRUCTED BY:	DWF LAW LLP
FOR PSNI:	MR. MARK ROBINSON KC MS. EILIS LUNNY BL
INSTRUCTED BY:	DCI JILL DUFFIE

INDEX

THE INQUIRY RESUMED ON MONDAY, 10TH JUNE 2024 AS FOLLOWS:

CHAIRPERSON: Good morning. Just before we start, first of all there's a rather sad notification to give you. Some of you may already be aware that Geraldine O'Hagan, who gave evidence some weeks ago and was a huge support to many of the families who are closely connected to this Inquiry, passed away this morning, and we've had notification from her son. And I know that many will want to reflect upon that and give thanks for her life and the good that she did in their own way. 09:58 09:59

Secondly, on a quite different note, I've been shown correspondence this morning from Phoenix Law, and have also had the advantage of reading a speaking note provided by Ms. Anyadike-Danes KC on behalf of Core Patient Groups 1 and 2. I think the best thing to do is that I address that after the next witness. Mr. Doran is going to be introducing Module 6, and that's really what the note is all about, and we've also had correspondence from Phoenix Law, and so I think the better time to address the issues, and the legitimate issues that they raise, is at that time. 09:59 09:59 10:00

I should also mention that we have had correspondence, I think this morning, from O'Reilly Stewart Solicitors. I'm afraid I haven't had an opportunity yet of reading

that, but of course I will.

So I think the best thing to do is, because we have a witness waiting in the wings, is to get on with that witness and then we can address these various issues afterwards. Yes, Ms. Tang. 10:00

MS. TANG: Good morning, Chair. Good morning, Panel. This morning the Inquiry will hear the evidence of Mr. Clinton Stewart as part of the staff evidence process. The internal page reference for his statement is 243. And if there are no other issues, could the witness be called, please? 10:00

MR. CLINTON STEWART HAVING AFFIRMED WAS EXAMINED BY MS. TANG AS FOLLOWS: 10:02

CHAIRPERSON: Mr. Stewart, can I just welcome you to the Inquiry. Thank you for the statement that you made, and thank you for coming along and giving your time to give evidence to the Inquiry. 10:02

A. Thank you.

CHAIRPERSON: I'll hand you over to Ms. Tang.

1 Q. MS. TANG: Thank you, Chair. Hello again, Mr. Stewart.

A. Hello.

2 Q. Hello. You and I met a short time ago, but just to remind you, I'm Shirley Tang. I'm one of the counsel to the Inquiry and I'm going to be taking you through your evidence today. Can I check you have a copy of your statement in front of you? 10:02

A. I've got a copy, yeah.

3 Q. And there's a screen in front of you, you'll see there. If I'm referring to a particular paragraph in your statement it'll be shown on the screen as well. And you should also have a cipher list in the file in front of you as well, and that is essentially a list of any names that you have made reference to in your statement with the cipher number that we've given them, so please try and use the cipher number, if at all possible. Can I check then that -- you've given a statement to the Inquiry of the 2nd May 2024, are you happy to adopt that statement as your evidence to the Inquiry? 10:02 10:03

A. Yes.

4 Q. Thank you. I'm not going to read in the statement because everyone in the room here has already been provided with it, but I'm going to cover key sections of it, and I may call up some on to the screen or read elements of it. But what I will introduce by saying is that you've told us that you were a nurse working at various different grades at Muckamore Abbey Hospital between 1974 and 1979 initially, and then you came back, you worked in England for a while and you came back in 1990 where you worked... 10:03 10:03

A. It was '78 I left.

5 Q. You left. Okay. Thank you. So you came back in 1990 and you worked at Muckamore for the rest of your time until you retired in 2015. And you tell us in your statement also that you worked in various different wards at Muckamore and that you also worked in the day 10:03

care services at that point in time. You had moved into management in 1999, and you were promoted to an I grade post in 2004.

A. Those dates would be approximate.

6 Q. Approximate dates. Thank you. In paragraph 3 of your statement, if that could be brought up, please? Just by way of introduction, you mention that you attended the Muckamore Abbey Hospital School of Nursing. What was that or how did that work? 10:04

A. I think that was in March 1975. 10:04

7 Q. Okay.

A. There was, I think that intake was the first group of student nurses that trained under what was called the Briggs type system of training, which meant that there was modular placements in other hospitals. Previous to that, the School of Nursing in Muckamore would have been the central focus of nurse training, but we would have travelled to Knockbracken, and there was people from the Downshire, Holywell, Muckamore, you know, psychiatric and learning disability... 10:04 10:05

8 Q. Mental health and learning disability was concentrated?

A. Yeah.

9 Q. In that school, from what you're saying?

A. Yeah. So the school in Muckamore did focus quite a bit, you know, in your modules there you went into the school and you got all your theory, and the tutors from the school would have visited you on the wards and those type of things, yeah. 10:05

10 Q. Okay.

CHAIRPERSON: Could I just ask you to pull the microphone slightly closer to you and to speak up a tiny bit. Thank you.

11 Q. MS. TANG: So how many students, forgive me if you've told me, but how many students would you have gone into that school with when you started there? 10:05

A. There was quite a few. There was quite a few. I couldn't give you an approximate numbers, but from Muckamore, probably more than a dozen, and then from the rest of the hospitals. I do remember there was a bus that took us to the central school in Purdysburn and it could have been fairly full. So there was quite a number of students. 10:06

12 Q. Okay. And how long did your training take? How many years were you at that school? 10:06

A. Three years.

13 Q. Three years. Okay. And after that time you went to England to work in Staffordshire?

A. In '78.

14 Q. '78. 10:06

A. I left to work in England, yeah.

15 Q. Okay. Can I move down to paragraph 7, please? Just over the page I think. It should be on the screen shortly. Thank you. There it is. Something caught my eye. There was a hospital garden area? 10:06

A. Yeah.

16 Q. Can you tell me how that was used with the patients? What part did that play in their therapy?

A. Okay. I think I said previously there had been two

distinct areas in day care when I first came back and was allocated to a charge nurse post in day care, I went to nursing day care, so the gardens area would have come under day care run by Social Services. That mainly provided work for less dependant fairly able people that lived in the hospital. They would have gone there. They would have used the greenhouse to procreate plants, they would have grown things in the garden, cut grass. I think there was a little bit of an industry in around producing fire-lighters, those type of things. So there was a bit of work for the people who were able to do that, yeah. 10:07 10:07

17 Q. So is that the kind of thing that we might today talk about as a day opportunity?

A. Yeah. 10:08

18 Q. Yeah. Okay. Thank you. And looking at that paragraph, the people who were using that day care, would they have been coming in from community placements or would there have been some in-patients going to that as well? 10:08

A. It was all in-patients.

19 Q. All in-patients. Okay. Thank you. Can I move down now to paragraph 10, please? In that paragraph, if you have it in front of you there, you tell us that in 1999 you were asked to transfer to the admin office, and can I ask, was that a role that took you completely away from patient contact or were you still doing some clinical work by then? 10:08

A. It would have been less, it would have been reduced

patient contact. My role was focusing in and around the management, day-to-day management of staff on the wards. I would still have patient contact, I would have visited wards for various reasons, but it wouldn't have been a case of direct hands-on care. 10:09

20 Q. Mhm-mhm. And how did you find being office based compared to being on the wards more?

A. Well I gave it, you know, I did enjoy my time in day care. Day care was, it was a nice place to work. There was opportunities to do things, so I did give it 10:09 a bit of thought. But sometimes, you know, you need a change. I felt a change would be good. Day care, I had been doing nine to five, Monday to Friday, you know, so it offered maybe a bit of flexibility in shifts, which maybe would have suited me at that time I 10:09 think. So, yeah, you know. I can't remember the question now, sorry.

21 Q. That's okay. It was just to see how you found the move across to an office environment?

DR. MAXWELL: Can I ask, when you were in the nursing 10:10 office as a nursing officer, I presume it was called at the time, how often would you have gone to the wards?

A. Oh, it's difficult to quantify.

DR. MAXWELL: Would you have gone every day?

A. You could go through a shift without visiting the 10:10 wards. It depends what was happening and what you were doing, you know. You might have other things that you had to attend to. But certainly, two, three times a week anyway, you know, you would have went to the

wards, and maybe three times a day if the need arose and they needed you there on the wards. So it could have been, you know, it could have been any of those.

DR. MAXWELL: And when you were on the wards, what were you actually doing on the wards? Were you asking about the patients, were you observing care, or were you going in to ask the nurse in charge something? 10:10

A. I could have been going for a specific reason. Sometimes as a Nurse Manager I was asked by the senior nurse managers to visit the wards if they were off, just to monitor what was going on, to speak to staff, you know, generally to observe and report back. So it could have been specific or it could have been just general visiting and speaking to people and looking at what was happening. 10:11 10:11

DR. MAXWELL: And did you interact with the patients? Did you ask the patients how they were?

A. Yeah, I would have knew quite a few, well most of the patients, you know, they all came to day care. I would have seen them in day care, so I would have interacted with the patients. 10:11

DR. MAXWELL: So you already knew a lot of the patients because they --

A. I would have --

DR. MAXWELL: -- and they had been in day care. 10:11

A. I would have known quite a lot, particularly people who were more dependent, you know, on those wards like they all -- when I first came to Muckamore, those were the type of patients that would have came to the area of

day care when I was in.

22 Q. MS. TANG: You've mentioned in paragraph 10 that you also took on management of the nurse bank. Can you tell me was that nurse bank made up of primarily nurses that were already employed in Muckamore, or in a mental 10:11
health facility, or were some of them people that weren't working in the Trust at all?

A. A mixture. Really -- sorry, there was people who put their names down, who were already working either part-time or full-time in Muckamore, who maybe would 10:12
have done an extra shift on the bank. Quite a few student nurses would have put their names forward to bank, and then there would have been not so many, but some people, who would have no connection with the hospital who would more or less be permanent job, you 10:12
know. Not too many, but some.

23 Q. But some. Okay. And you were Duty Officer. Were you able to authorise bank shifts to support individual patients even if the ward technically had enough staff at that point? If you saw a need there, could you 10:12
increase the amount of bank resource that was coming in?

A. Good question. I think in the early days you could have done that.

24 Q. Okay. 10:13

A. You know, when the bank first started -- sorry, when the bank first -- when I first came into the office the bank had just started. Basically it was up and running. At that time I've seen myself being in a

position that I had to go through the list of bank staff available and look what shifts they had worked and allocate people as best I could, because people might think, you know, 'oh, I didn't get a shift'. We had extra staff on the bank, and those were good days. The question you asked was did I ever allocate a staff to a ward that didn't need it? I'm sure I did. 10:13

25 Q. Well, I suppose what I was trying to get at was, if you thought that the ward technically had enough staff.

A. Yeah. 10:13

26 Q. But you in your own judgment thought they needed a bit of a top-up maybe for a particular patient?

DR. MAXWELL: I think you're talking specifically here about what used to be called "specialing" and is now called... 10:14

A. Sorry?

DR. MAXWELL: We're talking about patients who need "specialing", now called enhanced supervision.

A. Well, those would have been included in the numbers on the ward. When I moved into the nursing office as Nurse Manager, and mainly Duty Officer, I designed a little sheet. So -- particularly for myself. You know when you're new in a job, you know, you want to know what the requirements are. So I had a sheet that outlined the wards, the number of staff required on a daily basis, nightly basis for those wards, and any enhanced observation that would require additional staff. That information was always there in the nursing office. You know, okay, fair enough, if it 10:14 10:14

suddenly happened that a consultant put a patient on a level of supervision that required a nurse, then you would have to find one, but normally speaking, if that situation was there, you know, you knew about it and you staffed the ward accordingly. 10:15

DR. MAXWELL: So you were organising staff according to the daily assessment of need which could fluctuate from day-to-day, rather than to the funded posts?

A. Yeah, it could, you know, when you -- I take it a wee stage further in terms of maybe appointments or 10:15 activities like that was going on, you might need an extra staff on the ward. So, yes, you know, you were flexible in terms of the allocation of staff where possible.

DR. MAXWELL: But wouldn't that mean then that 10:15 sometimes you were overspending the staff budget?

A. To be honest with you, probably maybe so in a small way. I didn't really have much contact at that time with the requirements of a budget, but I'm sure somebody was monitoring, and it never was pointed out 10:16 to me that.

DR. MAXWELL: So you weren't constrained by the budget? You actually looked at the patient need and provided the staff?

A. Yeah. I don't -- 10:16

DR. MAXWELL: And if that wasn't within budget, that wasn't your problem. That was somebody else's.

A. I think if a staff on the ward, whether it be the Charge Nurse or a Staff Nurse alerted me to the fact

that there was a certain activity, a patient needed to go for an appointment, and maybe because of that particular patient's behaviour they needed an extra staff, I don't think there was a problem then. Budget never, money never came into it, you know.

DR. MAXWELL: You did say at the beginning of your answer that in the early days you could do that.

A. Yeah.

DR. MAXWELL: Does that mean your ability to do that changed over time? 10:16

A. I think the demands on the service increased over time. I think at that particular time we did have surplus bank staff, you could have done something like that. As time went on in later years then that opportunity wasn't there. 10:17

DR. MAXWELL: Was that because you didn't have enough bank nurses or was that because patient's needs changed and more of them needed enhanced supervision?

A. There was a number of factors, variables. The bank system changed, as I think I said. It was managed in 10:17 the central location, I think it was the Belfast City Hospital. It became more remote. You lost a little bit of contact with bank staff. Again I think one of the things I've said in my statement was that staff previously would have put their name down on the 10:17 hospital bank list and the Duty Officer could allocate the bank staff to where they were required, you had a degree of control. Under the new system, bank staff could dictate where they worked. So if a ward was

short, you know, staff mightn't want to work there, that was just the way it was, yeah.

DR. MAXWELL: Okay. Thank you.

27 Q. MS. TANG: I want to move down now to paragraph 11, please. And you tell us at that point, at the start of that you refer to your time as I Grade appointed in 2004. Can I ask you, how did you assure the quality of patient care on your wards whenever you were in that role? 10:18

A. Okay. I suppose there was a number of ways. Observation, visits to the wards, it would have been fairly routine. There was a monitoring tool "Equate", that was done, I think it was done at least yearly, twice yearly. It looked into the care plans, patient finances, things like that, you know. 10:18 10:19

28 Q. Is that the monitoring tool that you referred to that looked at those elements?

A. Yeah. Yeah. At later stages you had outside bodies like RQIA coming in doing inspections, various things like that, you know. That's basically how it happened. 10:19

29 Q. Yeah. In terms of if there was a complaint, or if there was a governance issue raised, would that have come to you first, or how was that dealt with?

A. It probably would have came through, you know, obviously if I wasn't there, on holidays, it would have came through to the Senior Nurse Manager on-call. If it was out-of-hours or during the day, it would have came through to one of the senior nurse managers, and it would have followed the procedure after that, yeah. 10:19

30 Q. Okay. Can I ask, in that very senior role how much time would you have got to actually spend time on the wards? What percentage of your time would you say was in a clinical area?

A. I suppose I started of -- I finished working in a job share capacity, which meant that I had reduced opportunity really to visit wards. But I had a colleague who was there when I wasn't there. In the early days I would have been on the wards quite regular. Quantifying it would be difficult, but I'm sure we would try to get round the wards daily, at least, you know, some of the wards anyway. 10:20 10:20

31 Q. Mhm-mhm.

A. And certainly at that time we would have been rotating the Duty Officer role. So weekends was always a brilliant opportunity, you know, you made sure you had visited every wards. 10:20

32 Q. At the weekend?

A. Yeah.

33 Q. Okay. 10:20

A. Saturday and Sunday when you were on, you know, you done every ward, and maybe all the wards in the hospital at that time as well. So, you know, I can't put a figure on it, but it would have been regular.

34 Q. Okay. It sounds like what you're saying is at some point in any working day you were on a ward? 10:21

A. Would have been. Well having said that, you know, if your working day consisted of going to meetings and things like that.

35 Q. Yes.
A. Then you were off site, you know. But most days if you were available you would have been visiting the ward, yeah.
36 Q. And you were asked earlier about whenever you went into these clinical areas what were you doing when you were there? Was that the same sort of thing, checking in with staff, or what was your interaction? 10:21
A. Various things. You could have been there -- I suppose, again going back to complaints, if you were there for a specific reason you were looking for certain things, you know, looking at care plans, those type of things, you visited the wards, you had an obligation to check patient finances every so often, you know, you were doing checks there, you were speaking to staff, you were speaking to staff maybe about certain issues, those were the type of things you were doing, and speaking to patients, you know, those general things, yeah. 10:21
37 Q. You made reference to staff there and I want to move down to paragraph 13 and pick up on an issue that you've raised in relation to staff being assaulted by patients, and you've mentioned there that it was a regular thing. "Reported through incident forms, ward reports or by phone." Who would you have raised the level of assaults on staff with? 10:22
A. Again, I'm trying to think was the -- you always got incident forms. Now having said that, there would have been times when the staff would have accepted it as

part of the job, and you didn't always, so you couldn't really quantify it in terms of how -- the numbers. But generally speaking, if there was an incident, a staff injury, it was reported to the incident reporting system, and that would have generated the numbers and types of assaults.

DR. MAXWELL: Did you raise it with the Directorate?

A. Sorry, when you say "Directorate"?

DR. MAXWELL: So at the time you were -- were you organised in a Directorate? Was Muckamore part of a management unit called a Directorate?

A. I wouldn't have, but my line manager may well have done.

DR. MAXWELL: So you would have -- would you have discussed it with your line manager, the number of injuries?

A. Certainly. It would have came through. We had a daily reporting system, as most hospitals do, so it would have come through on the daily reporting systems. Those reports then, I think in later years had changed. It went on to the electronic system.

DR. MAXWELL: PARIS.

A. PARIS, yeah. So prior --

DR. MAXWELL: So this was the daily nursing report going to the hospital manager, was it?

A. Yeah. Yeah. Before PARIS we would have always met with our line manager in the morning. We would have brought down the reports, discussed the reports, and those incidents would have been highlighted. Weekends,

weren't there, it was picked up again on Monday.
DR. MAXWELL: And who was your line manager at the time?
A. When I first went into the nursing office it was -- hang on. 10:24
MS. TANG: Your cipher list should be there.
A. H843.
DR. MAXWELL: Okay. Thank you.
CHAIRPERSON: And what would have been the job title, his or her job title? 10:24
A. It was -- his was Site Director, but he would have been the senior --
CHAIRPERSON: Site Director.
A. Yeah. It would have been the senior nurse on site. He was the senior nurse. 10:24
CHAIRPERSON: So whoever was in that role would be your line manager?
A. Yeah.
CHAIRPERSON: Thank you.
A. And then later on, H359. And I don't have a number for the last person. 10:25
38 Q. MS. TANG: Okay. Thank you. Can I ask you in terms of the risks that staff being assaulted presented, how was that risk mitigated? Was there anything that could be done to reduce it? 10:25
A. Okay. I suppose if you start at the basic level of staff induction to the wards, you know, probably the way they were inducted, the information they were given, you know, what to expect, those type of things.

You then progressed on to probably the training, you know, staff did have training in the management of aggression and everybody undertook vulnerable adults training. So there was various training and things. So that was one area. Every patient did have a care plan. So I know that risk assessments were done on individual patients and the care plan would have give information on risk behaviours, yeah.

39 Q. Did you notice that there were certain things that made it more or less likely that some patients might become aggressive, for instance? Were there triggers? 10:26

A. I suppose you can say that -- I've kind of been away from it a long time, but there was two main types of aggression, you know. You have the type of aggression that patients can plan, you know, for a specific need, for a specific end, and then you have the other type of aggression that, you know, is just spontaneous, you know, people, maybe because of an external stimuli or whatever, you know, react in that manner. The former would have been not as prolific, you know. I know of some instances where that was the case when staff were attacked and it was because a certain objective wanted to be obtained. But mainly the aggression was just spontaneous, maybe sometimes just lashing out, pulling hair, biting, those type of things, you know, that would have been the bulk of the type of behaviours that would have been seen, yeah. 10:26 10:27 10:27

CHAIRPERSON: Can you just give me an example of the sort of objective wanted that you've mentioned? Would

it be to do with attention or food or what?

A. Well, I suppose I am going back a wee bit. I was speaking to a colleague, an ex colleague I should say, who was badly injured. He nearly lost an eye in one of the semi-secure wards. It's going back some time. He still wears glasses. His eyesight is still affected. And that -- again, I'm kind of relating what I was told, I wasn't in the area at the time, and it was fairly able patients who were in the semi-secure ward who wanted to get a key I think, or something like that, you know. So they had planned to, two of them had planned to assault this staff member. 10:28 10:28

CHAIRPERSON: Did that apply more or not to forensic patients?

A. It would, it would have applied. I think I mention it in my statement, you know, I had occasion to visit a ward when I was late at night, I must have been Duty Officer, and a patient had been admitted and he had -- I suppose he was a very, very able person, he had come from jail I think, and he had managed to block the lock on his bedroom door. The doors were designed so that if something was behind them they could open both ways, you know, they would open out and in, but he had been in these situations before probably and he knew how to overcome that. So he had blocked the door and then he was using the, I think it was the toilet seat to destroy the room, and try and break the glass to get out through the window. So that would have been... 10:28 10:29 10:29

CHAIRPERSON: Right. So that was an example of a

planned --

A. Yeah, he had an objective that he wanted to get out and he was stopping the staff getting in while he smashed the window, yeah.

CHAIRPERSON: Yeah. Thank you. 10:29

40 Q. MS. TANG: Thanks. Just thinking about the unplanned more spontaneous episodes of aggression that could happen. Were there any particular patterns, like times of day, was it more likely at the weekend that you recall? 10:30

A. Okay. There was always kind of areas where you were, you were always kind of more kind of on alerts. Meal times was always an area that would have been -- I suppose morning, you know, people getting up, you know, sometimes people is not in the best of moods, that type 10:30 of thing. I think hand over time could have been a bit problematic as well. I remember I spoke to a Nurse Manager, Sister, Ward Sister, sorry, who was having problems in around the hand over period. It was kind of noted that behaviours kind of became less 10:30 controllable at that time, so they had designed an activity specifically around that area. I think they had arranged to have a film on, and all the kind of little things you have with that, you know, a drink and crisps and stuff, and said it did reduce the level of 10:31 incidents around that particular area. So, yeah.

41 Q. Do you remember, as the person organising the staffing levels in these areas, did you try and factor how many staff were on at various times to anticipate that there

might have been more chance of a flare-up?

A. I think the wards were, the wards were staffed. There was a tool, I can't remember what it was now, Telford, was it Telford? I'm not too sure. There was a tool that would have been used to kind of look at staffing, staffing allocation towards -- I can't, you know, the staffing numbers just reflected the needs generally on the ward, you know. You might have a ward who would have seven staff on in the morning perhaps, and then maybe dropped down to six in the afternoon, and then come up at 6:00 o'clock to maybe -- with 6 to 11 workers coming in, bring it back up to 7 or above, you know, for the evening kind of activities. So I suppose in that respect it did kind of look at the workload and what was happening, but very basic. 10:31 10:32 10:32

42 Q. Okay. Okay. I want to move down to paragraph 15, please, if that could be put on screen? I think it's the lower end of that paragraph where you say:

"There was always a doctor available if there was something physically wrong with the patient." 10:32

Was that a doctor on-call from off site or was that somebody actually on the site?

A. We would have had doctors on site. SHO would have been rotating into the hospital. There was always consultants in the hospital. And I suppose out-of-hours it would have been a GP service. 10:32

43 Q. Okay. So was there any junior mental health doctors on

site overnight, for instance?

A. There was. There would have been one on-call. The consultant was always on-call.

44 Q. Yes.

A. The junior doctor, there was a Dr. Ning, I remember, who would have frequently visited the hospital out-of-hours if there was a reason to do so. So I don't know what the -- I don't know what his arrangements were, but he was frequently there. 10:33

45 Q. Thank you. Can I turn now to paragraph 16, please? You mention the resettlement wards in that paragraph. And I wanted to ask you about the nurses who were working in those resettlement wards. Would it be fair to say that they were working with the knowledge that their jobs were to some degree under threat, they were going to change once resettlement was affected? 10:33

A. Not originally.

46 Q. Not originally?

A. I kind of look at the resettlement process, and if memory serves me right, in two phases. The first phase, resettlement was organised -- I don't have her -- under a consultant, consultant psychiatrist. She was the lead person. It related to Moyola Wards, Finglass Wards. Those type of wards. Very, very conscientious lady. She would have obviously been very strong on betterment for the patients. That was the driving force. She always looked to make sure that whatever they had in terms of day care in Muckamore was replicated in the community, those type of things, you 10:34 10:34

know. At that stage I never kind of got the feeling that there was any problems with staff retention or staff jobs, you know, it was grand.

I suppose in later years when the core hospital wards opened, and I refer to it there, then it did -- it did arise for a period of time when the ward closures started to happen, there was a kind of a scheme, I can't remember really, but there was a scheme whereby staff redundancies maybe was mentioned, but it would have been more redeployment and there was a couple of staff who did take up the opportunity to be redeployed somewhere else in the Trust, you know. 10:35 10:35

47 Q. So was there a policy that you recall of no compulsory redundancies, or might there have been the threat of some compulsory redundancies that you just didn't need those staff anymore? 10:35

A. I'm sure there was. I'm sure there was a process and a policy, I just can't recall, but I know there was, at the last resort, wards had closed and there was access staff, and there was failure to redeploy, probably redundancy was a final and last strong measure. 10:35

48 Q. Was there, to your recollection, any approach of scaling back on recruitment to make sure that the hospital wasn't overstaffed when resettlements happened? 10:36

A. I think there was. I'm not sure.

49 Q. Okay. Can I move down to paragraph 17, please? And at that point you describe your role in investigations where there had been some allegations of inappropriate

behaviour by staff, and you refer to a time when, as a Senior Nurse Manager, you had investigated an incident where it was alleged a member of staff had struck a patient. Can you tell us what you did as the investigating officer in that situation? 10:36

A. There was a process, probably, you worked very closely with the Human Resource Department in that process. Obviously I can't remember if I was on site when it happened, but if it -- if I wasn't -- there was a process that would have been followed in terms of 10:37 making sure the patient was examined and the relevant people were informed under the policy, you know. I believe police, family, and those type of things. And after that then it was a matter then of making sure that the staff member involved was not on site, was 10:37 suspended or whatever. That would have been done fairly quickly. And then information gathering after that in terms of witnesses, looking at the environment, you know, all the things that you do in an investigation. Putting together a report. And then, I 10:37 can't remember the disciplinary process, but you know, you would have followed the process at the time.

50 Q. Can I take it part of the investigation and gathering investigation, would you have spoken to the patient?

A. If -- I can't remember. If the patient had capacity 10:38 and that type of thing, yes, you would have involved the patient, yeah.

51 Q. You refer to being in the tribunal as the presenting officer. What was that? What did you have to do as

presenting officer?

A. There was -- whatever the kind of misdemeanour was, whether it was -- if there was gross misconduct, which obviously is something, that would be -- there would be a Panel set up to hear the evidence. The staff who was under the disciplinary process and the union rep would have got a copy of all the information that was going to be presented and a hearing would be arranged. If you were the presenting officer you made sure you had got all your information, all your witnesses, everything set up, and then on the day it was a matter of presenting the evidence that was gathered to the Panel, and the witness, or witnesses, giving their evidence at what they had seen at a particular time, yeah. 10:38 10:39 10:39

52 Q. So is that a different role to the Chair of the Panel? It sounds like what you're saying is you're almost presenting the case against the employee. Do I understand you correctly there?

A. The Panel would, similar to what we've got here, you know, there would have been three people on the Panel. I'm the presenting officer, I would be presenting the facts of what the incident entailed, and the individual who was under disciplinary proceedings would have their union rep, who would have the ability to question and kind of present alternative information to the Panel, and then the Panel would obviously make a decision based on the evidence that was produced. 10:39 10:40

53 Q. Thank you.

CHAIRPERSON: And what would be the make up of a Panel normally?

A. It would be certainly, it would be a Senior Nurse Manager, it would be above my grade, it would be an 8B. I suppose my line manager maybe would sit on that Panel, and then there would be other people, maybe somebody from outside the hospital as well, senior, there'd be senior staff.

54 Q. MS. TANG: Would there have been an HR person on the Panel? 10:40

A. Yeah, there would be a Chairperson, yep.

55 Q. Thinking about the process involved in that, how would you describe that process? Would you say it was a rigorous process or, when you reflect back on it how did it feel to be in it? 10:41

A. I suppose when you're doing those things you look on it as a process, you know, and you just have to follow the guidance and take advice from HR, whatever, you know, it's a process that you do. It's never a pleasant one, but you just focus on the process and that's it. 10:41

56 Q. And how would you say -- how did the Trust view these kinds of allegations in your recollection?

A. I'm sure there was -- I honestly don't know. They wouldn't have been happy about it, you know, but I honestly don't know that would have been -- it wouldn't 10:41 have been something you would have wanted to happen, put it like that, you know. So things do happen, but you try and avoid them as best you can.

57 Q. Mhm-mhm. You stated in the paragraph we've been

looking at, paragraph 17, that on the occasion that we've talked about, the member of staff was dismissed for gross misconduct. Did you feel that was a fair outcome?

A. Based on the evidence I presented and what the Panel heard, I take it it was a fair outcome. You know, that's what the Panel decided, and I think it's fair enough. 10:42

CHAIRPERSON: Can I just ask a date for this? When are we talking about, approximately? 10:42

A. It was when the Mallow Ward was being used for, I think it was children. So it was before the Iveagh Centre maybe opened.

CHAIRPERSON: So it's quite -- yeah. Okay.

A. Yeah. 10:42

58 Q. MS. TANG: I want to move down now to paragraph 19, please. Thank you. You have mentioned in the paragraph that you had a link in with the Ennis Ward. Can you tell us what sort of oversight role you had of Ennis in 2012? 10:43

A. Very similar to other wards. It wouldn't have been -- it wouldn't have been a ward that would have been any different really. I done all the usual things that you'd be expected, you know. I suppose Ennis Ward, Ennis Ward was designed -- it wasn't there when I left Muckamore in '78. So it had been built specifically for an elderly population I think. Ennis and Erne I think had been all one ward, I could be wrong, and then they decided that they would divide it and create two 10:43

wards. So it was in some terms environmentally better than the older type wards, the old E Wing wards. But again, at that particular time a fair few patients hadn't totally been resettled, their ward was closing, and a lot of the ladies in Fairview moved down, and I can't remember the numbers, say, 8, 9, 10, had moved down to Ennis, and they were -- there was two areas to the ward. The front of Ennis had individual bedrooms, and maybe a couple of bedrooms with two beds in it, and the back would have been, the back of the ward would have been more kind of four-bedded units and two-bedded, you know. So, I suppose during that time those ladies moved down, they were a different client group, they were mixed together, you know, and it did cause, you know, it did cause a wee bit of unsettlement, for want of a better word. 10:44 10:44 10:45

The Bohill Nursing Home that those ladies would have been moving to, I kind of remember thinking, well, they're there for a fairly short period of time and they would be moving out to Bohill. But, as usual, that didn't happen as planned, so they were there for like a longer period of time maybe than what I would have thought. So, it had a bit of an unsettling influence on the ward, yeah. I'm not too sure if that was the question you asked me? 10:45 10:45

59 Q. It was useful to know, though. Thank you. There was -- you refer to the safeguarding incident on Ennis Ward, and I want you to reflect back in November 2012,

how did you feel the senior nurses responded to the safeguarding incident in Ennis Ward?

A. Well as I said in my statement, it came as quite a shock to me. I wasn't on site when the complaint was raised. I was up on a training course in Belfast. I returned to the hospital and, you know, things kind of seemed to expand, you know. There was a couple of allegations made, I can't remember specifically what they were, and then obviously they increased over time to quite a number of allegations. Corporate management, it was people probably I had never seen before, appeared, and obviously the process kicked in then, there would have been all this process, police, and you know all the protection things, informing patient's relatives of what had happened, and that was all done. But generally speaking, I, and colleagues in the hospital really weren't involved. We didn't, we weren't allowed to visit the ward, we didn't go near the ward, and as I said in my statement, it was monitored 24/7 by people who were from outside the hospital, and that changed a wee bit after time, but initially, to my memory, that's what happened, yeah.

CHAIRPERSON: So could I just understand that. Normally you'd have been visiting the ward fairly regularly?

A. I would have been, yes. As I say, it was in a process of resettlement, so you would have been down there, you know. Those ladies had come down from Fairview, so I would have been down on that ward, and as I've alluded

to previously, you know, you visited the ward for routine checks, that type of thing.

CHAIRPERSON: And you'd have known the staff on the ward, presumably?

A. Sorry? 10:48

CHAIRPERSON: Would you have known the staff on the ward?

A. Yeah. Mhm-mhm.

CHAIRPERSON: Yeah. But then as soon as the Ennis allegations, or the Bohill staff allegations were made, 10:48 were you then prevented from going on the ward?

A. Yeah.

CHAIRPERSON: By whom?

A. By the investigating team, my line manager, it was her that informed me. But I wasn't the only one. I think 10:48 other senior nurse managers weren't allowed to go on the ward either.

CHAIRPERSON: So just in terms of the management of the ward, who took over?

A. There was a person appointed to lead the investigation, 10:48 I think it was a social worker, Aine Morrison, it could be her name. My line manager, who isn't on that list, would have been highly involved in that.

CHAIRPERSON: Yes. Right.

A. And I'm not sure, like I know there was a raft of 10:48 people came down from on high, and they were around the place as well. So I'm not absolutely sure. I would still have contact with the ward through the Duty Officer role and they type of thing, but we didn't

visit the ward.

CHAIRPERSON: Okay. Thank you.

A. Initially, I should say.

CHAIRPERSON: Sorry, what did you -- I didn't hear that?

A. Initially at the early stages.

MS. TANG: I was just going to pick up on the timescale that that covered.

CHAIRPERSON: Right.

60 Q. MS. TANG: How long did the exclusion of yourself and your senior colleagues from that ward go on? 10:49

A. I'm not absolutely sure. Probably -- it wouldn't have been, it wouldn't have been that long, I don't think, you know. But I couldn't put a time frame on it, I'm sorry. 10:49

61 Q. Okay. So we're not saying weeks or months, are we?

A. Probably talking weeks.

62 Q. Weeks.

A. I would say, yeah.

63 Q. Okay. Can I ask you about staffing levels on Ennis at the time? 10:49

A. Hmm.

64 Q. How would you have described them? Were they at what they should have been or were there challenges?

A. They had a staffing compliment like every other ward in the hospital. Like every other ward in the hospital at that particular time, you know, there was a shortage. The bank system, the bank system would have filled some of the posts, I'm not too sure whether there was other 10:49

means though at that time. I know there was agency staff brought into the hospital at some stage, I can't honestly remember whether that was before or after Ennis, but they would have had a recognised staff allocation, or a staff requirement, and would have been, if possible, met, you know. I'm not saying it was always met. There might have been occasions when they had to work a staff down, as other hospital wards did, but generally speaking it would have been, it would have been the intention that they would have been working with a certain level of staff. 10:50 10:50

65 Q. So can you recall, as the Senior Nurse Manager, did you have any concerns about the level of staffing in that particular area at that time?

A. Yeah, I did. I had levels concerned about a lot of wards. Staffing was always discussed at the meetings. And my late colleague, who I job shared with, I remember sitting down with her and the Ward Sister after a meeting, in the small meeting room, and discussing possible staff moves. I think just before that we had identified that she could have maybe been able to transfer staff over from one of her wards, but it wouldn't be for a couple of weeks, you know, but that's how tight it was, staff really was a concern all over the hospital at the time. 10:51 10:51 10:51

66 Q. Was there any kind of link across to other mental health facilities within the Trust to try and share staff between the sites, or was that not appropriate given the patient profile?

A. My line manager may have made inquiries in that direction. It's possible. I just can't say.

67 Q. You can't?

A. I can't recall getting assistance, but the attempts might have been made to look at possible help from those areas, yeah. 10:52

DR. MAXWELL: Can I just ask you? You said you had concerns about staffing throughout the hospital at this time. Was it particularly more a concern in 2012 than it had been in say 2005? 10:52

A. I think that would be fair to say, yeah.

DR. MAXWELL: So when do you think it moved from 'we could always do with a bit more' to 'this is actually quite significant'? What year do you think it was?

A. I think it was towards the end of my working period in Muckamore. Certainly when the bank changed to central, the bank system, I think there was a decline there in the support you could get. The staffing recruitment didn't seem to be successful. I honestly can't put a time period on it, but we didn't seem to be able to attract certainly qualified staff. I think at one stage the staff skill mix was reviewed, you know, and we were looking to reach maybe a 60/40 split in qualified, unqualified, something like that. But recruitment was very difficult. But I would say in the last four or five years of my time in Muckamore it was fairly difficult. 10:53 10:53 10:53

DR. MAXWELL: So as you say there's two things there. One is the movement of the bank away from your control

to a central bank, which made it less, less well connected, so less availability of bank staff, but you also said a change in skill mix to 60% registered. What had the skill mix been before that?

A. I would say, I would say it would have been 50/50 maybe, maybe even less at times, yeah. 10:54

DR. MAXWELL: Okay.

A. It could have been 40/60 the other way, you know. I'm not too sure.

PROFESSOR MURPHY: Do you think that it was kind of general knowledge that Muckamore was going to be closing and wards and patients were being resettled that put people off applying for jobs there? Because you say recruitment wasn't very successful. 10:54

A. I don't honestly think that was a factor. That's my own opinion. I've no evidence to think that. Certainly I just think there was difficulty, you know, in attracting people to Muckamore, and I'm not sure what other facilities probably may have had a similar problem. I honestly -- I don't think the fact that Muckamore was closing featured in that. But, you know, it may well have done. I don't know. 10:54 10:55

CHAIRPERSON: I'm sorry, I just want to come back to the skill mix. Sorry. Dr. Maxwell asked you that at one stage you were talking about the 60/40, so 60% registered staff to 40% unregistered. 10:55

A. Yeah.

CHAIRPERSON: Health care assistants and the like?

A. Yeah.

CHAIRPERSON: Right. And then you said it changed to 50/50?

A. I think what the question was, what was it before?

CHAIRPERSON: Yeah. So it had been 60/40.

A. No, I think we were trying to move it up to 60/40, and I stand corrected if that's not right, but we did try and increase the number of qualified staff on wards, yeah. 10:56

CHAIRPERSON: Right. And that did happen?

A. Well the attempt was there, but I'm not absolutely sure whether it was achieved or not. 10:56

CHAIRPERSON: Right. Okay. Thank you.

68 Q. MS. TANG: Can I ask you, in terms of the Ennis investigation itself, how did you feel it was conducted? What was your... 10:56

A. I'm sure it was conducted in a very professional manner. We just didn't -- I didn't know, I didn't have any information really, or I had limited information on what was happening. It was fairly secretive. We wouldn't have been informed of any meetings, any kind of ongoings of the investigation. So at that point, you know, we were really excluded. 10:56

DR. MAXWELL: Was that normal? Because this wasn't the first safeguarding investigation ever. Would it be normal to exclude senior nurses in that way? 10:57

A. It wouldn't have been, no. I've never known it to happen before. But, again, maybe the manner of the complaint and the way it escalated into -- started of at two issues, two complaints I think, and then

suddenly it blossomed out into a number of complaints, and I think that might have been something to do with it.

DR. MAXWELL: So how would a safeguarding investigation have usually been conducted? Would it have been a partnership between the senior nurse and the social worker? 10:57

A. Police, social worker.

DR. MAXWELL: And the police.

A. Yeah. And obviously the hospital, hospital staff, that would have been the way, and the relatives, obviously, would have been informed and kept updated, yeah. 10:58

PROFESSOR MURPHY: So did you pick up the phone to Aine Morrison and say "Why am I being excluded from the ward? Can you explain it to me?". 10:58

A. No, I didn't do that. And that's a good question. But, again, I suppose it's a traditional thing, you know, you go through your line manager and you speak to your line manager, you know, I didn't go outside that system. 10:58

69 Q. MS. TANG: Can I ask, whenever the Bohill staff allegations came to light, did that give you concerns that there may be issues in other ward areas, not just Ennis?

A. I suppose I'm trying to think back, you know, and as I say, it was a shock that the Ennis situation arose. Like I had, as I say, been on the ward. The RQIA had been in, done a full investigation without any issues fairly recent, in fairly recent times prior to the 10:59

complaint. I knew a lot of staff on the ward. There was some of those nurses on the wards who were looking after people with a learning disability at home, you know, and I know that they wouldn't have stood for any kind of untoward behaviour towards patients. 10:59

Other wards, I suppose there's always a possibility of things happen. Like, you know, all through my time in nursing, things have happened. There's been a response to them, like was described earlier on in terms of 11:00 disciplinary procedures. It's nothing new. And I think in every organisation you do get people whose maybe performance don't come up to recognised standards, and it happens. So, yes, you always have to be alert, and a lot of emphasis was put on training 11:00 staff in terms of the vulnerable adult process, and reporting incidents and things like that, and efforts made to support staff in terms of taking forward any kind of concerns they may have had. So, I suppose, yes, you know, you're always kind of aware that things 11:00 can happen, yeah.

70 Q. Did you detect a shift in the organisation's approach after the allegations that came out in Ennis?

A. I would have said, okay, on the ground in terms of that training was looked at, you know, ensuring that 11:01 everybody was trained in those areas, vulnerable adult areas. Certainly my recollection, the staff in Ennis were very deflated, you know, they did, they did tell me that they just felt that they were treated as if

they were all abusers, and that was just how it happened.

71 Q. I want to go turn to paragraph 20 now, but before I do so, I should say that Belfast Trust have brought some correspondence regarding the meeting that's referred to in paragraph 20 to the Inquiry's attention at the end of last week. We've shown you two of those items of paperwork that were brought to our attention which relate to that meeting in order to assist your recollection of the events at that time. 11:01

CHAIRPERSON: Can I just interject and say that this was brought to my attention at the end of last week. In general terms I'm very resistant to witnesses being shown documentation just before they give evidence, but having looked at the documentation, it was very limited, and specifically the two documents that have been shown to the witness have been effectively signed off by him, and I thought in those circumstances it was reasonable to allow him to be shown these documents. Sorry to interrupt. Yes. 11:02

MS. TANG: Thank you. I should say also, Chair, that these documents haven't been processed by the Inquiry yet, but we will do shortly.

CHAIRPERSON: And we'll obviously be disclosing those to the CPs. 11:02

72 Q. MS. TANG: We will indeed. Thank you.

Mr. Stewart, turning to paragraph 20 then. You refer to a complaint from a patient on Ennis Ward regarding a member of staff, and you describe a concern raised by a

social worker who was interviewing a patient along with a police officer, that a nursed deliberately tried to intimidate the patient, and that the co-director at the time had wanted to take action against the nurse in question. From your recollection, do you feel that there was any underlying issue in terms of how the nurse behaved? 11:03

A. Absolutely not. I can be fairly certain of that. This was a lady who had been transferred to Ennis after the incident happened. She had 45 years of nursing experience. She, you know, it would have been -- okay, it would have been fairly normal practice that people would be offered a drink or refreshments, I suppose it wasn't appropriate maybe in the circumstances of the type of interview. But as I say, you know, I was in the room, the speech and language therapist was in the room, the police officer was in the room, the social worker with the advanced training was in the room. I certainly detected no indication that the patient was being intimidated. I spoke to the police officer, I spoke to the speech therapist, and nobody in that room detected that there was an attempt to intimidate that individual patient. I think it was just unfortunate. But I think the reaction was over the top. 11:03 11:03 11:04

73 Q. Do you feel the social worker who raised this concern, do you feel -- 11:04

A. No, I think that the immediate reaction was to suspend the nurse, and I think without an investigation, and I thought that just spoke of how the atmosphere maybe in

Muckamore had changed, or was at the time.

74 Q. So the social worker perceived the incident differently. How would you view how the social worker viewed it? Can you see how they might have perceived it that way? 11:05

A. I can. Yes. Certainly if, you know, I don't know, I'm obviously not an expert in circumstances like that, you know, I have been there, but the social worker probably did, in all fairness like, you know, think there was a risk there that maybe the patient was being interfered with, and I don't blame her for that, but as I say, I think the reaction from the co-director was just over the top. 11:05

DR. MAXWELL: And from the documents that have been supplied, you spoke to the police who hadn't felt that it was intimidatory either? 11:05

A. No, nobody did, no.

DR. MAXWELL: Only the social worker?

A. Only the social worker, yeah. Which, you know, I'm happy enough to accept that that's her opinion, that was fine and it was investigated, and as far as I'm concerned I just think the knee-jerk reaction to suspend that staff after 45 years service, hadn't worked on the ward prior to this incident happening, and offering somebody a cup of tea, I just thought it was over the top. 11:06

DR. MAXWELL: But you think this was reflective of an atmosphere that had been created that all the staff were abusers?

A. I think it was starting to, you know, kind of blame culture to develop in the hospital, yeah.

75 Q. MS. TANG: I want to go down to paragraph 22, please, and to pick up on some comment about a sense of a decline in support. 11:07

A. Sorry?

76 Q. I'm just trying, I'm trying to focus on it here. Just about half way down the paragraph, the sentence begins:

"When the Belfast Trust opened their central nurse bank 11:07 system in and around 2012, I felt that there was an actual decline in support from that quarter."

Can you find that line in your statement?

A. I just think it became more distant. You hadn't that 11:07 personal contact with the bank staff. Bank staff had to go on-line and put shifts in that they were available. It wasn't really controlled through the nursing office as such. When I was Duty Officer and we had the bank system in Muckamore, you know, very often 11:07 if we were kind of short of staff, and it could happen, I would have known routines and what people were doing who were on the bank, and I have to say I did cold-call people on occasions and ask if they were available for a shift, and those type of things. So just those 11:08 little kind of contacts and those that didn't exist anymore. The wards then -- the bank staff, you know, they didn't -- it was the wards really who kind of located the people for the shifts and asked them to put

their names down a lot of the time on the bank and, you know, they were ready booked before they went through the system, if you know what I mean, you know. So it just wasn't as effective I don't think.

77 Q. So if I understand you right, it sounds like you're saying it was less responsive? 11:08

A. It was. You know, they were producing bank staff for a range of hospitals, you know, Muckamore was probably just one other hospital, like you know. Whereas we were focused on Muckamore when we had the bank system all the time, you know. 11:09

78 Q. In practical terms did that make it harder to have enough staff or were you still able to get what you needed?

A. I think it became -- I don't know if that was the overriding factor, but I think it did become harder to get staff. The wards spent more time and the Duty Officer spent more time trying to source staff to fill deficits over that period of time until I retired, that seemed to be an ongoing issue. 11:09 11:09

CHAIRPERSON: I'm just thinking about timing. We've been going about an hour and a quarter. How much longer? I don't want to stop now if you've only got 10 minutes left.

MS. TANG: I think probably 10 minutes would do it at most, Chair. 11:09

CHAIRPERSON: Are you okay to keep going or would you like a short break?

A. I would prefer to keep going, please.

CHAIRPERSON: Sure.

79 Q. MS. TANG: Thank you. I want to go finally to paragraph 24, please. You speak in that paragraph about your training in MAPA, management of aggression and potential aggression. When were you first trained in MAPA, to your recollection? 11:10

A. Let me see. It would have been -- I'm trying to think. We first trained in care and responsibility, I think that was in the early '90s. I think I was still working in day care at the time. So probably mid, early to mid '90s, and then maybe a couple of years later we then adopted the MAPA model. 11:10

80 Q. Okay. So some time in 'the 90s?

A. Yeah, I think so.

81 Q. Is what I think you're saying? 11:11

A. Yeah.

82 Q. And when you attended incidents, did you ever find staff having deployed inappropriate or unsafe holds in the course of those?

A. I would have maybe come in at a stage where a patient who had been posing a high level of risk was being restrained, and I have kind of seen staff, you know, I remember in one incident I came in and -- and things can happen, you know. In a crisis situation, you know, it's not, it's not a classroom you're dealing with, you know. There's a lot of things going on and things can happen. But I remember -- I'll give an example. I came into a situation where a patient was being restrained, and he was on the floor, and a member of 11:11 11:11

staff was the role of care of the legs, but they were facing the wrong road. Now this would in no way have caused any safety issues with the patient, but it could certainly have caused for the staff. So in that instance I -- we have a system where we teach people how to take over from colleagues, so I took over, and the staff obviously realised what had happened and, you know, it was corrected. Sometimes MAPA is about not restricting movement, but it's about keeping movement safe. You know patients can move, but to keep staff safe, you know, obviously you're safe far away from a risk, or you're safe close up to it, you know, and sometimes staff maybe would have a bit of space between them and a patient who was exhibiting risk behaviour. So, you know, it's about closing space down, asking people to close down, that type of thing, you know. So it would have been -- staff appreciated it as well, like you know. Wee comments, like you know, that would help them be more effective and safe, you know.

11:12
11:12
11:13
11:13

83 Q. Did you ever have any concerns that physical holds were being used perhaps before lesser approaches could have been tried to calm the situation down?

A. I would hope not. I think during the training we would always have kind of emphasised that it's something that we'd use only as a last resort, you know. So hopefully not, you know. You can never be sure.

11:13

84 Q. We have had some evidence from witnesses that indicated that recording of restraint and seclusion wasn't always accurate. Did you ever find examples of inaccuracies

in the wards that you covered?

A. You know, at one stage I did coordinate the training in Muckamore, and part of that role would have meant that I would have eyesight of all the audit forms coming through, and I'm sure there is times in those audit forms, because people do things quickly and stuff, that I would have questioned maybe what happened, and gone back to the ward and looked at that. So, yes, I probably would, on occasions, have questioned what exactly happened before the incident or, you know. There was a kind of an ABC, and antecedent behaviour consequences element to it, you know. So it would give a wee bit of an idea of why people had intervened, and then how they intervened, and what position at the time and that type of thing, you know. So, yeah, there's times when I've had forms through and gone back and clarified issues with staff. 11:14 11:14 11:14

85 Q. So did you do an audit of the MAPA forms, for instance, or how did you approach things?

A. Well at the period I was there, and probably after it, those audit forms came through and I would have looked at all the audit forms, the details, there might have been incident forms as well, there would have been incident forms through, and then those forms went to a lady over who had responsibility for putting them on to the computer system, and then she would have generated kind of information like -- well you could have got a lot, any information out of, you know, for individual patients, for groups of patients, you know. Wards 11:15 11:15

could see what the level of intervention was being used. You could have got the position of patients, how they were being held, those type of things. You had the names of the staff probably who was involved in it. So that information was all kind of correlated into charts, pie charts, bar charts, and then presented. You know, the wards could request that to be presented at reviews, patient reviews. Senior management obviously had those. I think they reviewed them monthly, you know, or fortnightly. So that basically was the system, yeah. 11:16 11:16

86 Q. And would there have been feedback given to the wards about the types of restraint and the issues coming in through these platforms?

A. Yeah, those reports are all available and they could or would have used them at their... 11:16

87 Q. Sorry, could you maybe speak to the microphone a wee bit?

A. Those reports were available and they could have used them at their ward reviews, yeah, the patient reviews. 11:16

88 Q. Okay. Thank you.

DR. MAXWELL: Can I ask, because by this time clinical governance had been going for some time, which committee would have looked at those charts and trends? Because it's one thing for people to ask for it and look at it, but you could miss something. To get systematic assurance you need to present it and discussed, even if you haven't got any particular concerns? 11:16

A. Yeah.

DR. MAXWELL: So which committee would have done that?

A. I'm only kind of aware, and there might have been others, but I'm only aware of the hospital management team, they would have got those reports. That would have been the co-director, medical director, the nursing -- chief nursing person, the senior nurse, and the social worker. So they would have been the ones that I'm aware of that would have reviewed those statistics. 11:17

DR. MAXWELL: So you weren't aware, during your time, of any committee that was specifically looking at clinical practice, clinical governance? You think it went into the general management committee?

A. I'm not aware of any other, no. 11:18

MS. TANG: Thank you. Mr. Stewart, those are all my questions for you, but I'm conscious the Panel may have some remaining questions, so I'm going to hand over to the Chair at this point.

11:18

MR. STEWART WAS QUESTIONED BY THE INQUIRY PANEL AS FOLLOWS:

89 Q. CHAIRPERSON: I just want to go back to the two investigations that you yourself conducted, just to see how they operated. 11:18

In paragraph 17 you were asked to investigate I think it was an assault on a patient, and you were asked to

act as the investigating officer for that. Can you remember if that member of staff was suspended pending the investigation?

A. He was, yeah.

90 Q. CHAIRPERSON: And you would have investigated that presumably by speaking to the witnesses? 11:18

A. Yeah.

91 Q. CHAIRPERSON: And as presenting officer, would you have called evidence? Would you have, rather like this, would witnesses have come along and given evidence, or would you simply have presented what you were told? 11:19

A. There was witnesses there, yeah.

92 Q. CHAIRPERSON: Yeah. So it was dealt with as a full and proper investigation?

A. Sorry, could you repeat that? 11:19

93 Q. CHAIRPERSON: It was dealt with as a full and proper investigation for that incident?

A. Yeah.

94 Q. CHAIRPERSON: And did the individual staff member have representation? 11:19

A. Yes.

95 Q. CHAIRPERSON: Either a union member or a lawyer?

A. A union member I think, yeah.

CHAIRPERSON: Yeah. Okay.

96 Q. DR. MAXWELL: Can I ask -- that's sounds like a disciplinary investigation. Was there a separate safeguarding investigation? 11:19

A. There probably would have been, yeah. Aye. There would have been safeguarding, yeah. I'm just trying to

think, and I just can't remember to be honest with you.

97 Q. CHAIRPERSON: And then so far as the second matter is concerned, which you've dealt with fairly fully, there was obviously a difference in interpretation from what the social worker thought she saw to what everybody else in the room saw? 11:20

A. As I said, I have absolutely no problem with what the social worker reported, you know. I just think like, you know, it was a little bit over the top.

98 Q. CHAIRPERSON: Your complaint was not about what the social worker did but about the reaction of management to it? 11:20

A. I just thought it was, I just thought it was off a knee-jerk reaction, if you want, and just it was a bit extreme. 11:20

CHAIRPERSON: Okay. That's all that I ask. I don't know if anybody else has got any questions?

Mr. Stewart, can I just thank you very much for coming along to assist the Inquiry and giving up your time in relation to your service at this hospital over quite a significant period. So thank you very much for coming to help the Inquiry. Is there -- you're looking as if there's something else you want to say. 11:20

A. I suppose really like, I know the future of the hospital has been decided, apparently it's to close, you know. But when I was thinking back of being questioned in and around the role of the Duty Officer, what I would say is we would have got calls from people 11:21

ringing in from their homes very distressed, their relatives have, you know, been causing major problems, they were finding it very difficult to cope. We would have had people maybe ringing in in tears, pleading for help, and what I'm saying is that I hope, like you know, that those people in the future would get the help that maybe they did get through Muckamore. That's it.

CHAIRPERSON: Well, thank you. All right. Again, Mr. Stewart, thank you very much indeed for your evidence. 11:21

A. Thank you.

CHAIRPERSON: If you'd like to go with the secretary to the Inquiry. We'll take a 15-minute break and try and start again at a quarter to. I've got a few remarks to make, and then I think counsel to the Inquiry is going to address the room. 11:22

We're going back on live stream from that point. So a quarter to, we'll back on YouTube or wherever it appears. Thank you. 11:22

SHORT ADJOURNMENT

THE INQUIRY RESUMED AFTER A SHORT ADJOURNMENT AS FOLLOWS: 11:22

CHAIRPERSON: Right, just before we start and Mr. Doran addresses everybody, I've been shown some

correspondence from Phoenix Law, and I've also had the advantage of reading a speaking note provided by Ms. Anyadike-Danes KC on behalf of Groups 1 and 2, and I've also seen a letter from O'Reilly Stewart on behalf of Group 3, raising similar issues in relation essentially to available preparation time. 11:53

Can I start by saying this, having spent a good part of both Friday and the weekend, myself, catching up on reading, I do have some sympathy for the complaints that are being made. And, in essence, the correspondence and the speaking note addressed the difficulties of receiving large amounts of evidence to be assimilated quickly and upon which instructions then need to be taken, and there is a concern that's been expressed that as a result Core Participants cannot be sufficiently engaged with what is being put before the Inquiry. 11:53 11:53

Now, I know that Mr. Doran KC is going to address some of those issues when he introduces Module 6. 11:54

Module 6B, which we are starting in part today, but really tomorrow, and hoping to complete next week, is, as I think we've all, and always recognised, is a complex module and focuses in essence on the issues arising from the Ennis investigation, and there are six central witnesses; Brenda Creaney and Aine Morrison, who are giving evidence tomorrow. Esther Rafferty and 11:54

Moira Mannion, who are giving evidence next Monday, the 17th June, and John Veitch and David Bingham on Tuesday 18th June. Mr. Owen Barr, who is giving evidence on Wednesday, deals with a separate topic.

11:55

Now the main Ennis bundle was served on the 17th May, so 16 working days ago, and well within our protocol, but nevertheless, a very significant bundle to read. We had not originally intended to start any of these witnesses until next Monday, the 17th, but as counsel 11:55
to the Inquiry will explain, that had to be changed to accommodate two of the witnesses. One had a booked and planned holiday and the other an event that they couldn't avoid. And to accommodate them, and ensure their evidence was heard before the summer break, we 11:55
moved them forward to this week. Now, it was only last week, once the schedule had been prepared, that Ms. Creaney changed her planned plans and would have been available next week, but by then the schedule for next week had been set and a number of flights and 11:55
accommodation had been booked for others. So that's just to explain why the Inquiry have moved those witnesses forward.

I am pleased to say that we have already received 11:56
questions for tomorrow's two witnesses from Core Participants, including Groups 1 and 2. But can I then address the question of preparation time?

In terms of preparation, one of the reasons we do not sit on Fridays is to allow people to have a reading day, and I'm sure those are being well used. We're also fortunate that we're not sitting Wednesday, Thursday or Friday of this week, so there is in fact further time for the preparation of those witnesses next week. 11:56

I can also indicate that as far as questions from Core Participants are concerned, I do intend to relax the rules, no doubt to the dismay of counsel to the Inquiry. But the relaxation of the rules will be as follows: to allow questions for Monday's witnesses to be submitted by close of business on Thursday, and questions for Tuesday's witnesses to be submitted by Friday. 11:56 11:57

I do think it's important with this evidence to deal with it according to the schedule, but there are two further factors that I hope are going to help significantly. The first is that the following witnesses will all be returning in other modules after the summer and will be recalled in the organisational modules. So Mr. Veitch is coming back on Module 7, Ms. Rafferty is coming back in Module 7, and Ms. Creaney is coming back in Module 9. So should there be any outstanding issues arising from Module 6, which could not have been dealt with in this session, those can be addressed in the summer, and I will 11:57 11:57

certainly be open to applications to allow that to happen.

Finally, if after hearing from witnesses who will not be returning, so that's Aine Morrison, Ms. Mannion and Mr. Bingham, if CPs want to submit questions which would have been asked of those witnesses and filtered through counsel to the Inquiry, then I will certainly give consideration to allow those questions to be submitted to the witnesses for a short further statement to be taken. If it proves absolutely necessary to do so, we will consider inviting them to return, but I hope that doesn't become necessary. 11:58 11:58

Now, although it's always a pleasure to hear from Ms. Anyadike-Danes KC, I have read the speaking note, I am aware of the issues, and it seems to me that we would lose precious time today, and I think the better course, if I may say so, is for her and for counsel to Group 3, to have a counsel's discussion with counsel to the Inquiry to find the best way forward to deal with the concerns raised. 11:58 11:59

Finally, I am aware of an issue being raised over the alacrity with which some of the correspondence is being answered. I think Core Participants have to understand that there is a great deal of correspondence received by the Inquiry which has to be processed. Each Core Participant will look at it from their own point of 11:59

view, but you will remember each that there are a number of Core Participants, all of whom are writing to us.

But having said that, I do accept that on some occasions it has taken the Inquiry longer to respond to letters than it perhaps should have done, and I am going to raise this internally and see how things can be better managed. 12:00

Now if Ms. Anyadike-Danes still wishes to speak to me after she has had the conversation with counsel to the Inquiry, then I will of course be content to hear her, and indeed from anybody else who wants to speak. But I think the best thing to do now is to hear first of all from Mr. Doran KC, and then move on to the witness. 12:00

INQUIRY COUNSEL'S INTRODUCTION TO MODULE 6

MR. DORAN: Thank you, Chair. 12:00

Chair, following on from your announcement at the start of this morning's hearing, I just want to say that the thoughts of the Inquiry team are with the family, friends, and colleagues of Geraldine O'Hagan, who was with us in this room so very recently. 12:00

Chair, Panel, before the Inquiry moves on to hear the oral evidence for the remaining parts of Evidence

Module 6, I'd like to provide a brief introduction to set that evidence in context. I also want to explain why we are dealing with this evidence now, rather than last year when most of the other evidence in the evidence modules was heard. I will also say something about the preparation for this evidence, and I will provide an overview of the various witnesses involved and how they fit into the module.

I wonder if we could just have on screen, please, the outline of the evidence modules which is of course published on the website. Just looking at the list, Module 1, Bamford and Mental Health Law in Northern Ireland. Module 2, Health Care Structures and Governance. Module 3, Policy and Procedure. Module 4, Staffing. Module 5, Regulation and Other Agencies. And then Module 6, MAH Reports and Responses.

These modules generally were designed to cover the law, policies, procedures and practices relevant to the Inquiry's Terms of References, and it's worth mentioning in passing that the Inquiry heard from 35 witnesses last year for the purpose of those modules, and the written evidence gathered in the course of this work was voluminous. The statements and exhibits I think provide a helpful compilation of the legal and policy documents of significance to the work of the Inquiry, and those statements and exhibits have been published on the Inquiry's website.

I want to turn now specifically to Evidence Module 6, and this relates to reports relating to the hospital and responses to those reports, and the Panel will see that there are five elements to Module 6. 12:03

First of all the EHSSB/NWBT Review of December 2005. Secondly, the Ennis Ward Adult Safeguarding Report, October 2013. Thirdly, Review of Safeguarding at Muckamore Abbey Hospital, "A way to go" November '18. 12:03 Fourthly, Review of Leadership and Governance at the hospital July 2020, and then, finally, identification of other key reports concerning MAH.

The Panel will recall that we dealt with both 6(a) and 12:04 6(c) in evidence last year. Miriam Somerville gave evidence on the 15th May about the Eastern Health and Social Services Board and North and West Belfast Health and Social Services Trust Review of Policies and Procedures to Safeguard Children and Vulnerable Adults 12:04 in Muckamore Abbey Hospital, which was completed in December 2005.

As regards 6(c), the Panel heard from Dr. Margaret Flynn on the 25th of May of last year. Dr. Flynn was, 12:04 of course, the Chair of the Review Team, whose work resulted in the report, A Review of Safeguarding At Muckamore Abbey Hospital, "A way to go", which was published in November 2018.

In order to address the Ennis Ward Adult Safeguarding Report, Module 6(b), the Inquiry asked Aine Morrison, who was the designated officer appointed to lead the safeguarding review, to make a statement and to give evidence about the process. She provided the Inquiry with a statement on the 1st May 2023.

By way of a very brief overview, the Ennis safeguarding process followed on from allegations made by a care assistant employed by an independent care provider about the conduct of certain staff towards patients on Ennis Ward in November 2012. The allegations prompted a lengthy vulnerable adult safeguarding procedure that resulted ultimately in the report by Ms. Morrison and her colleagues in October 2013. 12:05 12:05 12:06

As some of the allegations were criminal in nature, the investigation was conducted in parallel with a criminal investigation under the joint protocol. There were subsequent criminal proceedings against two staff members. One of them was acquitted. The assault conviction of the other was overturned on appeal. There was a disciplinary investigation that did not result in disciplinary proceedings being taken against the staff members concerned. 12:06 12:06

The response to the Ennis allegations also involved the introduction of an early protection plan and the

formulation of action points as the safeguarding process took its course. As well as the involvement of PSNI on the criminal side, there was input from RQIA, which made unannounced inspections of the ward and made recommendations as a result of those inspections. I emphasise that this is only a very brief sketch of the multiple processes that followed on from the initial reporting of concerns on the ward.

12:07

Now, aside from Module 6(b) and Ennis, the Inquiry had also asked David Bingham to attend to give evidence. Mr. Bingham was a member of the independent Review Team, whose work culminated in the review or the report titled "Review of Leadership and Governance" published in 2020, and that report is the subject of Module 6(d).

12:07

12:07

In addition to asking witnesses to assist the Inquiry with regards to individual reports, the Inquiry also asked the Trust to provide a statement addressing all of the reports referenced in Module 6. That statement was produced by Martin Dillon on the 26th April 2023. Mr. Dillon was Chief Executive of the Belfast Trust from 2017 to 2020.

12:08

In conducting its work in preparation for the evidence modules, the Inquiry team was also mindful of Module 6(e), which relates to the identification of other key reports concerning the hospital. I will return to those other reports in a moment.

12:08

As the Inquiry and Core Participants are aware, it was initially intended to hear all of the evidence relating to Module 6 last year. On consideration of the material that I have mentioned, however, a number of things became apparent, and I want to draw attention to three things particularly.

First, in order for the Inquiry to properly examine the Ennis report and its outworking, it would be necessary to hear accounts not only of the, or from the designated officer Ms. Morrison, but also from some others who were involved in the process at the relevant time.

Secondly, in order to assist the witnesses in providing their accounts of what occurred, it made sense to provide them with the core documentation relating to the safeguarding process and subsequent developments.

Thirdly, on considering the Ennis materials alongside the leadership and governance review, it was apparent that those two processes would be more effectively considered at or around the same time in oral evidence. And there are two reasons for that. First, the leadership and governance review regarded the Ennis investigation as one of the key events that needed to be considered for the purpose of its work. The Inquiry will see that a significant portion of the report is

devoted to reflections on Ennis and its aftermath.

Secondly, separately from the leadership and governance review, David Bingham was also involved in examining concerns raised by Aine Morrison about how she was treated in the course of the Ennis safeguarding process. He also produced two short reports about those matters. 12:11

Having regard to all of these matters, consideration of Ennis and leadership and governance was deferred to enable the Inquiry to take further preparatory steps prior to the oral evidence on these reports being heard. 12:11

You, Chair, explained the position in a statement of the fifth of May 2023, when you said: 12:11

"On consideration of the material received by the Inquiry to date in respect of topic 6(b) and topic 6(d), as well as the responses to those reports, the Panel has determined that further groundwork will be required prior to the hearing of oral evidence in respect of those matters. This may include the obtaining of further statements to ensure that the Panel will have obtained a comprehensive picture of the processes that led to the production of those reports." 12:12

And I will outline very briefly what that further

groundwork has entailed.

First, the Inquiry team compiled a bundle of the materials regarded as necessary for the various statement makers to consider when giving their account. 12:12
Statements were then requested and received from five individuals relating to the Ennis process. Each witness was asked to address questions tailored to their particular role or position, and the five witnesses are; first, Aine Morrison, who made a 12:12
statement on the 2nd February 2024. As I have said, she was the designated officer responsible for the investigation. She was also the lead author of the report with two colleagues, Colette Ireland and Carmel Drysdale. 12:13

I have mentioned that Ms. Morrison also made a statement about Ennis last year. That was, of course, without the benefit of the materials in the Ennis bundle. That statement has also been disclosed to Core 12:13
Participants in the interests of transparency, but the focus of the Inquiry will be on the second statement in which she responds to the specific matters raised by the Inquiry.

12:13

The second of the five witnesses is Esther Rafferty, who was Service Manager at the hospital in 2012, and she made a statement on the 13th April 2024.
Ms. Rafferty was also the Associate Director for

nursing for Muckamore Abbey Hospital and Community Learning Disability Services at that time. She was involved in the initiation of the safeguarding procedure and in the implementation of action points that were generated in the course of the safeguarding investigation. 12:14

Thirdly, John Veitch, who made a statement on the 23rd February 2024. He was Co-Director for Children and Adult Learning Disability Services in the Belfast Trust at the relevant time. Mr. Veitch was centrally involved in the Trust's strategic response to the allegations. 12:14

Fourthly, Moira Mannion, who was Co-Director for Nursing Education and Learning at the Trust. She made a statement on the 19th January 2024. Ms. Mannion was deployed to implement monitoring on the ward in the aftermath of the allegations and to provide an improvement plan as part of the strategic response to the issue. 12:14 12:15

I should mention that Ms. Mannion had also assisted the Inquiry through the provision of an earlier statement dated the 19th September 2023. This statement dealt more generally with Ms. Mannion's role as Co-Director of Nursing Education and Learning from 2007, and then from 2018 as the Deputy Director of Nursing Workforce, Education, Regulation and Information Technology. When 12:15

Ms. Mannion gives her evidence relating to Ennis, it is proposed also to ask questions as appropriate arising from that more general statement, in order to complete her evidence at one sitting if possible.

12:16

And finally then, Brenda Creaney, the Executive Director of Nursing and User Experience, has provided a corporate statement relating to Ennis on behalf of the Belfast Trust dated the 22nd of February 2024.

12:16

The witnesses were provided with the Ennis bundle for the purpose of assisting them in making their statements. They were also at liberty, of course, to exhibit other materials referenced in their statements. I should add that each witness has more recently been provided with the statements made by the others in advance of the oral evidence being given.

12:16

The five statements obtained as a result of this exercise are also being published on the website along with the other statements from the evidence modules, and the Ennis bundle itself will also be published on the website as soon as possible.

12:17

Now the Inquiry will hear from Ms. Creaney on behalf of the Trust tomorrow morning. As you indicated, Chair, it had initially been intended to call upon Ms. Creaney after the other witnesses next week, but due to an availability issue the evidence was moved forward to this week. As it transpires, the witness would have

12:17

been able to attend next week, but for the reasons you outline, Chair, we have decided to keep to the planned schedule.

If, of course, there are issues arising in the course of the other witnesses evidence that need to be addressed on behalf of the Trust, those matters can be picked up at a later stage, and I will say a little bit more about that in due course. 12:17

12:18

Chair, I should draw attention also to the fact that DLS, on behalf of the Trust, provided the Inquiry with two further compilations of material on Friday of last week for consideration in this phase of the evidence. One is a bundle of documents that are referred to in the statement of Ms. Creaney that do not appear in the MAHI bundles. The second is an additional bundle of documents that are not referred to in Ms. Creaney's statement, but that the Trust say would have been included as exhibits if they had been identified at the time the statement was made. And DLS indicate that Ms. Creaney may wish to refer the Panel to some of those documents during her evidence. 12:18 12:18

The Inquiry team is not going to conduct a last minute review exercise to prepare this material for disclosure in advance of the evidence. The material will be reviewed and disclosed as appropriate in due course. Having considered the material briefly, we are 12:18

confident that it can be dealt with in an appropriate way in the course of the evidence without causing disadvantage to anyone.

Ms. Morrison will give evidence then tomorrow afternoon. The Inquiry is not, as you have indicated, Chair, sitting on Wednesday or Thursday of this week. Ms. Rafferty will give evidence next Monday morning, the 17th of June, followed by Ms. Mannion in the afternoon. Mr. Veitch will give evidence next Tuesday morning, and then Mr. Bingham in respect of leadership and governance on Tuesday afternoon. 12:19 12:19

So the plan is that the oral evidence in respect of evidence Module 6(b) and 6(d) will be significantly advanced by next Tuesday, 18th June, and I use the term "significantly advanced", because as I have said, there may be issues arising from Ennis, and indeed leadership and governance, that will need to be addressed by the Trust in evidence at a later stage. 12:20 12:20

Mr. Veitch and Ms. Rafferty have been asked to assist the Inquiry with statements for Organisational Module M7, Hospital Organisational Management or, sorry, Operational Management. Ms. Creaney has been asked to provide a statement for Organisational Module M9, Trust Board. Mr. Dillon, who I have said made a global statement on behalf of the Trust in relation to the various reports, will also feature in Organisational 12:20

Module M9. The fact that these witnesses will also be involved in the Inquiry at a later stage has, of course, had a bearing on our approach to the two recently received bundles of material that I mentioned just now. If there are matters arising from those materials that really need to be addressed at a later stage, then the opportunity to do so will arise in the course of the organisational modules. And I should emphasise, Chair, that if any issues arise in the course of the Ennis oral evidence that need to be revisited at a later juncture once everyone has had the opportunity of taking stock of the evidence and the materials, that will be done at the appropriate time. 12:21 12:21

It's important to add that requests for corporate statements to other organisations have also included requests for assistance with the role of those organisations in the follow-up to the Ennis allegations. That applies to PSNI, RQIA, the Public Health Agency, and the Health and Social Care Board, which now of course has been superceded by the Strategic Planning and Performance Group or SPPG. 12:22 12:22

Ennis has been and will be raised with other witnesses as appropriate. It would neither be possible nor desirable to address the matter in a completely compartmentalised way. Nevertheless, as I've said, it is hoped that the evidence in relation to Ennis and its outworking will have been significantly advanced by 12:23

next week.

Now, before we hear from the witnesses, I want to make two important points in relation to the Inquiry's approach to this evidence. 12:23

Firstly, when the Inquiry was hearing evidence for the purpose of the evidence modules last year, the primary objective was to ensure that the Panel was fully informed of issues such as the legal and regulatory framework, the organisational structures, and the 12:23
relevant policies, procedures, and practices that were in place at the relevant time. Issues of adequacy and effectiveness would generally be deferred until the later stages of the Inquiry, and that was made clear in the correspondence to the relevant witnesses at the 12:24
time, and you, Chair, also outlined that approach in a statement on the 21st December 2022.

When it comes to considering the response to the Ennis allegations, the Inquiry will inevitably be doing so 12:24
with a critical eye, so to speak. So the Inquiry's interest in this evidence will not be confined to gaining an understanding of what occurred, but in the adequacy and effectiveness of the response. That is reflected in the questions that the witnesses were 12:25
asked to address in their statements.

The second point I want to make is that this part of Evidence Module 6 has generated a great deal of

material for consideration by the Panel and, indeed, Core Participants, as you have mentioned, Chair. The allegations gave rise to multiple responses, including, as I have outlined, a lengthy safeguarding process, criminal proceedings, and a disciplinary investigation. 12:25
The Inquiry has explained to Core Participants in a message of 3rd June 2024, that it does not intend to re-examine with the witnesses the facts that led to the Ennis safeguarding process, the related criminal proceedings, and the subsequent disciplinary 12:26
investigation. Neither does the Inquiry intend to explore in the oral hearings the granular details of those and related processes. Rather, the focus will be on issues such as the nature and effectiveness of the approach adopted to the issues arising, whether the 12:26
investigation and the subsequent report could have been or ought to have been dealt with differently, how Trust management responded to the investigation, the lessons to be learned, and whether the issues arising in Ennis ought to have prompted a wider examination of conduct 12:26
and practice within the hospital at that time.

Similarly, the approach to the leadership and governance review in oral evidence will be to assess how the report and its findings may assist with the 12:27
Panel's consideration of the Terms of Reference, rather than to revisit in detail the methodology and conduct of that review.

The Inquiry is also conscious of the interpersonal disputes to which these review processes gave rise, but witnesses will be reminded that the focus of the evidence will be on matters that can realistically assist with the Terms of Reference. 12:27

That brings me back then to evidence Module 6(e), the identification of other key reports concerning the hospital. This was to cater for the possibility that the authors of other reports of particular relevance or 12:27 interest might be invited to assist the Panel by answering questions from those reports. This list should not necessarily be regarded as a finite one, but the Panel has requested to hear evidence in relation to the following four reports specifically. First, Yvonne 12:28 McKnight, Francis Cannon, and Professor Owen Barr, authors of the final report of the Independent Assurance Team in September 2018. This report was the culmination of an independent assurance review of decisions taken by senior staff at the Belfast Trust 12:28 following the identification of safeguarding concerns in 2017.

Secondly, Lorna Montgomery, Professor Owen Barr, Maureen Brown, Jan Houghton, the Muckamore Abbey 12:29 Hospital Adult Safeguarding File Review from September 2021. This report was the result of a review commissioned by the Department of Health in response to concerns about the numbers of referrals implicating

staff in alleged abuse of patients, and the report related specifically to the period January 2020 to April 2021.

Third, Brianne Mongan and Ian Sutherland, the independent review of the Learning Disability Resettlement Programme in Northern Ireland, published in July 2022. This report resulted from an independent review commissioned by the Health and Social Care Board in October 2021. The subject of the review was the Learning Disability Resettlement Programme in Northern Ireland, with particular focus on resettlement from Muckamore. 12:29 12:29

And then fourthly and, finally, Gillian Traub, Muckamore Abbey Hospital, "What is different now?", from April 2021. This paper was prepared by Ms. Traub and colleagues when Ms. Traub was Interim Director for Learning Disability Services. The report is described as a product of a conscious new process of drawing on the combined expertise and experience of the Trust's Executive Directors for social work, medicine and nursing, with one or more service director to make corporate sense of what's going on in any of the Trust's services. In this case, Muckamore Abbey Hospital. And the paper was prompted by a discussion at Board level in September 2020 about a Muckamore safety report. 12:30 12:30 12:30

The Panel will note that Professor Owen Barr was one of the co-authors of the first two reports, the report of the Independent Assurance Team in 2018, and the Adult Safeguarding File Review in 2021. He has been asked to assist with the Inquiry's understanding of those two reports in oral evidence, and he will attend to give evidence on the morning of Wednesday, 19th June. 12:31

The Panel and Core Participants will recall that Professor Barr previously gave evidence to the Inquiry in Evidence Module 4 "Staffing", on behalf of the University of Ulster on Wednesday, 26th April last year. So Professor Barr will be attending again next Wednesday, the 19th. 12:31

12:32

The Inquiry considered that the third report, that is the Resettlement Review Report, would be best accommodated within the later Organisational Module M6, which focuses on the subject of resettlement. It is intended that Ms. Mongan and Mr. Sutherland will attend to give evidence in respect of their report in week commencing the 24th of June. 12:32

CHAIRPERSON: And I think the intention is to call them together?

MR. DORAN: That's correct, Chair. 12:32

CHAIRPERSON: To hot-tub them.

MR. DORAN: That's the expression indeed.

CHAIRPERSON: Yes.

MR. DORAN: Finally then Ms. Traub, the author of the

paper titled "What is different now?", is giving evidence this afternoon. Ms. Traub had in fact been invited to make a statement to assist with the staff phase of the Inquiry. Her statement covers matters that extend beyond the "What is different now?" paper, and her evidence will not therefore be confined to that paper alone.

CHAIRPERSON: I do apologise for interrupting, but is there any reason that that evidence in its entirety could not be streamed, or are we going to try and break it up? 12:33

MR. DORAN: Well, Chair, I think consistently with the approach to evidence that falls within the staff phase, it would probably not be appropriate to stream the evidence this afternoon. As regards the report itself, it will be available on the Inquiry's website. It is exhibited to the statement of Mr. Dillon, and of course the transcript of the evidence in relation to that report will be published on the Inquiry's website. 12:33

CHAIRPERSON: Yes. And after Ms. Traub is finished, from tomorrow on we should be able to stream all of Module 6? 12:34

MR. DORAN: Yes, Chair.

CHAIRPERSON: Okay. Thank you. Sorry to interrupt.

MR. DORAN: Chair, just let me qualify that in one respect. When Ms. Moira Mannion comes to give evidence, she will give evidence not only in relation to her role in the Ennis process, but also in relation to her broader role in respect of which she made a 12:34

statement for the purpose of the staff phase of the Inquiry. Now as regards her evidence, I do think it may be suitable to have a streamed session in the first instance that deals with the Ennis process specifically, because it would be somewhat unusual not to have the evidence of one of the Ennis witnesses streamed. 12:34

CHAIRPERSON: Quite.

MR. DORAN: But perhaps then once she has dealt with Ennis we could revert to the normal procedure that is used for witnesses within the staff phase. 12:35

CHAIRPERSON: Okay. Well we can -- I'll re-look at that again. In general terms there were very good public policy reasons for not streaming staff evidence, which I think has actually proven of some benefit for various reasons, but we can look at that individual and see if it's possible to split it up. 12:35

MR. DORAN: Absolutely. And of course as we move towards the later organisational evidence, Chair, that will all be streamed. 12:35

CHAIRPERSON: Yes. Okay. Sorry to interrupt you.

MR. DORAN: Not at all, Chair.

Now that completes my introduction to Evidence Module 6. On completion of the witness evidence relating to that module, the Inquiry intends to move on to evidence relating to Organisational Module 5, RQIA and the Mental Health Commission, on Wednesday, 19th June. And in the final week of evidence then before the summer 12:35

break, that is week commencing the 24th June 2024, we hope to hear evidence in Organisational Module M6 Resettlement, as well as some further staff evidence.

Now, Chair, I wanted to make some comments about that, and I think it's important to say that whilst we will hear evidence in relation to Organisational Modules 5 and 6 relating to the RQIA, MHC, and the topic of resettlement, I think it's important to repeat the comment that I made earlier about Evidence Module 6, and that is that it is neither possible nor desirable to deal with topics of that nature in an entirely compartmentalised way. So, Chair, whilst the Inquiry will hear evidence, for example, in relation to resettlement for the purpose of Organisational Module 6 prior to the summer, one can envisage that the topic of resettlement will feature very prominently in much of the later organisational evidence and, in particular, the evidence relating to operational management at the hospital and also the Trust Board evidence. So I think it's very important to emphasise that even though on paper one might look at the schedule and say, 'well, Organisational Modules 5 & 6 were attended to in the closing weeks of June 2024, it's very important not to lose sight of the fact... 12:36 12:37 12:37 12:37 12:38

CHAIRPERSON: Yes.

MR. DORAN: ...that the opportunity to address the matters addressing will arise at a later stage.

CHAIRPERSON: Yeah.

MR. DORAN: And I think that is generally an important point to make actually as we move towards the break for the summer, because once we have completed the evidence in this term, there is going to be quite a significant period of time in which I think we can all take stock, 12:38
the Inquiry team and Core Participants, just to make sure that when we resume the evidence in September, that nothing has been missed and that proper plans are put in place to ensure that all outstanding issues are properly covered prior to the close of oral evidence in 12:39
the Inquiry.
CHAIRPERSON: I think it may be worth interjecting at this point that I think it is planned also to have another week after the summer of staff evidence.
MR. DORAN: That's correct, Chair. Yes. 12:39
CHAIRPERSON: So if anybody is under the view that this is the staff and we've finished, we haven't, there is more staff evidence to come.
MR. DORAN: There will be more staff evidence in September. 12:39
CHAIRPERSON: Okay. Mr. Doran, thank you for that lengthy and useful explanation. I think the witness has been asked to be here for the afternoon session. So...
MR. DORAN: Yes, Chair. Can I just flag up that 12:39
Ms. Bergin will be taking the witness this afternoon.
CHAIRPERSON: Right. Fine. Okay.
MS. ANYADIKE-DANES: Chair.
CHAIRPERSON: Yes.

MS. ANYADIKE-DANES: I think I heard you correctly to offer the possibility of a meeting with you today? I would very much like that. I think it would be hugely constructive if we could do that, and I don't necessarily mean it's confined to me alone, there's senior counsel here for Group 3 if he would like to participate, but I think it would be helpful, if you could find that time do it? 12:40

CHAIRPERSON: Okay. We'll do that after the witness has given evidence. 12:40

MS. ANYADIKE-DANES: I'm in your hands.

CHAIRPERSON: Okay. Thank you very much. Okay. 2:00 o'clock.

LUNCHEON ADJOURNMENT 12:40

THE INQUIRY RESUMED AFTER THE LUNCHEON ADJOURNMENT AS FOLLOWS:

CHAIRPERSON: Thank you.

MS. BERGIN: Good afternoon, Chair, members of the Panel. This afternoon's witness is Gillian Traub. The statement reference is STM-230. There are no restriction orders. And subject to the Chair, if the witness can be brought in? 13:54

CHAIRPERSON: Yeah. Is it Traub or Traub? 13:55

MS. BERGIN: Traub. But she has indicated that she's happy to be referred to as Gillian.

CHAIRPERSON: Okay. All right.

MS. GILLIAN TRAUB, HAVING BEEN SWORN, WAS EXAMINED BY MS. BERGIN AS FOLLOWS: 13:55

CHAIRPERSON: Ms. Traub, can I just welcome you to the Inquiry. I understand you're happy to be referred to as "Gillian". 13:55

A. Yes, thanks.

CHAIRPERSON: I was going to call you "Ms. Traub". I'm going to hand you over to Ms. Bergin. Thank you though for your statement and thank you for giving up your time this afternoon. 13:56

A. No problem.

99 Q. MS. BERGIN: Thank you, Chair. Good afternoon, Gillian. I have met with you briefly this afternoon and explained to you how we'll be dealing with your

evidence. You should have a copy of your statement in front of you, it is dated 17th April 2024, and at the end you sign the declaration of truth and you have attached one exhibit to your statement called "What is different now?", a report dated 4th March 2021. Now, you have indicated helpfully that there is one small correction to be made at paragraph 4 of your statement, and it should read - if we can bring up paragraph 4 please? Thank you. It should read: 13:56

"In September 2019, I was approached by the Deputy Chief Executive and Medical Director of the Belfast Trust."

A. That's right. That's right. 13:57

100 Q. And subject to that correction, are you happy to adopt that statement as your evidence?

A. Yes, I'm happy. Thank you.

101 Q. Thank you.

CHAIRPERSON: And can I just check, what you've got in front of you is, you've got your statement in front of you? 13:57

A. Yes.

CHAIRPERSON: And anything else or not?

A. I brought some, I brought a copy of my report and some annotated notes that I had handwritten on it. 13:57

CHAIRPERSON: And they're your annotations.

A. They're my notes.

CHAIRPERSON: Absolutely fine. Thank you.

102 Q. MS. BERGIN: Thank you, Chair. And as I've already explained to you, because we all have a copy of your statement and report, I won't be reading your statement aloud, but I will be doing a brief summary in just a moment. The final matter of housekeeping is that you should have a cipher list in front of you? 13:57

A. Yes.

103 Q. And when you wish to refer to a member of staff, particularly those that you can see are already ciphered in your statement, if you could use that cipher, and if in doubt when referring to any patient or staff member, if you could check the cipher list and if you're unsure just ask the secretary? 13:57

A. No problem.

104 Q. Okay? Finally, something I also have to remind myself, if you could speak slowly and clearly into the microphone for the ease of the stenographer. 13:58

So turning to your statement, you outline your qualifications, including a postgraduate diploma in health services management, and a Masters in leadership, and your various professional experiences in various management positions from 2001 to 2019 at hospitals in England and Northern Ireland. Before going to Muckamore Abbey Hospital, you had no experience working in Learning Disability Services, but you had experience in various leadership positions in different specialities. You were appointed as the Interim Co-Director for MAH for eight months between 13:58 13:58

the 14th October 2019 and the 14th June 2020.

Dr. Cathy Jack, then Deputy Chief Executive of the Belfast Trust, was putting together a new management team in view of the significant challenges faced at Muckamore, and as part of this you, and other senior managers, were appointed to various posts. You reported to H786, Deputy Chief Executive, and you outline in your statement that you were well supported by this team and by your line manager. Jan McGall was appointed as Interim Senior Service Improvement Manager and reported to you. H296 remained the Director for Community Learning Disability Services, and they had responsibility for resettlement until June 2020, and H785 acted as a professional nursing adviser to the Belfast Trust during this time and was based on site two to three days per week in early 2020, and their role on behalf of the Department of Health included supporting the Trust to stabilise the nursing workforce and provide expert advice, and as part of the management team that you were working alongside, H315 became Interim Divisional Nurse and H425 was the divisional social worker for Learning Disability Services. 13:59 13:59 14:00 14:00 14:00

You then outline various aspects of your role as co-director, including responsibility for strategic direction of the service, safety and quality, stakeholder engagement, workforce management, and in

addition to this, Dr. Jack had asked you and the new management team to focus in particular on addressing the significant issues highlighted by RQIA in respect of three Improvement Notices issued to the Trust in August 2019, and we will come to those. And to provide assurance that care continued to be safe at Muckamore. 14:01

You were based in the administration building full-time and were on site every day, and you visited the wards regularly to meet with staff, and you also met patients. 14:01

You outline various changes made by your management team, including improvement or introduction of systems for safety, adult safeguarding, staffing levels, patient finances, and improving communication with families, and you were then the Interim Director for Adult Community Services and Learning Disability Services in the Belfast Trust between June 2020 and August 2021, and during this time you prepared the report "What is different now?". 14:01 14:02

Then in 2021, you took up a different Director post within the Belfast Trust, and you left the Trust in 2023 to take up a Director position within the Northern Trust. So hopefully that fairly summarises some of the key points in your statement. 14:02

What I am going to now ask you about are firstly in

this order; your experiences as a staff member at Muckamore Abbey Hospital, and then we will turn to the "What is different now?" report.

So if we could begin at paragraph 8, please? And looking to paragraphs 8 and 9. Thank you. Here you say that when you took up the role of co-director, staff suspensions were impacting staffing levels and the turnover in management team had left staff feeling unsupported and lacking communication, and I've already summarised some of the reasons why you were asked to take on the role. 14:02 14:03

Although you had previous management training and experience, did you have any concerns about launching yourself into what was essentially a remodelling of a learning disability service, given that you had no particular or specialist experience in the learning disability field? 14:03

A. I think naturally I was concerned because I understood that the service was experiencing significant challenges on an unprecedented scale and an ongoing PSNI investigation. So while I have experience of working in different services and different specialities, going into areas where I had no previous knowledge or understanding of the service, while I had some confidence from being able to do that and bring my skills with me, there was a level of concern because of really the extent of the challenge that I understood 14:03 14:03

there to be in Muckamore.

I suppose by way of addressing that, I knew that I wasn't going in on my own, I was going in as part of a team, so a team comprising, as you've said, the 14:04
divisional nurse, who had nursing, could bring a nursing oversight to the service. There was an existing senior social worker already there who had experience of working in Learning Disability Services. We had the professional advisers you've described there 14:04
in the summary of my statement, and a very clear line management into H786 at the time, and a very real sense of a collective approach within the organisation to supporting the management team.

14:04

So being able at any point to bring in assistance from, for example, the Director of HR, the Executive Director of Social Work, the Executive Director of Nursing, Medical Director. So, yes, there were concerns, but I understood what supports were available. I understood 14:05
there was a team approach and there was very clear visibility to the issues in Muckamore, and opportunity for discussion and escalation of any issues or concerns.

105 Q. In terms of the staff suspensions impacting staff 14:05
levels that I've referred to, when you became aware of the impact of suspensions on the service delivery, was there any discussion within the team about whether on balance all of those suspensions were necessary? Were

suspensions something that was looked at by that management team at all?

A. It was very clearly set out for us that our responsibility was in regard to the running of the hospital service, the safety of that service, and managing the risks associated with it. There was a separate process which by nature needed to be separate in respect of the historic abuse, the review of the CCTV, and the decision-making process around the need for suspension, and that happened entirely separate to us and, therefore, we were advised of staff suspensions and we made the necessary arrangements to ensure that any staffing gaps arising from that could be mitigated against. 14:05 14:06

106 Q. We will come to the staffing gaps in just a moment in more -- 14:06

DR. MAXWELL: Can I just ask you about that? So I understand that you weren't part of the decision-making for suspensions, but what you seem to be saying is that one of the unintended consequences of suspensions was that staffing was challenging. Was it potentially unsafe at times? 14:06

A. So when I came into post I think I recall there were 32 Registrants suspended. By the time I left post that had increased to over 60. So that level of reduction of the workforce undoubtably could lead to points in time when we were not -- we were unsure whether we would have sufficient staff to maintain a safe level of care on the ward, absolutely. But that was the 14:06

management task.

DR. MAXWELL: I understand, and I know you're not responsible for it, but we've heard from quite a lot of nurses giving evidence that actually at times there weren't any RNLDs on the ward, that they were down to one or two registered nurses on each shift. That doesn't sound like safe staffing to me. 14:07

A. I think the separation between the two was important, so that a decision around -- so the decision of 'Was the threshold met for suspension?', had to be answered separate to the question of 'Can we maintain a safe service?'. 14:07

DR. MAXWELL: Yes.

A. But, yes, it left us on occasion with challenging staffing levels, which were not ideal. 14:07

DR. MAXWELL: Which were not safe.

A. No.

DR. MAXWELL: Would you characterise it as not safe at times?

A. I would say on occasion we would find ourselves in situations when there was not a safe staffing level, as determined by our staffing model. So we put in place a staffing model to give us a framework to assess that, and that informed us around that, and then you tried to -- you took as many steps as you could to try and address it, but it was day to day. 14:07 14:08

DR. MAXWELL: Thank you.

107 Q. MS. BERGIN: Thank you. We will come on to the staffing levels in a little bit more detail in a moment

also. But in terms of the reference that I've already referred to about staff feeling unsupported and lacking communication about what was happening when you first arrived, potentially around those suspensions, did your management team take any steps to try and address those issues with the staff that were there?

A. I mean the lack in communication around what was happening for me was greater than the issue of staff suspensions. I think staff understood that they would not be forewarned that staff were being suspended, and actually nor were the management team. The management team were advised of a suspension when it happened. I think we were able to explain that to staff.

In terms of lacking communication about what was happening, that extended to, for example, the future of the hospital. It extended to PSNI investigation, the totality of what was happening in relation to Muckamore. The first day that the management team arrived on site in Muckamore happened to be the day of the first arrests of staff that took place, which was then documented in the media, and that was an example where staff felt 'Oh, we didn't know that that was going to happen', and obviously these were previous colleagues of staff members in Muckamore Abbey Hospital. Again, it was for us as a management team to explain 'Actually, it's not within our remit, we will not know that either, but let me explain that to you and this is', you know, we could help the staff to

understand the framework within which this was happening. And that when we did, we did put in place regular communication with staff, recognising that there was so much of what they were experiencing was being played out in other forum, for example, in the media or in the news, that it could leave them feeling, you know, that they weren't being communicated with. So it was trying to clarify what they could know and what they couldn't know.

14:10

108 Q. Between paragraphs 9, and then 11 and 13, and I don't expect you to be able to glance through all of those, but that's where we're focusing on now, you describe aspects of your role as ensuring systems were strengthened, and one example is strengthening systems in relation to understanding staffing levels and workforce, and another one is to ensure systems were in place. So this seems to be describing not only strengthening what's existing, but also introducing new systems. And in terms of patient safety in particular, you have outlined helpfully in your statement I suppose a list of measures or systems in place. For example, site wide daily safety briefs. A weekly safety report being circulated to staff management and the Trust Board on a monthly basis, including, for example, analysis of the use of restrictive practice, and contemporaneous CCTV reviewing reports. Were these, for example the patient safety systems, were these systems all in place prior to your arrival, or were these systems that were strengthened, or was it a

14:10

14:10

14:10

14:11

mixture of both?

A. It was a mixture of both. It was a mixture of both. And I think there were a number that had been in maybe a number of months, and I suppose coming in new as a management team, even though the systems and processes were already there, it was incumbent on us to review them and reflect on them to see if we could improve them. But I would say it was a combination. There were definitely systems and processes that had been introduced before we came. 14:11

109 Q. In terms of the RQIA inspection, and we will come to it in more detail, but you say at paragraphs 13 to 15, that there was robust reporting, recording, and analysis of the use of restrictive practice, and this is during your time, and there was a focus on reduction. The RQIA inspection in December 2019 determined that the hospital seclusion policy and procedure had been updated and there was strong governance, a significant reduction in the use of seclusion, and you give an example of establishing a Reducing Restrictive Practices Steering Group in 2019. What did the analysis of restrictive practice entail? What was actually being collated and analysed? What type of information? 14:12

A. Okay. So it's largely set out in my Section 13. We had a dataset of the various aspects of restrictive practice which may have been occurring on site, and they range from, as they're stated there, the use of seclusion as a restrictive practice, the use of 14:12

voluntary confinement as a restrictive practice, the use of physical intervention as a restrictive practice, the use of rapid tranquillisation, the use of restraint as a restrictive practice, and the use of medication, PRN medication as a restrictive practice. So there was a dataset which was, data was collated weekly in respect of the use of these practices, and ultimately the role of the group was to further -- to take that analysis further. But the weekly collation of that data looked at the week that had just passed, but also in the safety report there was analysis over time and analysis of themes, so that we could understand not just the detail of what had happened in the last week, but we could understand whether that represented an improving position, or a deteriorating position, or whether, you know, it allowed us to analyse to understand do we need to go further? Do we need to go back and look at something in more detail? We tried to have a systematic approach to the analysis of the data. 14:13 14:13 14:13

CHAIRPERSON: Could I just ask about that? Sorry, you're looking at data which means records. 14:14

A. Yes. No, not care records. So we're looking at, for example with seclusion, the number of times that seclusion occurred on site in the last week.

CHAIRPERSON: Yes. But you are gleaning that information? 14:14

A. Yes.

CHAIRPERSON: From a record?

A. Yes.

CHAIRPERSON: Yes.
DR. MAXWELL: A record or an audit form?
A. It could be -- so it could be either. I mean audit, we did seclusion audits monthly. So they actually supplemented the weekly analysis of seclusion. But the reporting of the use of, for example, physical intervention, came from records at ward level. So there's a variety of inputs to the data. 14:14
CHAIRPERSON: So what your analysis relied on was people recording seclusion and restraint accurately? 14:15
A. Yes. Yes.
CHAIRPERSON: Yes. Thank you.
DR. MAXWELL: And when you had done your thematic analysis, what change in practice did that lead to?
A. In a particular area or in any? 14:15
DR. MAXWELL: Well, just some examples, because you know, to quote various people, you can't inspect quality into a service. That just monitors what's happening. Actually changing practice is different.
A. I suppose if -- some of the analysis we also did was in relation to adult safeguarding incidents, it's not quite as restrictive -- it's not restrictive practice per se, but we were able to utilise some of the thematic analysis there to make changes at ward level to reduce opportunities for interactions between 14:15 14:16 patients, or to look at where were occasions within the day when we were more likely to experience patient-on-patient interaction, and we looked at amendments to meal times, and staggered meal times for

individuals, and staggering times when patients were on the ward. So there was some strategies taken at patient level in relation to that.

DR. MAXWELL: So was it possible to do that with this very challenging staffing? I can imagine that you would look at your thematic analysis and your safeguarding and say 'Well, clearly, this was a trigger. If only staff were engaging them or separating them.' But then you've also told us that it was sometimes unsafe staffing. How did you resolve the challenge between knowing what best practice is and implementing it? 14:16 14:16

A. I think that was, that was the lived experience of trying to manage that service safely and compassionately with the resources of the staff that we had and didn't have, and their experience. And I think on some occasion we achieved what we set out to do in terms of making those changes, and on some occasions we may have achieved it for a period of time and then they may have, you know, it could have lapsed because of the staffing challenge. I think it was very much a day-to-day, week-by-week, and I think that was part and parcel of why an additional management presence or input was required, because of the attention to detail needed by everybody, because it was such a fluid situation and a very vulnerable situation for everybody. 14:17 14:17 14:17

110 Q. MS. BERGIN: Thank you. In respect of the analysis of restrictive practices, you've discussed I suppose

tracking that and analysing that. Did that also include, or could that be broken down to, for example, how frequently a particular patient was involved in a restrictive practice, or was it more general in terms of how frequently restrictive practices were just being used on particular wards? 14:18

A. From memory there was a patient, also a patient that was anonymised, but there was an ability to analyse that by patient, because the use of seclusion would have by necessity been in the care plan of that individual, and therefore you would understand, you would expect to see seclusion only in the instances where those individuals was documented in their care plan. So it was important that we understood who seclusion was being used for at that patient level, and that the MDT associated with that ward of that patient would be reviewing those seclusions and reviewing them and reviewing the care plan after each event. 14:18 14:18

111 Q. So that analysis was then being fed into that patient's medical team? 14:18

A. Yes. Yes, absolutely. And at ward level in the MDT as well as at a managerial level.

112 Q. In terms of the site wide daily safety brief, you've already provided some context in respect of staffing levels, but one of the aspects of that was to review staffing levels for the next 24 hour period to help identify any areas that required staffing support. So this is one of the measures that was brought in by yourself and your team. Did this daily brief identify 14:19

for the next sort of shift, or the next day, what the levels of learning disability staff looked like?

A. So I routinely would not have been present at that huddle. That huddle would have been led by the Service Manager and lower managers attending with the service managers, and with the divisional nurse in attendance. So I wasn't a regular attender. But did it look ahead to the next period of time in terms of the staffing levels? Yes, it did, to understand the skill mix that each ward would have or expected to have. So you could be trying to plan ahead the next morning. So as you're looking ahead, the next morning you'll be 'Well, do we have everyone who we expected to have yesterday and where are we now if someone has phoned in sick or something had changed?', and then you take stock again, and you have to continually take stock of that situation. 14:19 14:20 14:20

113 Q. Okay. And you've indicated that the weekly safety report included contemporaneous CCTV viewing reports?

A. Yes. 14:20

114 Q. Was contemporaneous CCTV viewing something that was occurring right up until you left Muckamore?

A. Yes, it was.

115 Q. And when we talked about earlier the robust reporting, recording and analysis of the use of restrictive practice, did that CCTV viewing filter into that analysis in any way? 14:20

A. So when I first came in, when we came in as a new management team, the contemporaneous CCTV recording was

in the safety report, and I suppose we took stock of that and looked at that to see how could we improve how we were using that information. Because, yes, it was included in a safety report and it was maybe discussed at ward level, but we felt there was -- we could do more with that information. So we actually introduced a step in that process. We worked with our CCTV viewers on what they were recording and then we introduced a step whereby there would be a QA with the adult safeguarding team and the management team, and an analysis and an agreed action plan if there was any concerns on the CCTV. So over time within the safety report you would have had the account of the independent viewer and then the determination as to any actions required, whether that was an adult safeguarding investigation, or noting good practice, or for management team to pick up maybe if there was a management practice issue, but not necessarily a safeguarding issue. So we tried to strengthen how we used that information over the first six months that I was in post. 14:21 14:21 14:21 14:22

116 Q. So was your team involved then in a change essentially, or changes, to the CCTV policy or CCTV viewing?

A. Yes. When we came into post, yes. So I established a CCTV reviewing group, or a group that would look at that system and process of what had been in place. I talked to the CCTV viewers. There was some suggestions that they had around second screens, or making their, making what they were doing more effective, and we just 14:22

tried to improve that and strengthen that process, from the point of view of the staff themselves maximizing any learning, and also being assured that anything that they found that was of concern was being acted upon in a timely way. So there was a series of changes made over a number of months in relation to that.

117 Q. The Inquiry may already know the answer to this, but I am going to ask you just for the purposes of your evidence. So was there an updated, for example, written policy on CCTV viewing during that stage, or was it more that you were putting in place processes practically? 14:22 14:23

A. It was practical changes I suppose ultimately. So there was the original CCTV policy, as I understand it. I can't recall the date. There was then an addendum made to it in 2019 to extend its remit to contemporaneous viewing. Because as the policy was originally written, it purely was for the purposes of investigations into adult safeguarding. So the addendum in January 2019 widened the scope to contemporaneous viewing within the policy, so that that was the extant policy then when I came in. 14:23 14:23

One of the areas that was being considered, it didn't come to fruition when I was in post, was could the CCTV be used for training for staff and to support staff in their training and learning, and ultimately we were aware that if that was a direction of travel, the policy would need to be updated to reflect that, 14:23

because it had -- the scope of the policy was really key, you know, to the governance framework around that.

DR. MAXWELL: So the policy, the original policy, which I think was June 2017, didn't allow for using CCTV for educational and development policy, and the addendum in 2019 didn't allow for that either? 14:24

A. No. It extended its scope to, yes, the contemporaneous.

DR. MAXWELL: The contemporaneous. Without there being an identified concern? 14:24

A. Yeah.

DR. MAXWELL: Thank you.

118 Q. MS. BERGIN: If we could turn to paragraph 15, please? And here you outline that in 2019, the East London Foundation Trust visited the Belfast Trust to share 14:24 best practices. Do you know how often this sort of visit by another Trust had occurred before this?

A. You mean specifically the East London Foundation or more generally?

119 Q. Any other Trusts coming to visit the Belfast Trust to 14:25 share knowledge?

A. Beyond Learning Disability Services? Sorry, yes.

120 Q. Yes.

A. I mean I think that that is not uncommon. I think what was maybe, you know, services, we would all be 14:25 encouraged as leaders and managers of services to understand where there might be good practice outside of Northern Ireland, and to reach out and ask for support or input that may or may not be a visit. So I

think that's a fairly standard approach. I think this was possibly just slightly different in that the Chief Executive of our organisation had specifically asked for an organisation to come in very formally to assist us with Learning Disability Services.

121 Q. And what did that look like? What was the benefit, if there was one, of that process?

A. In terms of East London?

122 Q. Yes.

A. I mean I came into the service after the engagement piece, and the visit and the report had taken place. But that was the hoped for benefit, that we had gone to a Trust, which was recognised to be good practice in terms of Learning Disability Services, and that they had come in, assessed our arrangements, our environment, our workforce, talked to staff, talked to managers, professionals, clinicians, and given us an assessment of where they felt we were doing well and where they felt we could improve. So it was the aim to improve.

CHAIRPERSON: I'm just trying to get a sense of how common this was.

A. Yes.

CHAIRPERSON: Because I know some Trusts in England, and Dr. Maxwell probably knows much more about this, but I know some Trusts in England have a sort of buddy system with another Trust.

A. Yes.

CHAIRPERSON: And they will effectively not inspect,

but they will look at each other's practices. Do you have something similar in Northern Ireland?

A. No, not to that degree. It was very much for an individual Trust or service area to think 'Actually, that would be a useful thing to do'...

CHAIRPERSON: And actually outreach to somebody...

A. Yes.

CHAIRPERSON: And say...

A. Yes.

CHAIRPERSON: Yes. So, again, can I just come back to it. Before this event, how often had it happened in the last five years, do you know?

A. No, I don't know. I don't know. I'm sorry.

CHAIRPERSON: No. Fair enough. Okay. Fine. Thank you.

DR. MAXWELL: Can I just clarify then? You've put in your statement that they came to share best practice, but I think what you're saying is they came to do an assessment?

A. I think there was two strands to that.

DR. MAXWELL: And was there a written report of their assessment?

A. Yes, there was.

DR. MAXWELL: And so that should be available to the Inquiry if we want it?

A. Yes, it is. And a set of recommendations.

DR. MAXWELL: And did they follow up? Because East London Foundation Trust are getting a bit of a reputation for going around England doing this. Did

they ever follow up with the Trust, or was it just a one-off?

A. I think they came and they did a report. A number of us went and visited them in my time. And I think latterly since, since I left I understand they've had some involvement in resettlement, but that's... 14:28

DR. MAXWELL: So there has been an ongoing relationship?

A. There has. There has been, yes.

DR. MAXWELL: But you're not entirely sure what happened after you left? 14:28

A. No. But I understand it was in respect of resettlement.

123 Q. MS. BERGIN: Thank you. At paragraph 16 you outline some of the actions which were taken to ensure that staff understood adult safeguarding procedures, and you say that there were systems in place to deal with adult safeguarding referrals, adult protection plans were put in place, and some of these systems included training, reporting and MDT reviews. In terms of staff training, did existing staff then receive additional adult safeguarding training? Was there on update to the adult safeguarding training? 14:28 14:29

A. This was one of the areas where there had been a significant amount of work led by our divisional social worker H425 before I came in, myself and the team came in, and there was a programme of training for all staff on site in adult safeguarding. I don't know the detail other than to say I expect for many that that was a 14:29

refresher or an update from a pre-existing training, but we took the opportunity at that time to put everybody, insofar as we could, through training, bearing in mind some of the challenges with turnover, and that was part and parcel of preparation and responding to, sorry, responding to the RQIA Improvement Notice on safeguarding.

124 Q. In terms of the chronology of changes or improvements that were being made, just picking up on the visit by the East London Foundation Trust also, so are you saying that there were essentially a series of recommendations made earlier in 2019, and then yourself and the other members of the management team had then been approached to come in to Muckamore to essentially I suppose carry forward some of those recommendations, or some of them, as you've indicated, by the senior social worker were already in track?

A. I think -- so there was the RQIA inspection earlier in the year, which led to the three improvements notices. So as soon as the RQIA had reported on its concerns and put the notices out, then there was activity associated with trying to address those, of which one of them was, as I've described, the adult safeguarding piece, so that had started and considerable work had been done. In parallel to that, there was the East London piece, but they were two distinct pieces, and work had started in relation to both of them. We came in and we were continuing that on, or supporting that work, or adding to it.

125 Q. Okay. Thank you.

DR. MAXWELL: Can I ask about the safeguarding training? Because by this time you were using quite a lot of agency staff, and I understand a lot of them -- I think at one point there was block contract for 50 agency nurses -- how they were trained, because safeguarding is slightly different in Northern Ireland from England? 14:31

A. I couldn't be entirely sure on my accuracy on this point. 14:31

DR. MAXWELL: Okay.

A. I would be surmising. My sense is that we put all of our staff, whether they were substantive or agency, through the same training, because the legislation is the Northern Ireland legislation and, therefore, they needed to understand the context that they were working in. But I... 14:31

DR. MAXWELL: Okay. We can ask someone else about that.

A. Yes. Thank you. 14:32

MS. BERGIN: At paragraph 17 then, please, and here you outline that you reinstated and then co-chaired the Carers Forum, and there were three meetings before they stopped due to Covid-19 pandemic, before it was reinstated in 2021 by H627, and one of the purposes of that forum was to receive feedback and look at ways to improve care and services for patients, and your colleague, H627, oversaw carers questionnaires being issued to families and carers. 19 of the 48 were 14:32

returned and an action plan was developed to address some of the issues which emerged. Do you know what types of issues emerged from those engagements?

A. From the carers questionnaire? There was a very clear sense. So I think it was 66% of Respondents in those questionnaires were positive around the care and experience of their loved ones and their experience as a family member. But there was a very -- it was the remaining two third were indicating that more, the Trust could do more to support them as a carer, so give them more information, and also to give them more information around what other supports were available to them as carers. So that was one example, and that came across quite strongly. 14:33 14:33

126 Q. And in terms of any other engagement with relatives, outside of simply their being carers, in terms of that support, did your management team undertake any specific work or engagement with relatives in respect of patient care itself, in terms of how they were -- what their experiences were at Muckamore? 14:33

A. I suppose not per se. The clinical team and the ward team, we would encourage them to have regular and ongoing communication and involvement with families around their loved one's care. That was really fundamental. And families were, on occasion, you know, would raise on occasion their concerns around information not being timely, or how we could improve communication, and on those occasions then one or two of us as a management team might meet with a family 14:34

member if they didn't feel that a concern was being resolved.

127 Q. And in terms of those issues that were, I think you said by the one third raised about more support for them as carers, were any actions then taken to... 14:34

A. I mean part of our work, and it is referenced in my statement, in terms of the recruitment of a care involvement lead was really that there was so much that we couldn't recognise that we could and should do in support of carers in trying to create an ongoing 14:35 communication with them. So the ward level communication, and then as a management team, given all that was happening in relation to Muckamore. So we wanted to bring in our care involvement lead, and then when she came in latterly then she really, I think, 14:35 part of her remit was to say 'Well, how could we' -- reaching out to carers and families saying 'What is it that you need from us? What actually can we do to help you?' So that really got probably work started in detail when the individual was appointed as the carer 14:35 lead and involvement lead.

128 Q. And at paragraphs 23 and 24, and also within the exhibit, but I'll come to that later, you outline that, and we've discussed it briefly, shortly before you started at Muckamore there were three RQIA Improvement 14:35 Notices. They were in respect of firstly, workforce management of staffing levels; secondly, adult safeguarding, and, thirdly, patient finance. And the first RQIA unannounced inspection took place in

December 2019, which was within the first three months of the new management team's arrival. Now, in respect of the management of staffing levels, the first of those, you say here that:

14:36

"RQIA's concern was that nursing teams did not sufficiently understand the staffing levels and skills mix required to provide safe care."

And we've already discussed the staffing model that you developed with the divisional nurse to enable staff to assess staffing levels on a shift by shift basis. You say that: 14:36

"Subsequently, the RQIA inspection determined that whilst staffing levels were not where they should be, there was a robust approach based on this new model." 14:36

And as Dr. Maxwell has already asked you about in relation to 22% of Band 5 Registrants being Trust staff at one stage, the Trust then had a contract with a direct health care to provide registered nurses who were block-booked, and you also indicate here that there was progress in recruiting senior nursing positions in 2019 and 2020. 14:36 14:37

So, it seems that the assessment of what staffing levels were required had improved somewhat, but was the issue with staffing levels actually sorted out or was

the hospital not still very reliant on agency staff?
DR. MAXWELL: Before we get to that, can you help me understand what this new staffing model was? Because I've heard people talk about it and I don't really understand what they mean. People just constantly say Telford, and Telford is actually based on professional opinion. 14:37
A. Yes.
DR. MAXWELL: And then you add the on costs.
A. Yes. 14:38
DR. MAXWELL: So how was this model different?
A. So I suppose I'll start by saying I am not a professional nurse, and I was very heavily reliant on my divisional nurse and nursing expertise in that regard. So as I understand it, it was based on Telford, which does apply a professional judgment, and it was then supplemented by what was unique in this regard in Muckamore, which was the use of non-Registrants for one-to-one or for observation. So there was an element of it which was core, and then there was the patient by patient or ward assessment of what may be required to supplement that. 14:38 14:38
DR. MAXWELL: But we have heard from nurses telling us that from the '80s onward they were using Telford, and we've also heard just this morning that actually they were already adding to that when there was enhanced supervision. 14:38
A. Yes.
DR. MAXWELL: So I'm really -- and you may not be the

right person to answer this, but I'm really struggling to know how a model that was essentially the same was any different?

A. Again, as a non-professional, each ward manager's budget or funded staffing level for nursing within Muckamore had probably -- my understanding, had been set at a point in time in the past when the patient numbers were obviously much higher than they were in 2019. So there was an element of this which was about saying, well, actually that level of reporting and understanding or funded staffing level, which is what you should have in theory at a point in time has moved on. So for your eight patients that you have today, actually this is what we now think you need to work to, because the historic piece around that was potentially muddying it because it was so out of date. So it was paring it back in a way and bringing it to the point of 'Well, you've got eight patients and this is their observation level. Patient 1, 2, 3, 4, 5. If you add that on to your Telford, this is what we feel you should have by way of a funding staffing level, and this is what it might look like on a shift', and then that is the information that came into the safety huddle to say 'I believe I should have five Registrants and eight non-registrants and I don't today.' 14:39 14:39 14:39 14:40 14:40

DR. MAXWELL: So are you saying that when this, after the RQIA Improvement Notice and staffing was re-examined, the establishments for each ward were increased?

A. No, they were clarified. They were clarified.
DR. MAXWELL: So did that result in an overall increase or decrease or no difference? Or did it vary from ward to ward?
A. I think there were a number of wards, from memory, that were there or thereabouts where we felt they should have been on paper, and I'm talking about on the model. I think there was a number of other wards where there was one where we felt there could have been additionality and one which we felt actually we could probably make some changes and reductions here. But it was tied in to also the review of those observations, so at patient level, you know, asking ourselves 'This patient has been historically on a three to one. Can we understand, can the MDT just review that and reassure us or assess that that is still required and that's an appropriate level of -- what effectively is also a restrictive practice?'. 14:40 14:40 14:41
DR. MAXWELL: Okay. So there was this whole issue about how many were funded for, which on a few wards was just about right, and some were tweaked a little bit. But then there was the second problem that although you had the money, you couldn't fill the posts? 14:41
A. Yes. Yes. Yes. And it was -- the aim was to give us the ability to describe and to find the extent, was there a -- the extent of a workforce shortage on a ward, because we had a measure, and we could then communicate that where we needed to communicate it to, 14:41

including to outside of the organisation.

129 Q. MS. BERGIN: And so, was the hospital then still very reliant on agency workers?

A. Absolutely. Absolutely.

130 Q. And in terms of the profile of those workers, were they mostly overseas workers? Were they learning disability trained? 14:42

A. From memory the majority of them were mental health trained.

131 Q. Not learning disability? 14:42

A. Not learning disability trained.

132 Q. Okay. In terms of that skills deficit then around specialist learning disability, what, if any, steps were taken to try and meet that?

A. I mean, I think this was a work in progress and it continued on after I was the co-director. In support of the individuals coming in to their organisation and understanding, you know, appropriate induction arrangements, similar to preceptorship arrangements, so support over a period of time, that was challenging, because on occasion we could have been so short staffed that you were reliant on the individual coming in, but it could have been their first time in Muckamore, but trying to create the space for a supported period when they arrived. Helping them to get to know the individual patients that they would be caring for, having access to care plans, being able to observe other staff I suppose, and I think that was, you know with time the benefit, if I can call it that, of having 14:42 14:42 14:43

a block contract, was that we were trying to address the temporary nature of agency staff by saying 'We want to retain these staff for as long as possible because we need them' and, therefore, they are less temporary, and you can invest in them and develop them and support them, and they develop experience in Learning Disability Services and individual learning disability, if they don't arrive with it. But it was a challenge. 14:43

133 Q. Was any type of actual learning disability training provided to any of those staff? 14:43

A. I can't recall in all honesty. I would probably not be the best person to ask that question.

DR. MAXWELL: Can I ask then, you know, they're coming from another country, they're not learning disability, we've heard quite a lot of them were overseas trained and not UK trained. So it was quite a lot for them to take on board. Did the Trust fund supernumerary status for a while, while they adjusted, or did they come straight in and they were in the numbers on day one? 14:44

A. So I don't -- I couldn't be confident in answering that question. I think there was a desire to give them some time when they arrived to be supernumerary, as much as possible. 14:44

DR. MAXWELL: But you're not sure?

A. No. 14:44

DR. MAXWELL: To what extent?

A. No. No.

CHAIRPERSON: You were asked about the deficit around specialist learning disability and you said -- you

started off by saying "it's a work in progress".

A. Yes.

CHAIRPERSON: But does that really mean they were on the job and discovering -- they were learning on the job? Is that what that really came down to? 14:45

A. I think in terms of learning disability, even if we had been consistently able to provide them with a period of supernumerary status, that would have been, if achieved, a number of weeks. They would -- that is not sufficient. So really it was only through time, and 14:45 experience, and exposure, that they would develop more of an understanding and experience around Learning Disability Services with time.

CHAIRPERSON: I understand that. But for that to work, do you not need learning disability specialist nurses 14:45 or health care workers there at the same time?

A. Yes.

CHAIRPERSON: Did you make sure there were?

A. Again, I wouldn't have been operating at that level of detail around the management of those rotas. 14:45

CHAIRPERSON: Okay.

DR. MAXWELL: Can I ask one more question, and I appreciate you may not be able to answer this, but I appreciate the intention behind block booking...

A. Yes. 14:45

DR. MAXWELL: But as we've heard from witnesses, there's no obligation on an agency nurse to stay beyond the shift they're on.

A. No. That's right.

DR. MAXWELL: And we've also heard that whilst some stayed for a significant time, some did a week and said "not for me".

A. That's right.

DR. MAXWELL: So do you know what percentage actually stayed for a long time? 14:46

A. I don't. I don't know the percentage.

DR. MAXWELL: But that's potentially something the Trust should be able to supply?

A. Yes. Absolutely. And I do know of a number of staff that stayed. When I was there, there were numbers stayed, had been there a year or more, a number I saw being promoted, you know, and really establishing themselves as a resident in Northern Ireland effectively. But equally there definitely were a cohort who didn't appreciate what they were coming to and for whom very quickly apparent that it wasn't for them, and we wouldn't want anyone to stay who didn't feel it was for them. 14:46

DR. MAXWELL: So the contract was for the agency to supply 50 nurses. 14:46

A. Up to 50.

DR. MAXWELL: Ideally the same, but the contract couldn't enforce that, so it could be 50 different people. 14:47

A. Yes. I suppose I am just speaking from -- in practice I am aware that there were a number that stayed for a long period of time.

DR. MAXWELL: Yeah. Yeah.

A. But equally we had no ability to hold them to anything.

134 Q. MS. BERGIN: You then outline the number of measures to try and bolster new staff numbers, and one of those was a Directive from the Department of Health in October 2019 for other Trust to provide learning disability nurses to work at Muckamore, but only three or four staff came and they worked part-time. Didn't that Directive really just remove staff from one Trust or another department that needed them? So how successful was that? 14:47

A. Well I think as you can see, the intension was the provision of up to six nurses from each Trust, which would have given a cohort of up to 30 nurses, if successful, and the reality was we had a very small number, the majority of whom already had employment, obviously, with another Trust and, therefore, where they were able to help us they were doing it as additional hours, or additional shifts, which is really hence why it was part-time hours. So it was largely unsuccessful. And it was in the context, as I say there, that Northern Ireland was not, you know, had a challenge with learning disability nursing levels. Muckamore was not unique. We had a very extreme deficit, but other Trusts were also operating with vacancies, and so therefore were not plush to provide. 14:48

135 Q. In terms of how long those few nurses that did come stayed for, do you have any idea?

A. There was a variety. A number -- there was a number -- there was one or two that may have been a number of

months. I don't know. I don't know the detail. It was a variety, because it was so individualised to the personal circumstances of the person, and effectively they were coming forward to volunteer to help.

136 Q. Another measure was a 15% pay increase, but that was stood down in 2020. Again, how successful was that at recruiting anyone? 14:49

A. That was difficult to quantify, because did we find ourselves in a period where no staff member left during this time when they were getting 15%? No, we didn't. Did it provide a morale boost to staff when it was introduced? It undoubtedly did. Did it feel like a loss from staff when it was removed? Yes, it did. Did it address retention? No, it did not. But I understand that this has since been reestablished actually as a measure. 14:49 14:50

137 Q. Well, I was going to ask why was it stopped, and could you tell us then if you know anything about it being reestablished?

A. I think it was -- you'd have to ask the Department probably for the exact detail of why it was stood down. We understood at the time that it was to be an interim measure only and it would be reviewed, and I would understand the review. The review of it was that they couldn't confirm that it had addressed the issue and, therefore, could be removed. 14:50 14:50

138 Q. You say that exit interviews were conducted with staff who were leaving to understand why they were resigning. Can you recall what the main reasons or recurring

reasons were that staff were leaving?

A. I think there were a variety of reasons. There was a number of staff who retired. It was their time for retirement. There was a number of staff who were promoted, were leaving for a promotion. A number of staff who left to go closer to home or to work in a different Trust for personal reasons. There were a number of staff who said that their decision was retirement was expedited by the situation of working, the challenge of working in Muckamore and continuing to work in Muckamore. So there were a variety. 14:51 14:51

In terms of the staff for whom they referenced working, you know, their working life as a factor in their decision-making, that was in part due to the scrutiny that they were under, the uncertainty for their job, and the challenge of continuing to try and provide safe and compassionate care, with all of the factors that we've heard about today that went into making that difficult. 14:51 14:51

139 Q. Thank you. If we could look at paragraphs 26 and 27, please? Here you outline the steps that you yourself and the interim senior service improvement manager took to develop an action plan trying to tackle the issues raised by the RQIA Improvement Notice about patient finances, and you outline some of these steps, and I won't list them all, but these included a dedicated finance liaison officer, with spot checks on them. Introducing financial audits and meetings with patients 14:52

and relatives. You say that:

"When RQIA carried out the unannounced inspection they were satisfied with the progress made at MAH."

14:52

I appreciate that the RQIA Improvement Notices were before you started at MAH, but why do you think it required an Improvement Notice for MAH to realise there was an issue or, indeed, to act in relation to patient finances?

14:53

A. I couldn't answer that question, I'm sorry. I wasn't there at the time.

140 Q. Well in terms of the fact that the systems or the improvements, shall we call them, that you oversaw...

A. Yes.

14:53

141 Q. Were many of those already in place at the time? Or what did the landscape look like in terms of patient finances before you arrived?

A. So it was patchy, I think it's fair to say. So there was some very good examples where there was good documentation in relation to patient finances, finance plans for patients, financial capacity assessments, some good practice at ward level around management of monies. But it was not consistent and was incomplete in some instances. So every patient, you know, the number of patients who we would have expected to have a financial capacity assessment, we might have found a percentage of them did have it, but a percentage did not. So it may have been that there was systems and

14:53

14:53

processes introduced at a point in time and that they had lapsed in some instances. I would suspect that the turnover at many levels within the hospital from at the ward level, ward manager level, Assistant Service Manager level, would have taken some attention off this issue potentially. So we had to bring back the focus and the training that was necessary to refresh people on what their roles and responsibilities were. 14:54

142 Q. At paragraph 28, please, you say that when you began at Muckamore in October 2019, there were 53 in-patients. Responsibility for resettlement was retained by H296. But you also reported at a high level on resettlement progress to the Trust Board. What were the challenges to resettlement during your time at Muckamore? 14:54

A. So, I suppose I took on responsibility as when I came into the Director post overall for resettlement, which was in June 2020, really which was in the mouth of Covid-19, and that undoubtedly delayed significantly progress in relation to resettlement from a very practical point of view. For example, around reducing footfall onto the site going into other facilities, and in terms of the management attention needed to keep the site and our patients safe during Covid-19, and the number of outbreaks that we had to deal with. So there was a slowing down in that year around resettlement. 14:55 14:55

More broadly, the challenges in relation to resettlement I think are well described elsewhere, but really a lack of provision in the community for

resettlement of some very complex individuals. And again in my report to Trust Board, I talk around also the internal expertise and experience around planning and preparation for resettlement, and again we had lost a little bit of ground there around having the attention and the expertise to drive some of that forward. 14:56

143 Q. I think we're going to come to the report in just a moment, but I think one of the aspects of that report, if I am correct, is that essentially responsibility for resettlement rested with one person, and when they retired, a lot of that expertise went. Is that correct? 14:56

A. It was really the -- they didn't own the responsibility for resettlement, but they provided a core function in that process, which was around bringing a planning eye to it, understanding the needs of the individual, and looking for options for individuals and bringing a planning approach business case discussions with providers, et cetera, so that they -- and they had an expertise around that. So that particular function had been lost for a period of time, coupled with Covid-19, had a part to play for about 12 months or more. 14:56

144 Q. Okay. Thank you. Another aspect of your role as Interim Director from June 2020, was that you became responsible for raising any early alerts to the Department of Health. What is the early alerts system? 14:57

A. It's a system whereby the Trust will notify the Department of Health of an issue as set out in the

criteria for an early alert, and I don't have them to hand. But, for example, if there was an issue of particular significance, possibly involving patient harm where there would be police involvement, then that may meet for criteria for an early alert. You'd want to make the Department of Health aware that this had occurred, where you might anticipate there could be media interest in a particular issue within an organisation, you may feel that the threshold for an early alert has been met, and you would complete the early alert notification, you would telephone a named contact within the Department of Health to talk to them about their alert, and then it would be submitted through -- and I think other agencies have sight of the early alerts when they're submitted, such as RQIA, the Health and Social Care Board, as it was then. 14:57 14:58 14:58

145 Q. In terms of, you've said, completing the form and making the referral onwards, who decided whether something met that criteria that you've referred to within Muckamore? 14:58

A. So ultimately if one of my team raised an issue to me, or I was aware of an issue, I would take a view as to whether I felt it met the criteria for an early alert and the decision would be with the Director at the time. If there was a doubt, it would be good practice to talk to maybe the Deputy Chief Executive, Chief Executive, just to say 'look, this feels to me that it would be important to raise this', and you could sort of QA that if you felt -- if you weren't entirely sure. 14:58

But it was the Director's responsibility.

146 Q. And how frequently, if at all, were you involved in relation to early alerts during your time at Muckamore, or even before when you weren't directly responsible for raising them but were still in a management position? 14:59

A. Yes. Not infrequently. You know, it could be every couple of months. There may or may not have been an early alert or discussion around one. So. And prior to coming to Muckamore I would have had experience as well of the system of raising an issue. 14:59

147 Q. Without necessarily going into the specifics of a particular patient, but can you give us some examples of the types of I suppose incidents that would fall into early alert, as opposed to, for example, something that falls into serious adverse incident, or maybe they're parallel, or one follows the other? 14:59

A. So, they've different criteria. So you could find that an issue meets the criteria of an SAI, but it could also meet the criteria for an early alert, but not all SAIs will necessitate an early alert. 15:00

148 Q. Okay.

A. So it's a case-by-case assessment and guided by the early alert criteria. So if you had a concern that -- in Muckamore, it was, I suppose Muckamore was possibly unique in this regard because so much of it was in the media, and part of the criteria for the alert might be that consideration that an issue happening in the hospital might attract media attention. So you could 15:00

find yourself more regularly thinking 'Should we put an early alert in here so the department is aware of something that might find its way into the media?'.

CHAIRPERSON: So is it more focused on reputational issues? I'm sure we'll get the criteria, so don't worry, but was that your understanding or not? 15:00

A. An early -- yes, I think that's an element of it. Absolutely. So the Department of Health, we would not want, as a Trust, the Department of Health to learn about an issue, a significant issue in our organisation that we hadn't briefed them about. 15:01

CHAIRPERSON: Yes.

A. And I think it was also about that, the ability to brief. Because something gets played out somewhere else it may not be exactly the full set of facts. So we had an opportunity as a Trust to brief on an issue. 15:01

CHAIRPERSON: Okay.

149 Q. MS. BERGIN: During the time that you were the Interim Director from 2020, the Review of Leadership and Governance Review took place, and the Review of Leadership and Governance Report was published on 31st July 2020, and that was obviously during your time. Did you have any role or engagement in relation to that review or the report itself? 15:01

A. I was interviewed as part of -- by the Review Panel, alongside my colleague, H315, when we were co-director and divisional nurse respectively in Muckamore. And when the report was published, as the Interim Director for Muckamore Abbey Hospital, I had responsibility 15:01

respect of progressing a number of the recommendations made by the report, and also sharing the report internally and communicating with staff around its findings and sort of supporting them through 'This is the report. This is what it said. Here's what we're going to do next.' So sort of different levels of involvement and responsibility associated with it.

150 Q. Okay. Thank you. Chair, I wonder -- that's the first part of what I wanted to ask the witness. Before we move on to the "What is different now?" report, I wonder if it would be an appropriate time for a short break? 15:02

CHAIRPERSON: Okay. Yeah, I think that's a good idea. Okay. All right. So we normally take a 10 or 15 minute break around now, so we'll do that. But we'll certainly complete this afternoon I think? 15:02

MS. BERGIN: Yes, certainly. There's not too much further to go.

CHAIRPERSON: Okay. Thank you very much.

15:03

A SHORT ADJOURNMENT

THE INQUIRY RESUMED AFTER A SHORT ADJOURNMENT AS FOLLOWS:

15:21

CHAIRPERSON: Thank you.

151 Q. MS. BERGIN: Thank you, Chair and Panel. All right Ms. Traub. So picking up now, what I want to ask you about is the exhibit to your report, if we could have

that up on the screen, please? So during your time as Interim Director for Learning Disability, you prepared this report entitled "MAH: What is different now?", dated the 4th March 2021, and you say in your statement that you.

"...prepared this report alongside the Executive Director for Nursing, the Executive Director For Social Work, and the Medical Director, and that the report was a collective view of the situation at Muckamore. It was prepared in response to a request from the Chair of the Trust Board for a fulsome assessment of the service and of the learning disability context. It was presented and discussed at a Trust Board workshop in March 2021, and the report considers whether things have changed in Muckamore and is a response to the question of 'What is different now in Muckamore Abbey Hospital?'."

In addition to the Directors that you say you prepared the report with, you say that:

"The report was informed by the ongoing development of the quality management system and weekly safety reports."

So, who did you consult with or what evidence did you rely upon to prepare the report?

A. I suppose it was a collective set of evidence being

brought forward by all of the parties to the report, and that varied depending on the issue described in the report, so, you know, in respect of safety, and drew upon some of the data around seclusion. In respect of carers it drew upon some of the feedback from our carers. It varied by the subject matter, but it was -- and some of it was my own experience of being Co-Director and Director, and observing and experiencing, you know, what was happening in terms of Muckamore and Learning Disability Services. 15:23

152 Q. And was that also based on, for example, engagement with specific staff members?

A. So there was not a deliberate engagement with staff about this report.

153 Q. Okay. 15:23

A. It was, it was pulling together all of our experience over time, and data, and the collective, and the discussion with colleagues, to try and make sense of it or articulate some of the key points relating to it.

154 Q. In terms of, just staying on this point, I think if I'm correct, the team that you've described who were involved in preparing the report were mostly, if not all, new to Muckamore, in terms of that new management team. So I suppose what information -- when you're saying what is different now compared to previously around the 2017 allegations, I suppose how were you able to gauge what was now different? 15:23 15:24

A. Well, I suppose as you go through it you can see where we're able to understand, you know, data from '20, you

know, from that point in time, and we were able to draw comparisons too, and based on our own understanding -- and, yes, some of us were not there at the time, but we probably had some awareness of what was happening through other staff -- and certainly between the four, myself and my Executive Director colleagues, a number of them had been in post certainly for some time. So it wasn't just through my own experience or my own management team's experience, it was a wider set of experiences brought to the discussion. 15:24 15:25

155 Q. Okay. Thank you. At Section 2 the report states:

"While we do not know when it started, the 2012 Ennis Ward investigation was a missed opportunity to seek assurances that abuse was not happening across the site." 15:25

So you describe the Ennis Report as a missed opportunity. Wasn't that really a missed opportunity not by the Ennis investigators, but rather by the Trust? 15:25

A. So I suppose in respect of this comment, I was not in post at the time of the 2012 Ennis investigation, I was not party to it, or the report, or the outworkings of it, having come in some seven years later. This comment refers to what was probably very fresh in our minds, which was the Leadership and Governance Review Report, which the Trust had recently been on record as accepting the findings of. Our focus was on 15:25

implementation of the recommendations. But this is, I suppose, a direct lift across to that, which said that there was a missed opportunity I think.

CHAIRPERSON: So you were parroting the Leadership and Governance Report rather than actually giving your own comment? 15:26

A. Yes. Yes. Yes. It's not particularly clear there. I appreciate that.

CHAIRPERSON: No.

DR. MAXWELL: And were you aware, as the Inquiry is going to hear more of, that actually there were a number of different views about what had happened in Ennis? There was the safeguarding report, commonly called the Ennis Report; the work that Moira Mannion had done looking at the 24-hour monitoring of the wards, and disciplinary investigation, and they didn't actually all come to the same conclusion. Were you aware that there were these different narratives? 15:26

A. Not particularly. I wasn't aware of Ennis until some time into my post, because it wasn't -- 15:27

DR. MAXWELL: Okay.

A. You know, it wasn't -- it didn't have a direct bearing on my day-to-day role at the time as co-director. So I became aware of it through the --

DR. MAXWELL: So you became aware of it through the Leadership and Governance Review, and you're quoting them by saying this. 15:27

A. Yes.

DR. MAXWELL: Rather than having an independent

knowledge of the situation.

A. A direct opinion. No. That's right.

156 Q. MS. BERGIN: If we look at Section 3.1 of the report, please, and here admission pathways are discussed and this section outlines that: 15:27

"From December 2019, MAH stopped being the default option for patients with learning disabilities who became mentally unwell, so there was no admission pathway to MAH. This had a significant impact not only 15:27 on MAH but also the region, because whilst the Southern Health and Social Care Trust and the Western Trust had their own in-patient units, Muckamore was the service for the Northern Trust and the South Eastern Trust for patients with severe learning disabilities." 15:28

And the report goes on to say that:

"In the months before the report was written there had been requests for admission to MAH and proposals were 15:28 being developed to reopen some beds for patients with severe learning disabilities."

So you seem to be saying here that the effective closure of MAH as a pathway for those patients for 15:28 admission from the community looks like a significant downside or disadvantage for those patients?

A. So, Learning Disability Services nationally, you would expect to see a facility for individuals who have a

learning disability who maybe have a period of, you know, mentally unwell, who require a period of specialist assessment and treatment by a learning disability team, multidisciplinary team. Muckamore was designed to be that for patients from three Trust areas. So it's effective closure did remove that pathway. And, therefore, as we tried to describe, it was something which needed to be addressed, because we would expect, we should expect for our patients who require that, for it to be available for them. The reality at the time was that the staffing levels were not robust or resilient enough, and that patients coming in for an acute admission would require a significant level of intensive review, assessment, and treatment that we could not -- we did not feel we could stand over in terms of the workforce that we had at the time. So it wasn't a decision lightly made, and we were aware that it was something that needed to be addressed for the system as a whole. 15:29 15:29 15:29

157 Q. So what happened to those patients who required an acute admission? 15:30

A. So there were a number of different outworkings of that, and when we looked back in preparation, we looked back for a period of time, we looked at a seven month period, and we had 14 requests for admission from our own Trust. So we also were closing this pathway off for Belfast Trust as much as for our colleagues in our other two Trusts. A number of the patients were admitted for assessment and treatment into adult mental 15:30

health in-patient services. The majority from the Belfast Trust perspective found themselves in that pathway, and then a number were supported to remain in the community with additional support or wraparound from community services and community teams. So those were really the two main alternative pathways which were available to us.

158 Q. And I appreciate we're sort of speaking in the past tense around 2021, and I know you still work within health care within the Northern Trust? 15:30 15:31

A. Yes.

159 Q. Can you help us at all with what the current position is in terms of patients who do require a crisis admission who have a severe learning disability?

A. I couldn't comment on behalf of the Belfast Trust. My own organisation, the Northern Trust, they have established a small in-patient learning disability unit with three beds for people who require acute assessment and treatment. 15:31

CHAIRPERSON: And just so that I understand, if those patients were being admitted into an adult mental health service. 15:31

A. Yes.

CHAIRPERSON: They wouldn't necessarily have learning disability nurses there? 15:31

A. That's right.

CHAIRPERSON: So they're going into a mental health environment without their particular needs being catered for?

A. Yes, that's right. In some instances the learning disability team might have provided some in-reach or input, but the core staffing in those services was entirely mental health.

DR. MAXWELL: Can I just ask then, you're saying at the Northern Trust now there are three beds. Is that staffed with people with learning disability experience? 15:32

A. Yes, it is. Yes, it is.

DR. MAXWELL: And qualifications? 15:32

A. Yes, it is.

160 Q. MS. BERGIN: At Section 3.2 of the report, this deals with resettlement, and this section outlines the various resettlement targets from 1997 onwards, which have been missed, including the 1997 regional strategy 15:32 for health and well-being that stated that by 2002 all long stay patients were to be resettled, and then more recently some of the Bamford action plans that called for resettlement by March 2015. This section also states that there was a renewed focus on resettlement 15:33 at Muckamore following Covid-19, and that in 2021, 10 patients had been at Muckamore for more than 20 years and one resident had been there since 1976.

I'm jumping about, but we're still staying with this 15:33 theme of resettlement, but the conclusion of the report states that:

"Our sense is that as it is currently constructed MAH

offers an outdated service model which is providing care in the wrong place and at the wrong time and in a number of ways by the wrong staff. The future is a much pared-back hospital service sitting alongside a comprehensive community model and predominantly a social care model, not a nursing model."

So I suppose two points there. The targets for resettlements of patients from Muckamore seem to have consistently been missed for many years. That's the first point. Yes. And the second then, is there an argument that for a small group of patients Muckamore Abbey Hospital, or a hospital setting like it, is in fact the best place for them? 15:33 15:34

A. Yes, and it goes back to the previous discussion, that when you have a severe learning disability you may also have autism or other complexities, and you have a period of mental health crisis which requires the intervention of a specialist learning disability team, you would want to be in that environment in a hospital setting, but that should be for a period of time for your treatment, and at the point at which your treatment is completed that you would then move back out into your home or into a new home in the community. And that spoke to the fact that in Muckamore Abbey Hospital, at the point of writing this report, we had one patient in active treatment and the remaining 43, 41 patients, were delayed discharge. So they had come in, they had been assessed and treated, they were 15:34 15:34 15:34

delayed. What you would want to see is assessed and treated with the multi-disciplinary learning disability team, and a transition, a timely transition into their home environment and community.

DR. MAXWELL: Would it be your assertion then that for those patients not only was it the wrong place, but actually it was potentially harmful for them? 15:35

A. I think I mean we had many families who described confidence in the care and their experience of their loved one in Muckamore. You know 20/30 years it became their home. There is an obvious argument there that they became institutionalised and by default it became their home, but actually they weren't living in a home environment with the maximum amount of independence that they could have had. 15:35

DR. MAXWELL: So it wasn't harmful, but it wasn't ideal.

A. Yes. Yeah.

161 Q. MS. BERGIN: At Section 3.2 then, remaining in the same section, throughout the report there are some examples and discussion of some of the positive steps or strategies that were put in place, and some of the positive changes in terms of a focus on patient experience, for example, but at Section 3.2 it outlines that: 15:36

"What was different about MAH in 2021 was a loss of organisational memory and expertise."

So whilst there were some improvements, it seems that actually things had become worse in terms of knowledgeable management and staff who had experience in caring for learning disability patients.

A. Yes. Yes. That's undoubtably true. And I think we -- in writing the report we wanted to be very reflective of the fact that while we would be at pains to point out where we felt we had made some inroads and improvement, we were also aware that there were other aspects which we were struggling to improve, or were deteriorating, or had deteriorated. But I suppose in doing so, to be able to say 'Well, look, we've identified this, we can see this is a problem, but we're going to work on it', so we were cited on it. But that issue around loss of memory and knowledge and experience, spoke to that post. But it was a broader challenge for all of us, because, you know, because to take an issue to resolve it sometimes you need to go back to find out the provenance of it and get your head around it, but actually sometimes you couldn't do that because the person or people that were involved at the time were not there. So it could take longer, et cetera, et cetera. So there were a range of challenges associated with loss of organisational memory. 15:36 15:37 15:37 15:37

162 Q. And then at Section 4.2, please? So this section deals with safety, and one of the things that was different in 2021 was that there was now Ward to Board reporting on a range of safety metrics. What does "Ward to Board" actually mean in practice? 15:37

A. In respect of Muckamore Abbey Hospital, it meant that we had a safety report which described a range of safety measures, and we've talked around some of them earlier in relation to restrictive practice, and that that safety report was shared with the Trust Board. So you could see a line through from what was happening on the ground in Muckamore Abbey Hospital into the line of sight of Trust Board. So Ward up to Board.

CHAIRPERSON: But only in relation to safety reports?

A. Yes.

CHAIRPERSON: And tell us -- sorry, go on.

A. So there was -- in every Trust Board there was a Muckamore Abbey Hospital Update Report. We made a report to the Trust Board on a range of issues to update them, and we also provided a safety report by way of example. So the safety reports were weekly, Trust Board reports were monthly, but we provided one of them so they could understand the level of detail and data that existed around safety. But there was also a cover report which went into a little bit more detail around various issues.

163 Q. MS. BERGIN: Did that Ward to Board reporting, and indeed the frequency of that to the Trust Board, was that -- you've said "Muckamore", is that something that was particular to Muckamore or were other hospitals doing the same thing?

A. That frequency and that level of detail was particular to Muckamore Abbey Hospital in my time in the Belfast Trust.

164 Q. Okay.

DR. MAXWELL: Can I just ask you then around the governance arrangements in the Belfast Trust, because clearly not every hospital and not every speciality can make it to the Board every month, because there just wouldn't be enough time. If you had an area that hadn't had an area of grave concern like this, what would be the mechanism for the Board to assure themselves that actually safety was being monitored and they were being alerted when they needed to be? 15:39 15:40

A. So I suppose that was via the Integrated Assurance Framework that operated within the organisation. And there was, for example, the Assurance Committee, which reported directly into Trust Board.

DR. MAXWELL: How would the Assurance Committee know? What's the different levels? 15:40

A. What's the trigger? So I talk about it in this paper about the QMS, the Quality Management System approach. So the Belfast Trust introduced in 2020 this approach which was a proactive approach for all services to bring forward a dataset of information around their risks and issues, emerging risks, achievements, on a rota system. So there could be an assurance that every service was being -- there was an airing of every service with an agreed frequency coming through Assurance and into Trust Board. 15:40 15:41

DR. MAXWELL: So would it be fair to say the Assurance Committee decided what actually got discussed at the Board?

A. No. No, I don't think that's accurate.
DR. MAXWELL: In terms of the risks that had been --
A. No, I don't think that's accurate. I think the Assurance Committee was one feeder into Trust Board, but there could be, you know, a Director in discussion with the executive team could say 'Actually, we feel this needs to come to Trust Board. You know, it's not in our cycle of reporting, but it is an emerging issue', you could bring an issue to Trust Board if you felt it was necessary. 15:41
DR. MAXWELL: But one of the challenges if you have too many routes, things fall between two stools.
A. Yes. That's right.
DR. MAXWELL: So potentially if there lots of routes in, it might mean that potentially something gets lost if it hasn't gone through one route? 15:41
A. But I suppose the assurance system, or that system whereby every Director would twice yearly bring forward their service and summarise the risks and the safety issues, was only one part of it. So that was very clear, and it was clear it was into Assurance, and then Assurance into Trust Board. You know I suppose there has to be a mechanism for being able to bring an issue at a point in time as well as -- 15:42
DR. MAXWELL: So that's exceptional reporting really? 15:42
A. Yes.
DR. MAXWELL: Okay. Thank you.
MS. BERGIN: At Section 7.3 then.
A. Yes.

165 Q. And here the -- the screen is just catching up with us, but I'll begin reading. Here this section of the report states that:

"The service management and senior management input to the service is hugely disproportionate to its size. The scrutiny, accounting, responding and reporting required regarding every aspect of this service is relentless, outwith normal control limits, for obvious reasons." 15:42 15:43

And in the conclusion of the report it also states that:

"MAH is safer and better understood but it remains an inherently high risk service." 15:43

Now, in relation to the line that:

"...the input to the service is disproportionate to the size of MAH, but this is for obvious reasons." 15:43

I presume the "obvious reasons" is referring to the abuse at Muckamore?

A. I think it goes to the complexity and challenge of managing the service as well as working within a context where you are interacting with the Department of Health regularly around Muckamore, you're interacting with RQIA regularly in Muckamore, et 15:43

cetera, and a number of stakeholders and a number of groups. So the management of itself, given the challenge, and the workforce challenge, and the ongoing PSNI investigation is one aspect, but then the work, the detail required and the work required around the scrutiny is another, and the multiplicity of groups and stakeholders that we need to be able to have an ongoing conversation and communication with is a greater management, there's a greater management activity than anything I have ever experienced before, and that speaks to the issues that brought us here today in terms of the abuse, is the starting point. 15:44 15:44

166 Q. Presumably there is a balance to be struck between ensuring that management and Trust Board have enough oversight and detail about Muckamore so that they do know what's happening, but balanced against, they can't practically know every single outworking on a daily basis. Are you suggesting here that, I suppose, all of these measures, and you might call it course correcting in terms of Muckamore, have gone too far, or given that you've described the service as inherently high risk, are these proportionate to those risks? 15:44 15:45

A. Having worked in the service, and seen the management team, and the scale of the management team, and the management activities, and the work, and reflection, and discussion, and the attention to detail required, I think it was necessary, because there was so -- there was, and I'm sure there still is, so much to be done and continued to be done, so that we don't ever find 15:45

ourselves where we were. But in terms of a service finding itself in normal business, then you would expect to see a paring back of some of that. But I think because we're aware of the ongoing PSNI investigation, and there continue to be very real challenges in sustaining that service, it may need that greater level of management input for some time yet. But I think we would all have wished to see a Muckamore, you know, Muckamore may close and that may address some of that, but insofar as, as long as we have Muckamore I suspect we will need to have this level of engagement and input to it.

167 Q. The report outlines some actions to be taken, for example, that the Trust should map out patient experience of abuse to inform future care needs. It should explore how to obtain regular feedback in a learning disability setting, and that Muckamore was designing terms of reference for a full evaluation of advocacy arrangements at that time in 2021. After the "What is different now?" report was provided to the Trust Board, do you know what, if any, actions were then taken by the Trust in response to the issues raised?

A. I can talk to two of the three of those issues that you highlighted there. So in respect of the review of advocacy services, that was a recommendation of the leadership and governance review. So as Director, I initiated an independent review of advocacy services in my time there, and we involved families, it was an

organisation called "Families Involved NI", and we worked with them on a set of Terms of Reference for the review of advocacy services, and engaged two independent reviewers, and then that process started. I understand it's concluded, but I had left post in the intervening period from initiating it.

In terms of the section in relation to patient feedback. When I was still there in June 2021, we introduced real-time patient feedback into Muckamore Abbey Hospital. So that was an approach taken with our speech and language therapists with the use of talking mats and our real-time patient feedback independent staff. So they would come into the site and they would use talking mats as a tool with our patients and ask them a series of questions under a set of headings just to understand their experience, and then we received a report from that. So we were able to get, insofar as we could through this approach, some real-time feedback from our patients about their experience, and they would come on site fortnightly to do that. It was something which had been -- I think I may have said this in the report -- it was something which had been rolled out in other parts of the hospital, but never before in a learning disability setting. It just required a little bit more time and thought as to how do we engage with our patients, because some of them, for example, were non-verbal or had other needs, so hence the input of speech and language therapy and

talking mats. So that was introduced and gave us some useful feedback.

And in terms of the last point, I wouldn't have necessarily been involved in those ongoing discussions around the historic abuse and how we might understand the impact or the experience of those patients, and that probably was an ongoing discussion, but I couldn't update you on that today, I'm sorry. 15:48

168 Q. No, not at all. Apart from those two specific examples that I've pulled out, are you aware of any other actions or changes that occurred after the report was shared with the Trust Board at all? 15:48

A. I guess for me this report was a reflection of all of the ongoing work associated with being a Director involved or responsible for learning disability and being the Executive Director of Nursing, Medicine and Social Work. And, therefore, where issues were highlighted, they were highlighted in an understanding that the team had seen them and was trying to do something with them. So there was not an official action plan, as it were, arising from this report. It did -- we did then, subsequent to this report, have a risk summit with regional stakeholders in relation to Muckamore Abbey Hospital really to have an opportunity as a region to reflect on where we were with Muckamore or where our risks and gaps were, and to get a shared sort of collective sense of the situation. So that was maybe -- I think that had been in train, but came after 15:49 15:49

this report, which probably gave us a sense of 'Right, well here's where we are today', and then the risk summit, it fed into the risk summit where we were presenting that to our stakeholders, the other Trusts, RQIA, Department of Health, PHA.

169 Q. Thank you. I have no further questions.

MS. TRAUB WAS QUESTIONED BY THE INQUIRY PANEL AS FOLLOWS:

CHAIRPERSON: Can I just -- sorry, Ms. Bergin.

MS. BERGIN: No.

170 Q. CHAIRPERSON: Can I just understand a bit more what happens to this sort of report. You were asked to write it, and the date that we've got on the front, 4th March '21, is that the date that it was published or sent to the Trust?

A. Is there a cover sheet? Sorry, let me just check.

171 Q. CHAIRPERSON: Sorry, it's our page STM-230-21.

A. That was the date that it went to Trust Board.

172 Q. CHAIRPERSON: Right.

A. It should be -- I haven't checked that, but it should be the date of the Trust Board meeting.

CHAIRPERSON: Fine.

173 Q. DR. MAXWELL: It's described as a workshop.

A. Yes.

174 Q. DR. MAXWELL: Rather than a paper to the Board. So was it a separate event to the Trust Board meeting?

A. So, Trust Boards will have a range of workshops in the

course of the year, so it went to a workshop format as opposed to a formal Trust Board meeting. I think it may have been a single agenda item. I can't exactly recall.

175 Q. CHAIRPERSON: Right. So what I wanted to ask, so you had left that job in August '21? 15:51

A. Yes.

176 Q. CHAIRPERSON: And then you went on to another post?

A. Yes.

177 Q. CHAIRPERSON: So in between March '21 and August '21, is the only period when you were at the Trust in this post when could you have, I suppose, found out what was happening. 15:51

A. Yes. Yes.

178 Q. CHAIRPERSON: To your recommendations. And did you have any meetings? I know you've just mentioned that there was... 15:51

A. A risk summit.

179 Q. CHAIRPERSON: A summit. And when was that?

A. It was the 29th April 2021. 15:51

180 Q. CHAIRPERSON: And could you just explain a bit more about that? Who was there?

A. So from the Belfast Trust we had the Chief Executive; myself, the Director of Nursing; the Director of -- Executive Director of Nursing, apologies. The Executive Director of Social Work, Director of Medicine -- Medical Director, apologies. And then from the Department of Health we had the Chief Social Work Officer, we had the Director of Nursing from the 15:52

Department of Health, and a number of other officials from the Department of Health.

181 Q. CHAIRPERSON: Right. And at that summit were you presenting this report?

A. No, this was an internal report. But at the summit there is a slide set of what we presented to the summit, which was a summary of the key risks and issues that we felt were relevant for that regional discussion. So some of them will reflect what was in the "What's different now?", but some of them will not, because they were different audiences. 15:52

182 Q. CHAIRPERSON: Yes. No, I can see that. And so far as the Board of the Trust is concerned, did you have any -- and your report, or whatever this is, the workshop, went to the Board, were you ever invited to go and speak to the Board, or did you speak to the Chief Executive? 15:53

A. After or before?

183 Q. CHAIRPERSON: Yeah.

A. So I'm a member of the Board. As a Director I was a member of the Board. 15:53

184 Q. CHAIRPERSON: So did you present this at the Board?

A. I presented it at the Trust Board workshop.

185 Q. CHAIRPERSON: Right.

A. There was a discussion. Sorry, and it wasn't -- the four authors of the report collectively presented. 15:53

CHAIRPERSON: Okay.

186 Q. DR. MAXWELL: Were there minutes of the workshop?

A. I don't believe so. I would need to check that, but I

don't believe a workshop is minuted.

187 Q. CHAIRPERSON: And after that meeting did you get any updates, as it were, as to what had happened in terms of your views and recommendations?

A. Not as you've described it in that sentence. And I think because some of this, this was our work as well, it wasn't that we were expecting other parties to take forward a lot of what was in here, some of it was for us to do as directors responsible. 15:54

188 Q. CHAIRPERSON: Yes. Yes. 15:54

A. So it was an ongoing work for us.

189 Q. CHAIRPERSON: I see.

A. But we left -- I think our intention was with the Trust Board workshop to ensure that all of our Trust Board members had a broader, had a broader perspective on everything that was happening within the hospital, but also more broadly within Learning Disability Services. 15:54

190 Q. CHAIRPERSON: And I think one of your concerns, whether you put it explicitly or not, was that the closure of Muckamore, if that happened, was going to close off what might actually have been quite a useful necessary service? 15:54

A. [Witness nodded].

191 Q. CHAIRPERSON: You're nodding. Just for the transcript I think you're possibly agreeing with that? 15:55

A. I think the purpose for which it was there, there was still -- we still needed to fulfil the purpose which was for assessment and treatment in a learning disability specialist environment.

192 Q. CHAIRPERSON: Yes.
A. With Muckamore, it's the size, the scale, the location. The workforce, was that right? I'm not saying it was, but the purpose, we needed to recreate something.
193 Q. CHAIRPERSON: Yes. And can you remember what the reaction was to that suggestion? 15:55
A. I think that's absolutely accepted. You know the conclusion of Muckamore offering the wrong model of care at the wrong time, you know, that's part and parcel of that. So if we accept that patients will need assessed and treated at a point in time, how do we do that for northern -- how do we do that for Belfast Northern Trust and the South Eastern Trust? Muckamore, it's not Muckamore as it is today, but let's go right back to what its intention was. 15:55 15:56
CHAIRPERSON: Yes. Do you have anything else?
194 Q. DR. MAXWELL: I do. Can I ask you, on page 9 of your report, and Section 4.3, Adult Safeguarding, when you go on to page 9, you talk about the fact that there are -- at the time there were 27 staff working under enhanced training and supervision as part of a safeguarding protection plan, but you then go on to say: 15:56

"That plan isn't as robust as it should be due to the PSNI restrictions on disclosure." 15:56

Can you just say a little bit more about how that meant that the protection plan couldn't be as robust as it

should be?

A. Again to some extent I was a little peripheral to this, but I was a member of the operational group with the PSNI and RQIA where this was their business. It was because the detail -- so the reason for a member of staff being on a supervision, or a protection plan or a supervision and training plan, the full reason for that could not be disclosed to them. So, therefore, they were aware that there was an issue of concern, they weren't aware of the full detail of that, but they understood that we then needed to put them in to a training and supervision plan for a period of time. So that had been raised as a concern by the Department of Health, and I think by RQIA as well, as to how robust is it if the person who is -- I mean you're within this training plan, is doing what's being asked of them, but ultimately they don't, haven't been given full sight of what it was, was the original concern. In that sense it wasn't felt to be as robust. And I think as I've said, there wasn't a DAPO involved in the review process of that. 15:57 15:57 15:57 15:57

That did move on, as I understand it, there was then a period where all of those plans were reviewed, and there was an agreement made with the police as to what level of information could be provided to staff, and I think there was agreed themes or headings that could be shared, which helped, as I understood it, helped a little bit with that issue. 15:58

195 Q. DR. MAXWELL: We have had statements from staff who were supposed to be supervising these staff saying they didn't understand what they were supposed to be supervising them in. So that, you know, how did they work at all if neither the supervisor or the person being supervised knew what it was that they had to improve on?

A. Well I think that was -- I mean I think that was the inherent challenge for that as it was set up at the start, which is why -- 15:58

196 Q. DR. MAXWELL: This is 2021.

A. Yes.

197 Q. DR. MAXWELL: This is four years after the initial concerns were raised.

A. Yes. 15:58

198 Q. DR. MAXWELL: So it seems like it is a bit of a hole in the safeguarding plan.

A. I mean again, not being my area of expertise, but as I understood that the Trust was very much guided by the PSNI in terms of what information could be shared and what could not. That -- over time that moved on. 15:59

199 Q. DR. MAXWELL: No, I understand that. But the consequence was perhaps not what the PSNI were anticipating?

A. And I think you would have some sympathy with staff and the supervisors in trying to engage in that process when they didn't have all the information that you would wish, you know, perhaps wish that they could have. 15:59

200 Q. CHAIRPERSON: I just want to understand that. The tension is there. Because the Trust have duties to their patients, of course.

A. Yes.

201 Q. CHAIRPERSON: But they also have duties to their staff. 15:59

A. Yeah. That's right.

202 Q. CHAIRPERSON: And the two occasionally coincide, because if you don't look after the staff, the staff may not be able to look after the patients.

A. That's right. 15:59

203 Q. CHAIRPERSON: Are you saying effectively this whole thing was governed by what the PSNI wanted?

A. At the outset, and I appreciate that that's a number of years when I say "at the outset", but latterly I suppose the balance tried to be addressed to say 'Look, 16:00 this isn't as effective as it could be. It's not necessarily just fair to the individuals. What could we do to enhance that without compromising the investigation?', and I think that was also part of the issue is that obviously the CCTV viewing process, the 16:00 historic viewing process was ongoing. So there was an element of, you know, that hadn't concluded yet. So we didn't -- the system didn't necessarily know that it had got to know everything that it needed to know, but very challenging for all parties in trying to do the 16:00 right thing.

204 Q. DR. MAXWELL: It does sound potentially though that protecting the police investigation took precedence over protecting the patients?

A. Well I guess there was a training and supervision plan for individuals for whom there had been a level of concern raised, and they were -- appreciating the example you gave, but they should have been subject to regular review and supervision on whatever it was agreed that they needed to pay attention to. So there could be some improvement in relation to that.

205 Q. CHAIRPERSON: And it sounds as if -- because you couldn't tell the staff as openly as you may have wanted to what was going on, we've heard from members of staff who have told us that the uncertainty effectively caused them to leave. 16:01

A. Yes. Yes. Without doubt that was a driver in individuals choosing to leave.

206 Q. CHAIRPERSON: And those people who were leaving would normally be the LD trained staff? 16:01

A. That's right.

207 Q. CHAIRPERSON: Because they had been there.

A. That's right. That's right. And on occasion -- not on occasion -- for those that were not retiring but were moving on, they were largely moving on to other learning disability units in other Trusts. 16:01

208 Q. CHAIRPERSON: Which leaves those who remain with a greater burden and, therefore, more likely to eventually end up leaving? 16:02

A. Yes. Yes. You could see that as a self-fulfilling...

209 Q. CHAIRPERSON: Vicious circle. Yes.

A. Yes. And we did lose some really highly skilled and experienced staff as a result of the combination of

that, and scrutiny, and just the very real challenge of working on site.

CHAIRPERSON: Yes. No, I understand.

Ms. Traub, can I thank you very much indeed for coming along to assist the Inquiry, it's been helpful and enlightening, and thank you for giving up your time. 16:02

A. No problem. Thank you very much.

CHAIRPERSON: All right. If you would like to go with the Secretary to the Inquiry. Right. 10:00 o'clock tomorrow, please. Thank you very much. 16:02

THE INQUIRY ADJOURNED UNTIL TUESDAY, 11TH JUNE 2024 AT 10:00 A.M.

16:03