MUCKAMORE ABBEY HOSPITAL INQUIRY

SITTING AT CORN EXCHANGE, CATHEDRAL QUARTER, BELFAST

HEARD BEFORE THE INQUIRY PANEL

ON MONDAY, 17TH JUNE 2024 - DAY 92

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

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# APPEARANCES

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|---|---|
| CHAIRPERSON: | MR. TOM KARK KC |
| INQUIRY PANEL: | MR. TOM KARK KC - CHAIRPERSON<br>PROF. GLYNIS MURPHY<br>DR. ELAINE MAXWELL |
| COUNSEL TO THE INQUIRY: | MR. SEAN DORAN KC<br>MS. DENISE KILEY KC<br>MR. MARK McEVOY BL<br>MS. SHIRLEY TANG BL<br>MS. SOPHIE BRIGGS BL<br>MS. RACHEL BERGIN BL |
| INSTRUCTED BY: | MS. LORRAINE KEOWN<br>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<br>MR. AIDAN MCGOWAN BL<br>MS. AMY KINNEY BL |
| INSTRUCTED BY: | PHOENIX LAW SOLICITORS |
| FOR GROUP 3: | MR. CONOR MAGUIRE KC<br>MS. VICTORIA ROSS BL |
| INSTRUCTED BY: | MR. TOM ANDERSON<br>O'REILLY STEWART SOLICITORS |
| FOR BELFAST HEALTH & SOCIAL CARE TRUST: | MR. JOSEPH AIKEN KC<br>MS. ANNA MCLARNON BL<br>MS. LAURA KING BL<br>MS. SARAH SHARMAN BL<br>MS. SARAH MINFORD BL<br>MS. BETH MCMULLAN BL |
| INSTRUCTED BY: | DIRECTORATE OF LEGAL SERVICES |

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

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THE INQUIRY RESUMED ON MONDAY, 17TH JUNE 2024 AS FOLLOWS:

CHAIRPERSON: Good morning everyone.

MR. DORAN: Morning Chair, Panel. This morning's witness is Esther Rafferty. 09:55

CHAIRPERSON: Yes. Ms. Rafferty, good morning. I've met you very briefly. Can I just welcome you to the Inquiry and thank you for coming to assist us, and in a moment I'll hand you over to Mr. Doran, but you're just going to be sworn in. 09:56

MS. ESTHER RAFFERTY, HAVING BEEN SWORN, WAS EXAMINED BY MR. DORAN AS FOLLOWS:

09:56

CHAIRPERSON: And you know, as I've said to you, I think, if you want a break at any stage just let me know and we'll pause. All right.

A. Okay. Thank you.

CHAIRPERSON: Okay. Mr. Doran. 09:56

MR. DORAN: Ms. Rafferty, thanks for attending to give evidence this morning. We met briefly earlier this morning and I explained the process to you. Now, in this part of the Inquiry we're dealing specifically with the Ennis Ward safeguarding process and related matters. 09:56

A. Yes.

1 Q. And you made a statement concerning those matters, didn't you?

A. Yes.

2 Q. Yes, and I think it's dated 13th April 2024. Is that right?

A. Yes, that would be right.

3 Q. And do you have a copy of your statement with you this morning? 09:56

A. Yes, there's a copy here in front of me.

4 Q. That's great. So if you need to refer to that at any time you can, and you'll also find that some of the statement will be displayed on the screen? 09:57

A. Okay.

5 Q. As we go along. Now, for the record, Chair, the statement reference is MAHI-STM-229.

Now, Ms. Rafferty, are you content to adopt your statement as the basis of your evidence to the Inquiry this morning? 09:57

A. Yes, I am. I think it's just from my best recall from the time.

6 Q. Yes, indeed. And have you had the chance to look at it again? 09:57

A. I think, in looking at it again after reading the other statements that were shared with me, I think the surprise was that some of the people were on leave and that I would have maybe shared the information when they returned from leave. 09:57

7 Q. Yes.

A. But, that was, you know, they would have been informed of the situation, but I was unsure at the time of the day I informed them.

8 Q. Yes. But you've given the details to the best of your recollection in the statement?

A. Yes. Yes.

9 Q. And when you were making your statement, I think it's right to say you were provided with a bundle of documents relating to Ennis? 09:58

A. Yes.

10 Q. Isn't that right?

A. I was, yes.

11 Q. And did you find that helpful to jog your memory? 09:58

A. It was helpful to actually alert me to some of the stuff that I had worked through.

12 Q. Yes. Now, we'll come on in a while to look at your role at the time in a little bit more detail, but you were Service Manager at the time, isn't that right? 09:58

A. I took up role as Service Manager in Muckamore, the 2nd January 2012.

13 Q. Yes.

A. And it was a post of two components. I was the Service Manager for the site, but I was also Associate Director 09:59 of Nursing, Learning Disability Nursing, for the Belfast Trust, and that included nursing on the site as well as nursing in the community.

14 Q. Yes.

A. And that was the first time in the Trust that they had 09:59 one specifically for learning disability nursing.

15 Q. Ah, I see.

A. Before that the Associate Director of Nursing for Mental Health held the responsibility for both mental

health and learning disability.

16 Q. Yes. So it was really a dual role then; Service Manager at the hospital, but a more general role within the Trust.

A. Yes. A more general role. Service Manager of the hospital and then responsibility to Brenda Creaney as the Executive Director of Nursing for the nursing staff? 09:59

17 Q. Yes. And had you come from a nursing background yourself? 09:59

A. Now. I was qualified as a registered mental health nurse in 1987, and before that as a State enrolled nurse in 1984. I did my training in Purdysburn Hospital at the time, and as part of my training I had worked a few months in Muckamore Abbey Hospital, which was part of the core training that was available. 10:00

18 Q. And when exactly was that?

A. I think I worked in Muckamore during my training in 1984.

19 Q. Yes. And then you came back to work in 2012? 10:00

A. In 2012.

20 Q. In the Service Manager post?

A. Yes. I worked previously all my professional career in adult mental health services in a variety of roles. I managed supported housing, worked in residential care, managed community mental health teams, was a care manager, managed care management, was a locality manager and managed both supported housing, care management, and teams. I was project manager for 10:00

setting up crisis response and home treatment services. I managed self-harm services. I, at times, was responsible for resettlement for patients from Knockbracken Health Care Park, which was Purdysburn Hospital renamed.

21 Q. And when was that?

A. 2007. 2006/07.

22 Q. So that was prior to your arrival at Muckamore?

A. Oh, prior to Muckamore. I resettled a lot of patients out of Knockbracken, both as a care manager and as a care manager coordinator. I worked with patients who had acquired brain injury, patients with dementia, patients with severe enduring mental illness, and there was patients who were on the Knockbracken site who also had a learning disability.

23 Q. Yes. But a different patient profile generally from the patients at Muckamore?

A. From Muckamore.

24 Q. Yes. And actually you worked at Muckamore, I think, for a six year period. Is that right?

A. From 2012 to August 2018. But in different -- my last year in Muckamore was in a different role.

25 Q. What was that role?

A. I worked -- the Associate Director of Nursing role was reviewed within the Belfast Trust during my period of holding that post, and all of those posts were reviewed within the Belfast Trust, there was about 12 of us, and they determined that that was a standalone post and not an add on to a substantive role, and they created the

divisional nurse roles specifically to be part of the collective leadership team to provide nursing leadership and governance across each directorate and service area.

26 Q. And so did you do that slightly different role for the last year of your time at Muckamore? 10:03

A. I was appointed to that role in September 2017, but I didn't take it up in a full-time capacity until April 2018, as the Service Manager post was difficult to backfill. 10:03

27 Q. Yes. And because you spent a significant period of time at the hospital in management, you've also been asked to make a statement for the later organisational parts of the Inquiry, isn't that right?

A. Yes, and I have sent that -- well, I'm working to send that in at the moment. The first draft is already in. 10:03

28 Q. So your statement is well under way for that purpose?

A. Mhm-mhm.

29 Q. And of course if we do miss things today, or if there are other matters arising from the remaining evidence about Ennis, we can... 10:03

A. Yes.

30 Q. ...catch up with those at a later stage. So today is not necessarily the last word on the matter?

A. Okay. 10:04

31 Q. And you're aware that others have made statements for the purpose of this part of the Inquiry as well.

A. Yes.

32 Q. We have statements from Brenda Creaney, Aine Morrison,

John Veitch, and Moira Mannion?

A. Yes.

33 Q. And I think you've seen those statements, haven't you?

A. They have been shared with me, yes.

34 Q. And have you had the chance to read them? 10:04

A. I have, yes.

35 Q. And I think you told me earlier that you didn't have an opportunity to watch the evidence last week, but you may have had the chance to read the transcript, is that right? 10:04

A. I have tried to read through as much as possible of the transcripts.

36 Q. Yes. So you're familiar --

A. Now there's quite a lot of information.

37 Q. Quite a lot of detail, indeed. 10:04

A. Yes.

38 Q. But you're familiar with the issues that the Inquiry is looking at in this phase?

A. Yes.

39 Q. Now, I'm going to come back again to your role at the 10:04 hospital at the time of Service Manager and Associate Director of Nursing for the hospital, and Community Learning Disability Services within the Trust. But is it right to say that your role was actually hospital based, were you based at the hospital five days a week? 10:05

A. I had -- I was majority of the time based in the hospital, but I did have to -- I had an office as well in Fairview in the Mater Hospital, and I would have spent some time there, though it was limited, because

the majority of the nursing staff actually were based in the hospital. Community learning disability nursing at that point was a small entity and, you know, you spent time with those teams, but the majority of the staff I was responsible for were in the hospital. I did start off when I took up post of being based in Fairview, but I actually moved to Muckamore.

40 Q. Yes. But you then --

A. Because I felt that's where I needed to be.

41 Q. And would you then have spent most of your working time at Muckamore? 10:05

A. In the hospital, yes.

42 Q. And can I ask this; was it largely an office based post or would you have been in and around the wards?

A. As part of the role you were expected to go out to the wards anyway to talk to staff, to visit the patients, you know. It would have been some visits to the wards, but meeting people as well, and meeting as well with some of the providers and staff. So I wouldn't have been out on the wards every day, because that was the responsibility of the Ward Sisters and the Senior Nurse Managers, whose role was to oversee their groups of wards, and they would have reported to me, but I certainly would have been out on the wards at times. 10:06

43 Q. But would you have known the staff or the majority of staff? 10:06

A. I would have known all of the deputies and Ward Sisters, and I would have known some of the other staff by meeting them. Also, being on-call for the hospital

at times, I was part of the on-call rota, and had on occasions went in and actually helped out on some of the wards during the night, especially if, I mean an example could have been if someone got hurt.

44 Q. You mean a patient? 10:07

A. And needed to go in to hospital. A member of staff had got hurt, I, on occasion, did go in and would have taken over one-to-one observation of a patient to free up other staff to do, you know, their work.

45 Q. Yes. 10:07

A. So I would have sat with the patient on that one-to-one. Now, that was very ad hoc, and it wasn't -- I could probably count on my hands how often I did that. So it wasn't something that was a regular occurrence. 10:07

46 Q. Yes.

A. But if it was required, I did it.

47 Q. Yes. But can I just ask you also about the role of Service Manager, because we've seen it written down so many times on paper, but if you had to give a short 10:08 description of what Service Manager, what that role actually entailed, what would you say?

A. I think it was to oversee the management of the hospital and to liaise with all of the different departments and staff that was on the site, and to 10:08 support the wards and the senior nurse managers to deliver the care to the patients. But to oversee that the care to the patients was appropriate and timely, and that it was, as far as possible, the right care at

the right time, and it was around managing the resource, around, you know, I had budget responsibility for the staff, for the resource of the wards. I was responsible for a lot of the resources that were on site. But it was also about leadership for the nursing staff who were working there.

48 Q. So presumably the standard of care would have been a matter of concern to you?

A. Of course standard of care was -- well, you were wanting that the best care was given to the patients on the site, and certainly even through walking around wards and all you would have witnessed care that was being delivered to patients, and you would have seen the environments that the staff had to work in, and some that were excellent environments and some that were extremely challenging.

49 Q. And what do you mean by "extremely challenging"?

A. The wards themselves in the resettlement area weren't fit for purpose. They were old buildings. Some of them very historical in nature were the old villas. But equally some of the, like an example being Finglass, which was the ward that we had to close in October/November time, it really consisted of four areas which was to accommodate about 20 patients, and it was two big bedrooms, which were dorms with 10 beds in each, a big day room for all the patients, and a shower and toileting area.

50 Q. Yes.

A. It wasn't, you know, the contrast between the core

hospital and the new hospital to the resettlement wards was very very extreme, you know.

51 Q. Yes.

A. Because in the core hospital you had en suite bedrooms, individual rooms. The patients had their own space. There was a lot more seating areas and living rooms and breakout areas. This ward just had one big day room. 10:11

52 Q. Yes. We'll maybe come back to some of those more general issues at a later stage?

A. Yeah. 10:11

53 Q. I just wanted to ask you again about your role at the hospital. You were also a member of the core management group, isn't that right?

A. Yes, there was -- when I started there, there was already an established group that was Chaired by the Co-Director John Veitch. Sorry, the Co-Director. 10:11

54 Q. That's fine. John Veitch will be giving evidence in relation to Ennis this week?

A. All right. So there was the governance manager, the senior social worker, the lead consultant, and the co-director and myself would meet every fortnight, and that was an established meeting when I started working there. We met every fortnight, there was discussions at that meeting around issues that were in the hospital, staffing, resettlement, admissions, lack of beds for admissions. There would have also been discussion around reports that were presented to that group around accidents, incidents, seclusion. 10:11 10:12

55 Q. Yes.

A. Use of MAPA and restraint.

56 Q. Yes. Well that's definitely something we will be looking at in the later organisational modules, but I'm going to turn now to look at the Ennis allegations and what occurred. In paragraphs 3 and 4 of your statement you explain that the information came to you in a slightly roundabout way. Is that fair to say? 10:13

A. Yes. I got the call from RQIA, which was unusual to get a safeguarding report in from RQIA, because normally we would have been notified to the hospital direct, but RQIA notified me via phone call that a member of the Bohill staff had contacted them to tell them about an incident in Ennis Ward the day before and they were reporting it that morning. They said they had rung the hospital and had spoken to the switchboard and asked for to speak to the safeguarding person and were re-directed to the Belfast Trust safeguarding team, and they chose then to ring RQIA. 10:13 10:13

The safeguarding person in the hospital at that time was the senior social worker, and he would have taken a call if he was there and, if not, it would have been one of the senior nurse managers who would have acted as the designated officer in the absence of senior social worker. 10:14

57 Q. Yes. Well you say then that you and the Senior Nurse Manager, Eileen McLarnon, immediately started safeguarding procedures. Is that right? 10:14

A. Yes. As soon as the call came through we took down as much information as we could at that point, and

actually identified -- contacted the ward to see who was on duty, and the duty nursing office went up and seen, because the off duty lists were held in the nursing office, so you could go up and look at that and see who was on duty, and you could look for the names and see if they were on, and if they were on then you could ask for them to come over to the office and then, if need be, send them home. And that -- Eileen went up to the office and checked, and then, you know, you would have checked with the nursing officer who was on that day 'Well, did somebody go out on relief to that ward as well?' 10:14 10:15

58 Q. Yes.

A. You know. So we knew who should have been there. I think from what I recall Eileen then went over to the ward and identified that the other staff member was also there, and they had been coming I think on a bank shift. So we made arrangements for those people to leave the ward. 10:15

59 Q. You effectively had to activate the suspension procedures then? 10:15

A. Well normally what you do is send the person home at that point and ask them to leave their shift. You later invite them in, alongside their staff side representation to initiate a suspension, because you have to give them a copy of the policy and notify them of what support or who their contact person is whilst they're out on suspension. So what you do immediately is actually just send them home and ask them to leave 10:16

the site.

60 Q. Yes. Now in your statement you say that you'd actually had to start such procedures on a number of occasions before, including, in fact, on your first day at the hospital? 10:16

A. I think I was only on -- started the post five minutes when I got that call, and it was for a health care assistant had assaulted a patient in one of the core wards, I think it was Killead.

61 Q. Yes. 10:16

A. And he had assaulted the patient, and the staff on the ward immediately had rung the nursing office to inform them, and the nursing office contacted me. We agreed that that person should be sent off the site there and then, and John Veitch later issued the suspension to 10:17 that person.

62 Q. Do you recall what became of that individual afterwards?

A. Yes. The police were involved and the person accepted an adult caution outside the court the day of the 10:17 hearing. He accepted the adult caution, and then we done the, or commenced our own investigation, and that led to a disciplinary hearing, and at the disciplinary hearing he was dismissed. He appealed that decision, and the decision to dismiss him was upheld at appeal. 10:17 But that -- to say most people appeal a disciplinary hearing, because the Trust procedures are that if you're disciplined and you get a sanction, even if you appeal, the sanction can't be increased, but it can be

reduced.

63 Q. Yes.

A. So it's, you know, in the person's interest to appeal.

64 Q. Yes.

A. You know, because they may have their sanction reduced. 10:18

65 Q. Yes. But just moving away from those procedures, you actually say that between January and November you had received reports of a number of cases of alleged abuse at the hospital?

A. There would have been other cases. I mean there's one -- I'm trying to remember now. There was an incident of where someone in Ennis was accused of manhandling a patient. This was not -- from what I recall this did not happen on the ward, this happened in day care, and day care were the ones that reported it. 10:18 10:19

66 Q. But it was someone who worked in Ennis?

A. Yes.

67 Q. Have you have any recollection was it one of the individuals who was alleged to have been involved in the Ennis allegations themselves? 10:19

A. No, it wasn't, because this person left before they were -- they actually left our employment before they were through the disciplinary procedure.

68 Q. Yes.

A. And because they left before they went through the disciplinary procedure, and that case was not heard, the Trust referred them to the safeguarding authority, so that if an access check was done on them, that that would have been flagged. 10:19

69 Q. Yes. Now, again without getting into the specifics of individual cases at this stage, do you recall was there any pattern of reporting in terms of individual wards within the hospital, or did the allegations of abuse tend to be sporadic? 10:20

A. Mm-hmm, there was incidents of where staff reported incidents of abuse within the hospital. I remember, well I recall them in Erne, Ennis, Greenan, Killead. I mean there was -- the majority of the incidents of safeguarding happened between patient-on-patient, but 10:20 those were managed with the senior social worker. Where the staff or a patient made an allegation against staff, we put a protection plan in place. Depending on the allegation, sometimes that person was moved to an area where they could only practice under supervision 10:21 and with, you know, say a patient was on two-to-one care, and that person could work alongside them, so there was always someone right beside them when they were working whilst that was investigated.

70 Q. Yes. But are you saying an allegation wouldn't 10:21 necessarily have led to immediate suspension on a precautionary basis?

A. It depended whether it was rough handling or whether it was an assault or an allegation of assault. There was incidents of where someone maybe was accused of 10:21 verbally abusing a patient, which may have led them to be in a supervised capacity as opposed to a suspension. We would have discussed with the senior social worker, any time we were discussing it with what action we were

going to take, we'd have taken immediate action and then looked at it to see, well, was that enough or did we need to do more? Or as the investigation progressed, whether or not we needed to review that decision, including suspending them at a later point or reducing that action. Any time we did consider suspending someone we always had the discussion with HR, and HR would have said it was proportionate in relation to the allegation. 10:22

71 Q. Yes. 10:22

A. So different circumstances warranted different protection plans. But any that were reported were investigated, and protection plans were always considered on every allegation, and the senior social worker would record the protection plan and share that with the patient's owning Trust. So if the person -- if the patient was from the Northern Trust, the community team in the Northern Trust would have been contacted. 10:22

72 Q. Yes. 10:23

A. And informed of the allegation. So if it was Belfast Trust, Belfast Trust would have been notified.

73 Q. And can I ask, were those initial operating procedures set out in writing in a document?

A. Well, there was the safeguarding policy that was in place at the time, and I think, I think it was reviewed around '14/'15, and actually Muckamore was one of the, Muckamore and Newry and Morne, were the two sites that were picked for the review. 10:23

74 Q. Yes. But this was prior to then obviously?
A. Prior.
75 Q. But were you acting on the basis, at the time of Ennis were you acting on the basis of a written document that was in place at the time? 10:24
A. Well, we were acting on the basis of that policy and being kept right by the senior social worker, who was the designated officer.
76 Q. Yes.
A. Also that we bore in mind the Trust disciplinary procedures as well. 10:24
77 Q. Yes.
A. That we didn't...
78 Q. And we'll come on to deal with that. But you've spoken about previous complaints and allegations. Did these particular allegations strike you as being on a different level or of a different character? 10:24
A. I actually -- the allegation of where the staff member hit the patient on the first day was really serious, you know, I think any assault on a patient is serious. The Ennis one, it was serious in that it was an outside agency reported it. I was also concerned that they didn't feel confident reporting it before they left shift. 10:24
79 Q. Yes. 10:25
A. And that they did so when they went home as opposed to telling someone about in the hospital.
80 Q. Yes?
A. And it was also that it was more than one incident that

was reported and not a singular incident.

81 Q. Yes. Well you've singled out a number of features; the nature of the assault, the fact that there were multiple incidents, and also, as you have said significantly, these matters were observed by external staff? 10:25

A. An external, yeah. And we did have a lot of external staff coming into the hospital as part of resettlement. We had -- not only from Bohill, but from other organisations. We would have invited them in to -- any organisation that was working with the patient were invited in to work with the staff group and the patients so that they were familiar with them before they left. 10:26

82 Q. Yes. And did you tell the staff then that they were to be subject to precautionary suspension? 10:26

A. Yes.

83 Q. Was it you who delivered the message, so to speak?

A. Yes. It was -- yes. I met with them with their staff side reps and they were issued with a suspension letter. 10:26

84 Q. Had you known them personally?

A. I don't, I don't recall, you know, having individual conversations with them. I may have met them going in and out of the ward, but not as individual. You know, there was -- I got to know the team and the individuals in the ward a lot more after the allegations, simply because I was down there a lot doing a lot of the work alongside Moira. 10:26

85 Q. Was that as part of the monitoring?
A. Yes.
86 Q. Now, we'll come on to deal with that, but one point you make in paragraph 7 is that the removal of those staff from the ward meant deployment of others to the ward? 10:27
A. Well if you take two staff out of the ward, that automatically leaves them short staffed, so you then have to find staff to replace them, and some of that involves looking around the site for where there is some capacity. Now, when I say "some capacity", it 10:27 usually means standing down something that was due to happen to make that happen, you know. So it may well have been that we took some staff out of day care, or we took some staff out of another ward, or we would have been also contacting people at home to say 'Can 10:28 you come in?'. If there was training on site and we were really short, we would have went in and seen if there was anyone who had experience in Ennis to go in from the training to help cover, because it would have been an emergency situation. 10:28
87 Q. Yes. But every action has a consequence?
A. Consequence.
88 Q. As you put it I think in your statement?
A. Yes. And we were already very -- the staffing situation on the site was already in a difficult and 10:28 precarious situation, because we were having difficulty already covering shifts, and staff themselves and the ward managers were escalating to their managers that cover was becoming increasingly difficult.

89 Q. And you then report to the Co-Director of Governance, David Robinson. Is that right?

A. When -- you would have been advised to do an Early Alert, because if a Director was on leave you would have asked for the co-director, and so David was one of the co-directors, and he helped, or I would have helped him with the information to complete the Early Alert. 10:29

90 Q. Yes.

A. And that would have been sent in and David would have checked the information out with me. 10:29

91 Q. Just one thing we picked up on last week, and I'll not take you to the Early Alert document now, but there was no mention of the fact that the...

A. That there was external staff.

92 Q. That the conduct had been observed by external staff. 10:29 Do you think that should have been included at the time?

A. It should have been, yes.

93 Q. Yes. And whose responsibility was that?

A. I think in proofreading it I missed that, that we didn't put it in. 10:29

94 Q. Yes. But you'd accept that's a significant factor?

A. Yeah. Yeah.

95 Q. You also make the point in your statement that normally when an Early Alert is made, a Serious Adverse Incident Report is also completed. Had you had experience of that occurring before? 10:30

A. Serious -- I mean there was occasions when we were asked -- when incidents occurred we would have notified

them to the governance team, which is, they would have said "Do an Early Alert". They would have also queried with you "Should we do an SAI or a Serious Adverse Incident this time?", and we would have taken advice from the governance team, but you would have discussed it, but the advice would have come from governance very often about 'Well, yes, this is what we should be considering', or 'No, it's too early at this point'.

96 Q. So you would have an input to that decision, but governance would have taken the lead, is that a fair summary

A. Governance would have given us advice on "yes" or "no", and certainly John Veitch, I have to say, was very much a process person. So he would have always queried about an SAI as well. He would have asked 'Right, what do we need to do now? What needs reporting and to whom?'.

MR. DORAN: Now, you say now --

DR. MAXWELL: Sorry, can I just ask, did you have experience of safeguarding incidences being reported as SAIs before?

A. I actually don't -- I don't know. That's being honest. I know I've done SAIs before.

DR. MAXWELL: But not necessarily safeguarding.

A. But I'm not sure whether it was in relation to a safeguarding or -- I had done them in relation to sudden deaths and, you know -- but I'm not sure whether or not one had -- I don't -- I can't remember whether one went in for the incident on the first time I

worked. So I don't know whether we were used to doing them for this type of incident. I know at a later point the criteria for SAIs changed, which mentions specifically suspension, but I'm not sure when that come in.

DR. MAXWELL: So would it be fair to say that at this time it was not clear that it should be reported both through safeguarding and SAI.

A. I would say probably, yeah, it's not clear, but I'm not sure when that changed. And I know, I know there was discussion within the Trust about when the change happened, because it hadn't been circulated for a couple of months even after the change come in, but I know it was added to the SAI, but I'm not sure when.

DR. MAXWELL: Okay. Thank you.

97 Q. MR. DORAN: Could you comment on how this matter would have been dealt with if the SAI procedure had been activated?

A. SAIs normally meant that there was an independent person looked at it. They would have categorised it as into one of the three areas, and it would have meant that there was a timescale for a report to have been produced on it, and somebody independent would have looked at the incident and provided learning from that, and then the learning would have been taken to one of our governance meetings where they would have determined whether or not that learning was specific to the service area or relevant to other service areas or the whole Trust, and then a learning letter would have

went out.

98 Q. Yes. So it potentially would have had more far reaching implications than a specific safeguarding process?

A. It could have been. If, you know, if that process happened. 10:34

99 Q. Yes. Now just looking at the safeguarding process. You had taken the initial steps, including dealing with the precautionary suspensions?

A. Mhm-mhm. 10:34

100 Q. And then Aine Morrison was appointed to lead the investigation, and she, of course, was independent of the hospital itself. Was that the normal procedure that would have been followed in such situations?

A. Certainly we always referred out on staffing instances to the owning Trust, and the senior social worker or the community team would have had a discussion with us how they wanted it to proceed, and some Trusts would have said 'Right, we're happy that you investigate this', and other Trusts in, this instance, Aine, said that she was acting as DO and was taking the lead, which we accepted, that that was a decision for her. 10:34 10:35

101 Q. Yes. And I think you acknowledge later in your statement that she was very good on adult safeguarding, you say that she knew it inside out? 10:35

A. Well, she does, she does know. I mean Aine is very clear on adult safeguarding and she knew the policy.

102 Q. And there was a strategy meeting then, isn't that right, the day after the allegations emerged?

A. There was quite quickly after it, and the patients' families were notified of the incident, or the incidents that related to them, of the allegations, very quickly.

103 Q. Did you have responsibility for that? 10:36

A. I think it was the Senior Nurse Manager who was on, who were on that day done it between, you know, that afternoon and evening.

104 Q. And then an issue arose about who should be in attendance at the strategy meetings, isn't that right? 10:36

A. Well, my recollection was that I was querying Dr. Milliken being there, because Dr. Milliken had said he was going to go and...

105 Q. You say you were querying Dr. Milliken there. You wanted him to be there, is that right? 10:36

A. No, my recollection was is Dr. Milliken wanted to be there.

106 Q. Yes.

A. Because he was the consultant for the ward. He was the RMO for that ward. So that was my recollection, that 10:36 he wanted to be there, and that, I think, started the discussion with Aine Morrison, and we had the discussion, and she says that she would prefer nobody from Muckamore to be there. And then she said "But you can come", and... 10:37

107 Q. So she was content for you to attend, but no-one else from the hospital?

A. Mhm-mhm. And I was going "Well, you either want us in or you want us out", I was having this debate with her

as in, "Well, you said you don't want anybody there but you want me there", and I was saying "Well, look, I want some clarity on this", so I actually gave the Director a phone call, and Catherine McNicholl and myself discussed it, and she says, 'Look, if there's a query about whether people from Muckamore should be in it, all of you stand back until we see how it goes', and I asked Aine to give Catherine a ring, and she did, and at that point I think the next meeting I didn't go to. 10:37

108 Q. Yes, but were you at the first meeting? It's just that your -- to be fair, your name is recorded as being at the meeting, and yet --

A. I don't think I was. I don't think I was. No. I didn't go. I don't remember being at the first one. 10:38

109 Q. And it was at a later stage you rejoined the meetings?

A. Because I think -- I remember Aine coming to me after the meeting and saying that they wanted another staff member to be considered for suspension, and I just actioned that, and that there was 24-hour monitoring to be put in place and we worked to get that done. 10:38

110 Q. But even though you're recorded as being at the first meeting, you can't recall being there?

A. I can't -- no, I can't recall being there.

111 Q. And you rejoin the meetings then in December 2012? 10:38

A. In December I was asked to rejoin.

112 Q. Yes. Just going back to the issue of Dr. Milligan's attendance. Now he was obviously the Clinical Director at the time, isn't that right?

A. Yes. I think it was specific because he was consultant for the ward.

113 Q. Yes. And Aine Morrison said, you know, she thought that he ought not to be present, and she said that you had invited Dr. Milliken, and you disagreed vehemently with the approach that she was adopting. Is that a fair description of your reaction at the time? 10:39

A. I had said I didn't understand why Dr. Milliken wasn't invited, simply because he was the Clinical Director, he was the consultant for the ward. He wouldn't have been present when the incident took place. He could have offered support and advice in relation to the patient population on the ward. I think certainly I asked Aine why she didn't want any of us there, and she just said "Well, I don't want anybody there because it's Muckamore, they all know each other", and I was going "Well, you know, look, I need to go take advice on this", and that's why I went and sought advice as opposed to arguing. 10:39 10:39

114 Q. Yes. 10:40

A. So, yes, I disagreed with what she was telling me, but I didn't get into a to and fro argument. She told me why her view was, I told her why mine was, and I went and sought advice to resolve that. I spoke to Catherine and she gave me advice, I took it. 10:40

115 Q. What was the norm in these situations? Would the Clinical Director have been in attendance at strategy meetings in relation to previous safeguarding processes you had been involved in?

A. I would have expected the Senior Nurse Manager for the ward and the RMO for the ward to be invited.

116 Q. Yes. Now, Aine Morrison explained the rationale by saying, you know, essentially she did not want to compromise the independence of the investigation in any way. Looking back, would you accept that there was some sense in that, or do you think she went too far in excluding the lead consultant? 10:41

A. I think not having them there slowed down the process of completing the investigation, because a lot of the discussion they had, they ended up having to come out and have that discussion again with the medical staff and the team to action the points, when actually having Dr. Milliken in the room as the RMO for the ward would have answered those queries. 10:41

117 Q. Yes.

A. So it I think delayed some of the actions, slowed it down, but it didn't stop it getting completed.

118 Q. Yes. And when you make those observations, are you referring to your own exclusion from the early meetings as well, or solely Dr. Milliken? 10:42

A. It didn't -- Aine would come down and just give me a list of 'Well, this is the outcome of the meeting', and would I say 'Well, yes, I'll be able to do that, that, and that', and if I had some queries I would have said, you know, we would have -- she would have chatted to me about 'Well, this is why we're doing this'. So it wasn't that she just handed me a list and walked off, it wasn't like that, she did tell me the rationale for 10:42

why the decision was taken, which was helpful for me, and she told me that her rationale was in relation to the 24-hour monitoring, this happened, you know, in front of external staff, and it seemed to have been they were confident to do it in front of people who did not work in the hospital, these allegations. So that was a reasonable request, so we actioned it.

119 Q. Yes. So you were essentially not at the meetings but putting the actions into place?

A. Well, certainly I then had to direct the Senior Nurse Managers to do this, and because the Senior Nurse Managers were over different groups of wards, we already had difficulties with staffing. It did provide a lot of challenges simply on the basis that you were asking this Senior Nurse Manager to give staff over to this team to provide monitoring, to provide cover, and leaving them shorter than they already were. So a lot of it was negotiation and talking through 'Well, who could move? What's practical?', you know. You would say 'Well, can we move somebody back who has already, you know, who knows the ward?', and it could have been something as simple as 'Well, that person is going on two weeks leave, well that's not going to help', you know.

120 Q. Yes.

A. So a lot of it was the negotiation around 'Well, what's going to work here?'.

121 Q. In the context of monitoring specifically?

A. In the context of monitoring and getting that

established and set up. And then we had the discussion that the monitoring needed to be someone of a level of seniority so that it was credible monitoring and that, you know. So we said that anyone who held a Deputy Sister, Deputy Charge Nurse role and above could do this, so that was Band 6 and above. We asked the -- we put it out to staff that we would pay overtime to get them to do it, because staff were already doing bank shifts and things. A lot of the managers and deputy managers didn't really do that much banking, so they didn't want to do banking, and so we, you know, offered incentives to get it covered. 10:44 10:45

122 Q. Yes.

A. I know we did get a social worker from our day care team who did a lot of the shifts, and we got some community staff, but those were very few and far between the community shifts. 10:45

123 Q. Well I'm going to come back to the issue of monitoring in a moment, but I want to look at the more general staffing issues that you raise in paragraphs 15 and 16 of the statement, and you refer to the issue of staffing being on the Risk Register since March 2012, what exactly do you mean by that? 10:45

A. When I took up post in January there was a moratorium on recruitment to Muckamore, and there hadn't been any recruitment done in a while, and posts were not going through scrutiny, and it's a process, and you put posts forward, they are scrutinised, as in 'Is there money for them? Is there backfill options? Is there 10:46

redeployments who can come to them?', and all of that had to go through. But posts were being held and not filled, and there was excessive use of bank even at that point.

124 Q. This was in March 2012 or thereabouts? 10:46

A. Yes. And that's why it was added to the Risk Register.

125 Q. And do you mean the hospital Risk Register?

A. No, the service area Risk Register.

126 Q. What does that mean exactly?

A. So every area would have a Risk Register of which they 10:46 would -- they would put the risk on, and whether they graded it as, you know, a medium risk or a high risk, and then what their mitigation they could do to reduce that risk, and if the mitigation would reduce the risk, did it come out of the red zone or was it still a 10:47 serious risk?

127 Q. Yes. Now we can look at the relevant documentation in due course, as an Inquiry, but you mention the red zone. Was staffing at Muckamore in the red zone?

A. Yes. 10:47

DR. MAXWELL: Are you talking about -- when you say the service area, do you mean Learning Disability Services?

A. Yes.

DR. MAXWELL: And that's a subsection of the Directorate. 10:47

A. Yes, the Directorate was adult social and primary care.

DR. MAXWELL: Yeah. So it was on the learning disability Risk Register as red. As I understand it, Risk Registers, anything that's red at a service level

then gets discussed at Directorate.

A. It should do, yes.

DR. MAXWELL: And there is a Directorate Risk Register, and anything that's red on that then gets escalated until eventually it might get to the Board. 10:47

A. Yes.

DR. MAXWELL: So it was red for the service area. Do you know how it was graded by the Directorate?

A. No, I don't. I don't remember. I know it was on the Risk Register and it went to our governance meeting 10:48 that was chaired by the Head of Governance.

DR. MAXWELL: Yes.

A. And it would have been discussed there, as in 'Is this coming down? Is this one still red?', and you would have had to update prior to every governance meeting. 10:48

DR. MAXWELL: But you don't know when it was discussed at the Directorates' governance meeting whether it was red for the Directorate, even though it remained red for the service?

A. I don't, no. 10:48

DR. MAXWELL: No, that's fine. Thank you,

128 Q. MR. DORAN: And you note in your statement in fact that you specifically reported the staffing issue later to the RQIA in September 2012?

A. That was in relation to -- I'm trying to remember who 10:48 was the head of RQIA at the time, but she made contact with us to ask about bringing forward the ward closure, and asked for a notification of the circumstances leading up to our decision-making. So I was asked to

produce...

129 Q. Sorry, who were you asked by?

A. I think it -- RQIA was interested in the closure of Finglass, so I think it was -- is it Ms. Nixon, Theresa Nixon was in RQIA at the time, it might have been her. 10:49

130 Q. Yes, but the request came from the RQIA?

A. I think that's what I recall is that the request was around why Finglass Ward was being brought forward.

131 Q. And was the request made directly to you or was it to the hospital management generally? 10:49

A. It may have been -- well, when we were planning to close the ward we would have notified RQIA of our planned closure, so then they would have asked for additional information as to why we were doing that. So it was like, we told them we were going to close the 10:50 ward, they come back and asked for more information, and then we produced the information as to why.

132 Q. Yes.

A. So it was like a to and fro conversation.

133 Q. And we can see the report actually at page 24 of the 10:50 statement, and it's actually -- I'm not going to go into all the detail, but it's actually titled "Patient Safety Situation", as opposed to staffing. Were those words deliberately chosen?

A. I think looking back I'm not sure why I chose those 10:50 words. I think certainly we were looking at -- I mean the overall situation was about patient safety.

134 Q. Yes.

A. And it was about all the wards as opposed to just one

particular ward.

135 Q. Yes. This was the hospital wide report?

A. Yes.

136 Q. And you were hearing from the senior staff that staffing levels were dangerously low? 10:51

A. They were having difficulty meeting and the -- what they were saying is, it was taking longer and longer to get the wards sorted. Yes, there was -- you'd come in of a morning and it used to be that 'Well, we've some sickness on that ward and we need to redeploy somebody 10:51 or phone around and get some people in', they were saying it was taking longer and longer to resolve the situation each day and that they were finding it difficult, and that the -- even though we had moved and were recruiting staff, the process is slow, so it takes 10:51 a while for those posts to get in. Even if you interview somebody it normally takes three, four, maybe five months for that person to actually take up post.

137 Q. Yes.

A. So you don't -- it doesn't resolve itself very quickly. 10:52 So you have, you interview somebody, and by the time you go through the checks and then they hand in their notice to where they work, and then they come and get a start date, you're talking four or five months. So, you know -- so staff were -- the Ward Sisters were 10:52 telling us that this was really hard for them, they were having people leave. We did -- I mean even in that it references that there's people being suspended. We did have resignations. People -- as a -- there's

unintended consequences of some of the resettlement processes, as in what is really good is there's community investment, so you get investment in the community to help resettlement. Resettlement happens and you get somebody out. But to have that investment you have to then recruit people, and those posts tend to be of a higher band than those that are working in the hospital, so the people in the hospital go for the promotion in the community and you have staff leave to go do those jobs. So it's... 10:52 10:53

138 Q. Can I just bring you back to the issue of patient safety, because for those of us working outside the health system, one can see generally how low staffing levels might affect patient safety, but I wonder can you explain from the perspective of someone working within the hospital what the risks are of low staffing levels? 10:53

A. Well a simple one at ward level is that, you know, if you are one or two staff down on a ward, that may mean that where patients are interacting with each other, and in normal circumstances even in the day room, but somebody becomes agitated or, you know, one patient lifts something else belonging to someone else, that there's not someone to immediately intervene, or assist that person, or redirect them to another activity. So then you would find that a safeguarding incident between patients would go up. It could also mean that a planned outing that they were going out in the ward car was, you know, patients were looking forward to 10:53 10:54

that, and because there wasn't enough staff that person couldn't leave.

The ward cars, you know, staff were assessed and trained to actually drive them themselves. So the person -- they didn't have a driver to take them out, and that actually meant that staff member drove the car with the patient, so it meant that then that didn't happen, so there was then disappointment at times with patients who sometimes that led to incidents. 10:54

Other things like if the hospital was very short and they were redeploying a lot of day care staff, some of the rooms in day care were not able to open. So those patients who were intending to attend for that activity that day, that might have been cancelled for two hours in the morning. I mean, you try to prioritise some of the things that were difficult to replace. So, you know, that day room maybe cancelled, but someone who had maybe waited on an appointment in another department or dental down in the Royal, had to be prioritised over the day room, so you identified staff to maybe go to the Royal, but you had to cancel the day room, and that maybe affected five patients as opposed to just the one, but it might have taken longer to get the appointment back at the Royal. So it just was -- you were juggling I think is probably... 10:55 10:55 10:55 10:56

139 Q. Yes.

A. You know, the resource itself.

140 Q. Yes. I just wanted to refer you to page 25 now at the top, if we could scroll down, please? You refer there

to other safeguarding investigations. You refer to this:

"Following this an audit of training in these two key areas revealed a substantial number of staff needed the training as well as those outside of timescales for VA as well as child protection. This was in the context of recent RQIA inspection on safeguarding and recent known investigations into other serious vulnerable adult concerns in learning disability of abuse and restriction practice concerns." 10:56 10:56

And you refer there to WT Winterbourne Maine PNH and historical issues on site. Were you very conscious at the time of those other issues that had arisen elsewhere? 10:57

A. Certainly when I took up post in Muckamore I tried to familiarise myself with the context of a learning disability hospital and the issues that could be pertinent to it. And certainly I became aware of, you know Winterbourne, the issues at the time in the Western Trust, and Maine, but also was informed of historical investigations that had been on the Muckamore site. 10:57

141 Q. Well, I was going to ask you about that. To what investigations are you referring in that context? 10:57

A. There was -- I mean there was records held in Muckamore of investigations by the police in relation to both staff and patient incidents of abuse, which were major

investigation, but there was also the Eastern Board investigation into abuse in long-stay hospitals. The Head of Governance was the link for Muckamore in that.

142 Q. Who was that?

A. The Head of Governance is Mairead Mitchell. 10:58

143 Q. Mairead Mitchell?

A. Yes.

144 Q. Yes.

A. So she was the link for Muckamore in relation to the Eastern Board, or the investigation in relation to 10:58 that. But I had -- we -- myself and Dr. Humphries would have looked at that in relation to resettlement, because we had to look at the risk assessments in relation to patients and whether or not any of that had a bearing on their future placement. But there was 10:59 also incidents in those investigations of where staff were named and investigated too, and so it was worth having an understanding that there was a history in Muckamore of previous incidents, and there was also legal requests through our Legal Department around 10:59 claims that were being made against the Trust in relation to situations that had happened in the past.

145 Q. And you were conscious of those issues at the time?

A. Yes.

146 Q. Now, I'm just wondering about the use of the term or 10:59 terms such as "staffing crisis" and the "staffing levels being dangerously low". We've already mentioned the SAI procedure, could a staffing crisis of this kind in itself have constituted an SAI?

A. I think it certainly would have constituted an Early Alert of, you know, alerting the nursing at the department that we were having difficulties in the hospital.

147 Q. Do you know if the early alerts procedure was used specifically in this context? 11:00

A. I don't remember it being used.

148 Q. But it was an option?

A. It would -- well, I don't remember it being used. I know I certainly involved all of the leads in medical and nursing in relation to this issue, simply because I needed support to try and resolve it. So certainly with corporate nursing, the co-director for workforce, I had lots of discussion with her in relation to how we could manage this, and I was seeking advice from her as to what I should do next. I don't remember discussing an Early Alert. 11:00 11:01

149 Q. Who was the co-director, sorry, for workforce?

A. Nicky Patterson.

150 Q. Nicky Patterson. 11:01

A. I don't remember discussing an Early Alert with her.

151 Q. Well looking back, do you think that might have been an appropriate course to take at the time?

A. Looking back, it probably would have alerted the Department earlier to the staffing issues on the site. Certainly all of our meetings that we would have had with the Board representatives around resettlement, around going down to them, seeking additional resources, it would have been very much telling them we 11:01

were having difficulties with staffing, because they did -- whilst we had a high level of special, and one-to-one, and two-to-one for some patients on site, that was a huge drain on our resources, because you had to free up staff to stay with those patients. So if a patient, because of a risk was on one-to-one, we would have -- we were asked by the Board to actually capture how many additional hours we were using on a weekly basis and submit that to the Board. They did give us additional funding to help with our specialing, and then -- so that relieved the financial pressure, but we still had to find the resource, so we would have over-recruited. 11:02 11:02

152 Q. What do you mean by "over-recruited"?

A. You have a staff in post budget. So when your ward is constituted, you're given an assessment of the ward and the number of staff you require to manage those patients, and that would have been used doing a Telford Assessment, which was a professional judgment. You did that, and then you worked out how many Band 3s, how many Registrants you required, and a ward manager and whatever, and deputy, and you done it on a bed to patient ratio. So it was -- a lot of the wards in Muckamore were on 50/50, some of them were on 40/60. 11:02 11:03

CHAIRPERSON: Sorry, is that 40/60? 11:03

A. 40% Registrant.

CHAIRPERSON: Yep.

A. As the patients were resettled and left, our Telfords all was indicated we needed more Registrants because

the people who were left were more, you know, had behaviours that would challenge staff more and also needed a lot more one-to-one and two-to-one support. So we recognised that the number of registrants we required actually was increasing as opposed to decreasing. But normative staffing had not been identified for learning disability at this point. Normative staffing started in the general hospital, not in mental health and learning disability. And actually even when I was leaving, it was only just being added on learning disability, as in phase eight or nine, but we had done some work with the PHA and Briege Quinn in relation to trying to identify what our projection of registrants that would be required, so that we could inform the workforce plan for the hospital going forward. 11:04 11:04 11:04

153 Q. I'm going to stop you at this moment, not that these matters are not of interest to the Inquiry, because they very much are, but we will have the opportunity of returning to them at a later stage. So I'm going to get back now to Ennis itself, and specifically to the introduction of monitoring, which we mentioned earlier, and you deal with this at paragraphs 17 and 18, that's at page 7 of the statement. And you had said earlier that one of the action points arising from the strategy meetings was the drafting of a guidance note for staff to explain the implementation of monitoring. You drafted the note yourself, I believe? 11:05 11:05

A. I drafted it, shared it with Aine, and Aine approved it

to go out. One was for the staff themselves on the ward, and the monitors, and one was for the ward manager. So there was -- well, there was actually two ward managers allocated to the ward at that point. So it was to say these -- I'm trying to remember what was in it -- but we actually identified and said, you're here to actually observe practice, to be supernumerary, but to look for good practice, to look for any concerns and to highlight them, and to do a monitoring report on every shift detailing anything that would be of interest or of concern to us. 11:06 11:06

154 Q. And that was guidance to those who were conducting the monitoring?

A. Yes.

155 Q. Now, what about the staff on the ward? Did anyone speak to the staff at the time and say 'Look, this is what we're doing and this is why we're doing it'? 11:06

A. That was why we issued the guidance directly to the Ward Sisters, we issued guidance to them, and it was to advise them of what the role of the monitor was so that they could keep their staff informed. 11:06

156 Q. But the staff who were being monitored essentially, were they informed as to what was happening?

A. Only through the Ward Sister.

157 Q. Through the Ward Sister? 11:07

A. Through the Ward Sister. And the two Ward Sisters -- because we actually put another Ward Sister into it.

158 Q. Yes. Now you say in your statement that you agreed that the use of monitoring was an appropriate

short-term measure. What do you mean by "short-term"?
A. I think I -- in recall I think I felt that when it started it was likely to last for probably six to eight weeks, so that they could get a feel for what was happening on the ward, the staff group, if people were there 24-hours a day they would see the practice that the staff were delivering and the care that was being delivered. We had removed the staff who had allegedly perpetrated the abuse, so we wanted to assure ourselves that the remaining staff were providing compassionate care. So it was to provide assurance around the care that was currently being delivered, and in those circumstances I would have assumed, rightly or wrongly, that six to eight weeks was probably in my head thinking that's probably how long this is going to last. 11:07 11:07 11:08
159 Q. Did you regard it as an effective way of ensuring patient protection?
A. I think it did give us confidence around what was being delivered directly to the patients at that time, and the reports coming out talked about that the staff cared for the patients and were delivering appropriate care, albeit that there was lots of challenges in the care they were having to deliver because of the environmental challenges of the ward, but also about some of the changes that had happened on the ward over a period of time, that, you know, it was being reported to me that they were -- that the Senior Nurse Manager who was on the ward wasn't aware that some of the 11:08 11:08

changes had happened, and that surprised me because some of that would have cost money to have achieved, and I didn't understand how a Ward Sister could authorise building works and funding for that without the knowledge.

160 Q. Yes. But just let's look again at the principle of monitoring. Aine Morrison suggested that you and Moira Mannion were resistant or objecting to the idea after a fairly short period?

A. I think we -- we had the discussion I think around January time. 11:09

161 Q. Yes. Well I think if one looks at the meeting of the 20th December 2012.

A. Right.

162 Q. That's the first meeting that you attended. 11:10

A. Right.

163 Q. If you weren't in attendance at the first, at the very first strategy meeting. We can have a look at that actually, it's at the Ennis Bundle, that's Ennis 1, page 48. If you just pause there, please. The fourth paragraph down: 11:10

"Moira voiced her concern in relation to the impact the monitoring is having on patients. Patients are thought to be reacting badly to the presence of strange staff on the ward. Aine noted that this factor was presumably also exacerbated by the need to use bank and agency staff at present to make up staffing numbers." 11:10

And if you scroll down, please?

A. So it would have been running for about six or seven weeks at this point.

164 Q. Yes. This was the 20th December. But I actually wanted to look at the next bit, where: 11:11

"Moira said that as the monitoring had shown no signs of a culture of abuse on the ward and indeed indicated a lot of good practice, she felt that the monitoring arrangements could change and put forward a proposal in 11:11 relation to this. The plan proposed that 24-hour monitoring would cease and be replaced by the implementation of the 15 Steps Challenge. This would involve both further monitoring and inspection but also improvements. Moira said that she would lead a team of 11:11 people charged with carrying this out. If any concerns came to light, 24-hour monitoring would be reinstated immediately."

And then: 11:11

"Aine said that while she welcomed the proposal as a means of moving forward she felt it was too early to move away from 24-hour monitoring."

11:11

And she went on to refer to the seriousness of the allegations. Can you scroll down, please? So in the next paragraph then there's a reference to Margaret Cullen, Lesley Jones, and Yvonne McKnight concurring

with Aine's opinion. Can you remember whether you took a view at that meeting?

A. I think -- I mean it refers to me there that we talked about integrating people into the team who could provide reports. The monitoring -- at that meeting, I mean Moira was putting forward the proposal to step it down and do something different. I think... 11:12

165 Q. And would you have agreed with her?

A. I would have agreed with her in that I felt that we had done it for -- in my head I thought six to eight weeks was probably the timeline that we should have been looking at. I felt that once we got -- weren't identifying additional concerns of abusive nature, that we should be supporting the team to move to a different way of monitoring. We did put forward the proposal of having a monitor as part of the team. We had been using the additional Ward Sister, a bit like that as part of the monitoring, because we had brought her in from another ward and we knew she was additional support. You know she became the Ward Sister there. We did have other people who were on the ward who were new, so there was -- it was becoming more and more of a new team all the time. The feedback I was getting from different people was indicating to me that any of these changes always had an impact on the patient, so the easier it was going to be on the patients the more you stabilised the team, and of course I was trying to be supportive of anything that would stabilise the team and have a lot less disruptive input. So looking at 11:12 11:13 11:13 11:14

that I feel I would have been supportive of Moira's stance, in that we moved to a different model of monitoring.

166 Q. Yes. Did you voice --

A. That's what I recall, that I think in my head at the time I always thought it was a short-term measure, not a long-term one. 11:14

167 Q. Did you voice that opinion at the meeting?

A. I think I listened to all the discussion and then concurred with Moira that we should move to something different about trying to develop a new team come the January, but I would have been listening in to the whole discussion and then trying to negotiate a way forward. 11:14

CHAIRPERSON: We can see that right at the bottom of the page where your comments are noted. 11:15

MR. DORAN: Yes. Yes.

A. I think just at the bottom it says I was probably in the position to...

MR. DORAN: That's in relation to the proposal from Moira. 11:15

CHAIRPERSON: Yep.

MR. DORAN: As to what could occur in January.

A. Yeah. Yeah.

168 Q. MR. DORAN: Now, moving back to paragraphs 19 and 20 of your statement, that's at page 8. You explain that the resettlement to Bohill didn't take place. Was that a Bohill decision rather than a Muckamore decision? 11:15

A. It didn't take place the following week because, and

this is from what I recall, is that staff were very reluctant to go up to Bohill on their own, because the patients were supposed to at this point move out and go to Bohill and be accompanied by our staff up with them, the same way that Bohill staff had come in to work with us, our staff was supposed to go up there and work with the Bohill staff, so that the first few days, if the staff had any concerns or needed help with something, that there was someone on site who could give them assistance who could help them settle and was a familiar face to get them settled in. But because of the allegations, and because of the suspensions, and the concerns that were raised, staff themselves I know at the time said "I don't want to go", and we were then managing a lot of anxiety with staff, and some said "Well I'll go, but I want others to come with me and, you know, go in pairs", and we were managing that staff anxiety alongside it, but some of the patients' behaviours were also continuing to deteriorate because of more new staff coming into the ward. The monitors were changing, you know, every few hours. So there was challenges in all of it, and from what I recollect there was some patients went up to the Bohill, but they weren't from the Ennis Ward, they went from other wards, but not Ennis. 11:16 11:16 11:16 11:17 11:17

169 Q. But those Ennis patients who were preparing for Bohill?

A. Yeah, I think there was four, I think there was four identified to go, and those four didn't go.

170 Q. They lost out on that opportunity at the time

essentially?

A. They lost -- it was a really good placement and the environment was great. It was a purpose built facility for people, you know, with care needs with a learning disability. I think longer term -- well they still got a similar environment because the Priory Group really provided that similar service in Armagh. 11:17

171 Q. In Armagh.

A. So they did go to a similar type environment. I think the staff who met the patients from Armagh seemed to be a more confident group of individuals who worked with them. 11:18

172 Q. Yes.

A. And I think that may, you know, the Priory Group employed in Armagh some people who had previous experience in learning disability in Longstone, was my recollection. 11:18

173 Q. Yes. I think it might be a suitable time for break in a moment. There's one question I want to ask, Chair, before we take the break. It's just eventually you refer to the 15 Step Challenge being implemented. Was that as a replacement for the monitoring? 11:18

A. No, the monitoring continued right up until July, but it was done differently, as in we had reports that were done from the Ward Sister, but also we put a deputy into the ward who would give us out reports on what she felt the environment and changes that were needed on the ward. We also had new Staff Nurses join the team and we asked for reports from them. 11:19

174 Q. And that was in the context of monitoring?
A. That was in the context of monitoring. And that continued -- we had daily reports from the monitors right up I think until July.
175 Q. Yes. Did it go on for too long in your view? 11:19
A. I think we all just got used to it and just kept going, because the meetings -- we had integrated it into the team I think around March time I think it was, and we just kept going until I think at one point we went -- there was a meeting in July and we said "Look, can we 11:20 stand it down now?". But I think at that point we just went "Well, she'll tell us when it's over."
CHAIRPERSON: Just on that note, before we take a break, we've got some guidance for supervising staff in the Ennis Bundle, and it's our page Ennis-1-84, and 11:20 I've just got a question around that. Do you recognise that document? Do you remember that at all?
A. Yes.
CHAIRPERSON: Did you contribute to this?
A. I wrote it. 11:20
CHAIRPERSON: Right. And that is talking about the monitoring, is it?
A. It's talking about?
CHAIRPERSON: The monitoring?
A. Yes. 11:21
CHAIRPERSON: So you were calling the monitors "supervising staff".
A. Yes.
CHAIRPERSON: Yes, and is --

A. I'm not sure whether that was the right word or not, but I shared the guidance with Aine, and Aine...

CHAIRPERSON: And can you remember when this guidance -- Mr. Doran probably knows this, but I don't. When did the guidance come out? 11:21

A. It was -- it would have been in November time.

CHAIRPERSON: Right. So this was the original form of monitoring rather than what it changed to?

A. Yes.

CHAIRPERSON: Right. And finally this, am I right in thinking there was only one monitor at a time on the ward? 11:21

A. Yes.

CHAIRPERSON: Fine.

A. And that's why it says around spending 70% of their time in the bottom end of the ward, because that's where the allegations were. 30% was at the top end. 11:21

CHAIRPERSON: Right.

A. So the patients in the bottom end of the ward had limited verbal ability, whereas a lot of the patients in the top end of the ward could interact verbally and could report stuff, so we concentrated a lot of the time in the lower end. 11:21

CHAIRPERSON: Yes.

A. To give those people a voice. 11:22

CHAIRPERSON: Yes. That's very helpful.

176 Q. MR. DORAN: Just to confirm, that's the document you were referring to and that you refer to in your statement?

A. Yes.

177 Q. Thank you.

CHAIRPERSON: Yes. Thank you very much. Okay. We'll take 15 minutes. You'll be given a cup of tea or something and we'll see you back a bit later. Thank you. 11:22

SHORT ADJOURNMENT

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

MR. DORAN: Now, Ms. Rafferty, we mentioned very briefly the 15 Step Challenge, and I'm not going to ask you to spell out the 15 steps, but I wonder if you were asked to give a description, a short description of what that entails within the context of a ward such as Ennis, what would you say? 11:40

A. It was where on entering a ward your first 15 steps should -- you should be far enough into a ward to get the feel for it's atmosphere and how people around you are being treated, and the welcome you receive, and the engagement of staff with patients, the overall ambience of the place, and whether it's calm, whether it's clean, tidy, you know, it's your whole perception that you take in when you, you know, and you're going in with a purpose to reach into the environment far enough so that you can get an overall perception of; does this place look okay? 11:40

178 Q. So the 15 steps doesn't refer to a 1 to 15, it refers to how one feels after taking 15 steps into the environment?

A. Yes. It's 15 steps into it, but also looking at there was things that you had to look for and you had -- you read the guidance before you do it and there's systems and observations that you're expected to undertake as you do this. 11:41

179 Q. And it's a general programme that would be used within the health service, is that right? 11:41

A. It's something that Moira Mannion would have discussed with me and explained to me the purpose of it, and that it is a tool to help explore how a ward is functioning, or a team, or you know. So it was using the methodology that would support the information that she was bringing back to the strategy group. 11:42

180 Q. And that's what Moira Mannion wanted to introduce in December 2012, is that right?

A. Yes, and I think it was to -- it was to look at a methodology for everyone to use as part of the monitoring, whether you were going in as a lead nurse, or going in as a senior nurse, or going in as a visitor, to think about how to envisage and how to report on what your perception of the ward was and what you were finding. You still had to look at the systems that were in place, and the processes, but it also gave you an understanding of what you should observe. So the dynamics between the patients and staff, the dynamics between the Ward Sister and the staff. 11:42 11:42

181 Q. And was that eventually used on Ennis?
A. I think Moira used that approach very much in her approach. I certainly would have used the methodology in my head as I'm walking through so that I would have, in my later discussions with Moira have said, 'Well, when I went into the ward this is the type of interactions that I was observing. These are the patient and patient contacts. This is who is feeling comfortable with who else.' So, it would have informed sort of how we were having our discussions. 11:43
182 Q. Yes. Now, I want to bring you back to the meetings, excuse me, the strategy meetings, and I want to ask you about a specific issue that arose, and that was as to whether there was evidence of institutional abuse. It was the focus of particular attention in a later meeting on 28th October 2013, and that's at Ennis 1-71. So you'll see that's the meeting of the 28th October, and you were present at that meeting. 11:44
A. Mhm-mhm.
183 Q. If we just scroll down then to page 75, please? And again if you could scroll down, please? Thank you. If you stop there. So the minute of the meeting reads: 11:44

"Mr. Veitch acknowledged the very thorough investigation carried out and highlighted the very intense monitoring process which showed no evidence of institutional abuse. Ms. Mannion noted that the monitoring processed has been stepped down as there was no concern about institutional abuse. 11:45

Ms. Morrison stated that while the monitoring reports confirmed no evidence of institutional abuse post the allegations being made, she did not feel that this could be necessarily generalised to the period before the allegations were made. Ms. Morrison reiterated the 11:45
conclusions in point 2 of the Recommendations and Conclusions section of the report and felt that this summed up the best judgment that the investigating team could form. Ms. Morrison did not feel that the investigation was conclusive enough to be able to state 11:45
categorically that there had not been institutional abuse. Ms. Kelly concurred with Ms. Morrison's views that it had not been possible to reach a conclusion on whether or not there had been institutional abuse. She also stated that RQIA felt there was enough evidence to 11:46
justify at least some concern about wider practice on the ward."

Now there's a difference of view here, obviously. Mr. Veitch is saying monitoring showed no evidence of 11:46
institutional abuse, Aine Morrison said it would be wrong to state categorically that there had not been institutional abuse. Do you recall what your view on that matter was at that time?

A. I think that -- I think if there was ongoing 11:46
institutional abuse it would have been demonstrated in the monitoring reports, and that the monitoring reports hadn't raised further concerns around the care practice. I know -- it's very hard to say that it's

not institutional abuse when it's a very clear institutional setting. The ward itself was institutional in how it was laid out and how it operated, in that there was overcrowding in bedrooms, there was overcrowding in the lower end of the ward. It was an old ward. There was doors that were locked, and there was limited, limited space to actually allow the patients to personalise their environment. So from that point of view the setting was institutional, but the care practice within it was -- they were trying to do their very best within the limitations of their setting. So... 11:47 11:47

184 Q. When you say "they were trying to do their very best"?

A. The staff.

185 Q. Are you referring to the staff generally, or the staff who were observed after the allegations came to light? 11:48

A. I think the staff in any of the older wards were struggling with the limitations of their environment, which in essential was an institutional setting, but they were trying to deliver compassionate care within that setting. I think they struggled within that. 11:48

186 Q. Are you making that observation in respect of those against whom the allegations were made?

A. No, because hitting someone or allegedly hitting someone is not do with setting, it's about your attitude and actions. So if someone hits someone, that should not is have happened. But some practices of locking doors to try and keep people in an area whilst you try to feed others and manage a situation of where 11:48

there's not enough space to have separate dining rooms outside of a sitting area, is to do with the institutional setting.

187 Q. Yes.

A. The staff had very little control over that. So that made it extremely difficult for them to deliver, I'm sure, the type of care that they would want for some of their patients. But, you know, you're looking at apples and oranges here. You have wards that have lots of space and lots of areas for the patients to sit and have a good experience, and you're also looking at an area where the experience for patients isn't that good, and the reason that resettlement was definitely going to be better for them because they were getting out of that environment. So, is it then that as, you know, as a hospital, and as a Trust, and as a Board, we allowed those patients to remain living in that environment, you know. So we're equally responsible, because how do we move them on? How do we get them out of that? And the only way to do that would have been to have everyone get en suite accommodation on the Muckamore site at that point when they redeveloped the hospital. So why were some patients chosen to have nice environments and some were chosen not to have? 11:49 11:49 11:49 11:50

188 Q. Now you're -- 11:50

A. You know that was, that was a decision taken at a point in time where some people got good accommodations and some people didn't.

189 Q. Now you're making these reflections now some years

later.

A. Yes.

190 Q. I wonder at the time did you --

A. At the time I was recognising that those wards were not fit for purpose, and that was being recorded in minutes with the Board. 11:50

191 Q. And we've seen your report generally that was made to RQIA. But I wanted to ask you this: did you contribute to the discussion at the meeting about whether or not there was evidence of institutional abuse? 11:51

A. From what I recall I think my discussion was we haven't seen it in the monitoring reports and, therefore, we have no evidence to support that statement. But that's as far as it would have went. And we would have been sticking to what, what is the evidence here that is showing it? But equally I would have agreed with Aine that the environment wasn't good, you know. 11:51

192 Q. But when she made the point that she said it would be wrong to state categorically that there had not been institutional abuse, did you support her on that? 11:51

A. I do recall part of that meeting, and the discussion was very much between John and Aine, you know, it was -- clearly John was trying to bring out more information from Aine to say one way or the other, and Aine was saying 'Well we can't rule it out but we can't rule it in.' 11:52

DR. MAXWELL: Can I ask, this is, you know, these are two quite senior people, both social workers I think.

A. Yes.

DR. MAXWELL: Having a difference of opinion on quite an important point, which then gets brought up later. Did they just agree to disagree or...

A. No, John, from -- I think from even reading the bundle, I think John agreed to go back over the minutes and to read through them and see had he raised this in a previous time when the strategy meetings were being held, and had he, you know, had he settled himself on it at an earlier point? But he agreed, I think, to go back and read over and review what had already been produced. 11:52 11:53

DR. MAXWELL: And if he had changed his mind and thought 'Well, there's a possibility that there's institutional abuse', what difference would that have made to the way the ward and hospital were managed? 11:53

A. If the consensus of a strategy meeting had said there's institutional abuse, I think there would have been implications for the whole site, because the staff themselves were moving about the site on a regular basis. If there was institutional abuse and it wasn't being flagged by the staff, we would have had to look at that. 11:53

DR. MAXWELL: And how would you have done that? I'm just thinking, I'm not saying there was but, you know, if the consensus had been that there was a risk of this, what actions could have been taken? If you were the Service Manager and this had been presented to you? 11:54

A. I think we would have looked at external training for

staff, well further external training. We would have also looked at the professional make up on the wards to see whether or not introducing other staff in those environments would have helped for oversight.

DR. MAXWELL: Do you mean other professions? 11:54

A. Other professions. Muckamore was very much, you know, two disciplines mostly on site. There's very few other people. So it was medical and nursing mostly. The social work team was very small. So I think we would have explored other ways of looking at it. We probably 11:55 also would have commissioned other people who could have come and helped us with that, because we wouldn't have tried to do it on our own, we would have asked for assistance and looking for people in other areas who had explored this and how they dealt with it. 11:55

DR. MAXWELL: So the fact that that didn't happen implies that the resolution of this was, it wasn't felt that there was a strong possibility of institutional abuse?

A. It wasn't, but it didn't mean that we didn't open 11:55 ourselves up to external examination, because we worked with the Quality Network For Learning Disability to come and inspect our services.

DR. MAXWELL: In 2012?

A. No, we done that in 2014 or '15. 11:56

DR. MAXWELL: Okay.

A. I think it was 2014 in Iveagh and 2015 in Muckamore.

DR. MAXWELL: And where did they come from?

A. From a range of learning disability hospitals in

England.

DR. MAXWELL: Right.

A. And we went and seen hospitals over there, or we had teams who went and seen hospitals over there. They had teams who come and looked at our wards, and mainly the core wards that we invested in that process. You know, we had become accredited with the Quality Network For Learning Disability on all of the words, bar the PICU, and Iveagh, the children's ward, with the quality network for CAMHS. We tried to benchmark ourselves against their standards, and we also then invited them in to look and verify what we were submitting. 11:56 11:56

DR. MAXWELL: So they came and did site visits?

A. They did. We also opened ourselves up to an ex-director, Bernie McNally, would have brought visitors from overseas to Muckamore, and there was walk-arounds with those staffs, and they visited wards and talked to staff around the care that was given. We also invited staff down from our colleagues in the Western Trust who had in-patient services, you know, to come and look at our service. So it wasn't that we didn't want to improve the service, we actually did explore 'Well, how do we benchmark?', and we did that through the quality network. 11:57 11:57

DR. MAXWELL: Thank you. 11:58

193 Q. MR. DORAN: Now Ms. Rafferty, as regards the difference of views between Mr. Veitch and Ms. Morrison, we can obviously ask Mr. Veitch about that, but I do want to give you an opportunity to comment on what Aine

Morrison said more generally about her experience at the time, and I wonder if we could have Aine Morrison's statement on screen? It's STM-198, page 26. If you could scroll down, please? I just want to look at paragraph 100: 11:58

"At the time I believed that the reasons for the behaviour I experienced were attitudinal. I did not believe that there was any attempt to cover up or hide anything. I attributed the difficulties I experienced 11:58
to a range of possible factors, including professional defensiveness on the part of nursing and a reflection of some community hospital and social work nursing tensions. While some defensiveness is not unusual from services which are under investigation, this was beyond 11:59
the normal. I also believed that there was a reluctance, perhaps subconsciously, to accept the possibility of widespread abuse on Ennis Ward. The pressure from John Veitch was one of the most difficult parts of the investigation for me as it was repeated 11:59
and coming from within my own line management hierarchy."

And scroll down, please: 11:59

"John Veitch's position as Co-Director for Learning Disability Services, and subsequently as my line manager, Moira Mannion's position also as Co-Director, and Esther Rafferty at Service Manager level were all

more senior to me up until July 2013, when I took up a Service Manager post. This made the challenges I faced from them particularly difficult to handle."

If you scroll down, please: 11:59

"I believe that the behaviour of John Veitch, Moira Mannion, and to a lesser extent Esther Rafferty, was bullying in nature and it took a significant personal toll on me to have to maintain my own position and not 12:00 give into the pressure and to carry out my professional responsibilities in the face of such opposition."

Now, I just wanted to give you the opportunity to comment on the suggestion that Aine Morrison makes that 12:00 the behaviour of John Veitch, Moira Mannion, and to a lesser extent yourself, was bullying in nature?

A. I have to say, sitting in the meetings I didn't feel any of the meetings were overwhelming or, you know, there was management challenge and professional 12:00 challenge that went on in those meetings and certainly that was to explore the issues. Any of the discussions I had with Aine I felt were respectful. I mean, I don't believe that any of the actions I took were bullying of nature. Aine is actually a very assertive 12:01 individual, and Aine herself would, I mean in my dealings with her, there's usually not areas of grey, she's normally black or white in how she approaches things. I don't know whether I'm saying -- but she,

you know, Aine will put forward her thing, and if you make an argument with her she will then say 'Well, that's a reasonable argument. Okay, we'll do this'. If she didn't feel it was a reasonable argument, she will stand her ground. 12:01

194 Q. Yes. But could you understand how she might have felt pressurised at the time?

A. I actually don't think she was pressurised, simply because she did exactly what she said she was going to do on every occasion. I don't think she ever changed 12:02 her direction or mode of travel because of what I, Moira, or John said.

195 Q. Just looking back now, do you think you would approach the matter differently?

A. I don't think at any point that we, you know, it was 12:02 heated arguments or anything. I think there was viewpoints put forward, but they weren't overbearing, that I remember. I know -- on occasion I know like Aine said to me on one occasion that it's hard to listen to incidents of abuse and hear from patients, 12:02 because she had done investigations before and it -- those impact on you, and I totally agree with her. If you hear a patient recount something, and you have to take that evidence, it's -- you become emotional with it. So certainly she had the best interests of the 12:03 patients in place, but so did the rest of us. I certainly never wanted a patient to be hurt, and Moira would be of the same. Moira, Moira is actually -- even how she speaks to staff is very supportive and soft.

196 Q. Well I'm going to stop you...
A. So, I just...
197 Q. Because the Inquiry will be hearing from Moira Mannion at a later stage.
A. Oh, right. But I mean I don't remember shouting at Aine. I don't remember being in a heated argument with her. Yes, we had discussions about things, but as I said before is, when we had a difference of opinion I went and sought other advice so that I was resolving the concern as opposed to continuing it. 12:03 12:04
198 Q. Do you think the differences of opinion impacted on the effectiveness of the process?
A. I think the investigation itself took a very long time.
199 Q. Do you think it took too long?
A. I think it could have been concluded sooner. Simply because -- we lost witnesses because of the length of it. You know, even Aine when her team were interviewing and you read the report, you know, you start off with so many witnesses and then you're talking to them and getting statements and going back, but even going back there's 50% of the witnesses refused to come forward again. And the length of time, people then choose 'Well, you know, this is stressing me out too much' and things. I think if a lot of that additional probing had been done at the original statement, and getting those statements agreed and signed off, would have lessened the stress on people, and we might have engaged and maintained that engagement with some of those staff to keep the 12:04 12:04 12:05

investigation live and active.

200 Q. Now you're talking about the safeguarding process as opposed to the disciplinary investigation?

A. I think both of them, because even in the original safeguarding report by Aine, I mean 50% of the staff refused to come back to be interviewed, you know. So the longer these things go on you lose the momentum with it, and whether people leave, or sick, or whatever, and recall is also more difficult. It's a bit like me trying to remember back 12 years or so. You remember parts of it and not others. So I think the longer any investigation takes, it makes it more difficult. So, you know, it is always helpful to get them concluded as soon as possible. 12:05 12:05

201 Q. I'm going to ask you about something else specifically that happened 12 years ago, because in her statement Aine Morrison also raised an issue about Moira Mannion at a meeting at which you were said to be present, and I just wanted to ask you about that. It's in the -- it's page 24 of the statement that's currently on screen, and paragraph 95 please. 12:06 12:06

So at paragraph 95, Aine Morrison said:

"Moira Mannion challenged many of the aspects of the decisions and actions I was making, many of which were routine safeguarding practices. Whilst some challenge and questioning is normal and often useful, I believe this was excessive and unreasonable and delivered in a 12:06

tone and manner that I found intimidating. Minutes do not convey tone and manner. However, the minutes of various meetings, in particular the minutes of 20th December 2012 do, I believe, show the level of challenge and opposition I was faced with." 12:07

And this is what I want -- you've talked about the conduct of the meetings generally, but this is the extract that I wanted to ask you about:

12:07

"I also recall that Moira Mannion berated me in a meeting for daring to suggest that nurses could be involved in abuse, pointing to their professional registration, their professional codes of conduct, their duty to uphold their code of conduct and 12:07 accountability for their own practice."

Do you remember Moira Mannion saying those things in the course of a meeting?

A. I do remember Moira responding to a comment that Aine 12:07 made in a meeting around, I'm unsure whether it was to do with registration of nurses, or how nurses are held to account, but Moira was reiterating that their registration and that, you know, professional codes of conduct are all in place to ensure that nurses are held 12:08 to account, and it was more in her explaining to Aine 'Well there is systems in place for nurses equally that will, if a nurse does wrong they will be held to account. There is professional code of conduct, their

duty to uphold conduct', and she was stating those as this is what will happen if a nurse is found guilty of abuse. But it was assuring Aine that there is processes in place to hold us, as a nurse, to account. Not as in 'I don't believe nurses can abuse', it was held -- her response, from what I recall, was in relation to a statement Aine made. I don't know whether Aine meant it in that way, or whatever, but certainly Moira's response was more about 'nurses can be held to account if they abuse because of their registration, because of the duty to report.'

202 Q. But would you accept then -- well, what's your comment on the suggestion that: "Moira Mannion berated me in a meeting for daring to suggest that nurses could be involved in abuse"?

A. Well, I don't think it -- no, it wasn't -- I wouldn't use the word "berated". It was responding to a concern or a statement that Aine made at the meeting. Moira responded to it and said that those processes were in place and that staff are accountable for their practice, and if someone is guilty of abuse they will be held accountable.

DR. MAXWELL: So was Aine suggesting that nurses weren't held to account?

A. I think it was more just as to how it was said, that Moira was just explaining 'this is what would happen', and Moira at that time, I recall, was -- had some responsibility I think for the Nurses in Difficulty process, so I think she was more recounting that as

opposed to getting into an argument.

203 Q. MR. DORAN: I'm going to move on to the report itself. In paragraph 29 of your statement, if we can return to the witness' statement, please? That's at page 10, and if you scroll down to paragraph 29? You criticise the report as being a bit disjointed. Did you express any criticism at the time? 12:10

A. The discussion very much centred on the amount of issues that were raised. You're reading through it, you know, you get it that -- you're trying -- when you read -- 12:11

204 Q. Can I just pause? When you refer to "the discussion", are you referring to the July meeting?

A. Yes.

205 Q. At which the draft report was first discussed? 12:11

A. It was, yeah, the July meeting. It would have been -- all of the issues were sort of laid out and, you know, you're reading through it and you're thinking 'this is awful, you know, look at much come out of this.' But I think for me the reason I said it was a bit disjointed is, when you read it you sometimes go 'Well, did that happen or did it not?', and you were jumping back and forward in the report to figure out 'Well, is that one we have to take forward or is that something that has been dismissed or not, or as in not upheld, or the concern has been resolved.' So I felt I was jumping back and forward in the report a wee bit to try to ascertain what comes next. 12:11 12:12

206 Q. I think --

A. And that's why I think it was a bit disjointed, but that's for me.

207 Q. But is that your view now, or was that your view at the time? And, if so, did you express that view at the time? 12:12

A. No, I didn't express it at the time. I accepted the report from Aine, I read the report, and I looked for 'Right, what is my responsibilities next now that I have this?'

208 Q. But you would have had the opportunity and, indeed, did have the opportunity at the time to make comments, if you had so wished? 12:12

A. Yes. But the style of how a report is produced is very much with the authors, because all, you know, no matter when do you an investigation report, everyone does them differently, and it may not be the way you personally would have structured it, but that doesn't mean to say that what they did was wrong, it was just in a way that I found it more difficult to read. So more the issue lies with me as opposed to with Aine. 12:13

DR. MAXWELL: But in your statement you actually say that there's little drill down on evidence and at times no evidence was produced to substantiate or collaborate.

A. Because when you read some of the allegations it actually says 'there's no evidence to substantiate this, there's no evidence to substantiate this', or 'we can't find evidence to substantiate it', so they weren't grouped in those ones together. There was ones 12:13

in between it that were saying 'well, this is upheld', there was evidence at the back that queried and said 'well, even though we've no evidence, I believe this happened', so it was --

DR. MAXWELL: So you're saying the report wasn't clear about which allegations had evidence to support them? 12:13

A. There were some statements that were more ambiguous, and that's probably why I was jumping back and forward to go, 'Well, was there not evidence back here, or why did you believe it there?', you know. But this was me trying to understand the evidence and the information that was presented to me. 12:14

DR. MAXWELL: So as the manager of the service, received the final report which was ambiguous and hard to follow, did you then make a judgment about which had been upheld and needed action and which hadn't? 12:14

A. Because of some it, it said that 'We have been unable to locate the evidence in relation to this', when we commissioned the investigation disciplinary report, we asked that all of the allegations were explored. 12:14

DR. MAXWELL: Okay.

A. Which is why they actually say, you know, they went back and talked to some staff and said 'Well, did you report this and how was it dealt with?'. So, it was to clear those ones up, because they felt as if they were still hanging there a little bit. 12:15

DR. MAXWELL: So the ones where there wasn't a clear conclusion, you felt the disciplinary investigation --

A. Could explore that further and drill down to see.

Because I think relating to, is it the -- there's something to do with about the belt tightening, and more than one person said there was belt tightening, but yet they said there's not enough evidence, or there was no evidence to support this. Well, I know if I was doing a disciplinary investigation and more than one person said to me that happened, that should be enough to collaborate the original statement, and then it would be up to the person to explain their actions and why they undertook them. 12:15

DR. MAXWELL: Okay.

209 Q. MR. DORAN: But just as part of the strategy group that was examining the issues that led to the report, did you not feel that it was your responsibility at the time to go back and say 'Look, I have issues with the report and I want to bring them to your attention'? Because I think you were all given two weeks to go off and consider whether you wanted to make any representations about the draft? 12:16

A. I don't believe representation would have changed the report because the information that they were basing on was their professional judgment, and they said that 'In our professional judgment we believe that there is' -- so it would not have changed the outcome under each of the allegations and, therefore, I understood that within a further investigation we could have drilled down better to actually rule in or rule out whether or not we could action on those. So, it was clear from Aine's report that the two staff who we originally 12:16

suspended, we all had concerns that those allegations were likely, you know, to have happened, because the report was clear, there was, you know, support backup of, you know, patients recounting stuff. So we, we were looking at those and saying, well, those are the ones that still appear to require action. But we weren't content to say all the rest didn't happen. We wanted some assurance, or well I wanted some assurance that those behaviours were appropriate, and if it was a restrictive practice well then the ward needed to document that properly within the care plan. But if it was actions that were based on certain staff on certain days 'we're just going do this', well actually that's not appropriate, and we would want to educate staff that those things shouldn't happen again. 12:17 12:17 12:18

210 Q. But you say in your statement that you hoped that any shortcomings, as you put it in the report, could be resolved?

A. Through the disciplinary.

211 Q. In the disciplinary investigation. 12:18

A. Yes, and that's what I'm saying.

212 Q. What exactly did you mean by that?

A. That's what I mean is asking for -- in a disciplinary investigation they will take those statements and they will then ask for clarification on, 'Did that happen?'. They went and spoke to the staff, but because one of the investigation team was an experienced learning disability nurse, she could -- and she was also -- had a qualification in behaviour management, she was then 12:18

able to look at that objectively and say well -- and ask the questions of the staff 'Well, why did you do it in that way? Your training would have indicated you did it this way.' So she was in a stronger position to drill down on that as part of the overall disciplinary investigation, and the disciplinary investigation --

213 Q. A stronger position than who?

A. Well, the social workers who done the safeguarding investigation, I wasn't aware whether or not they had specific experience in direct care of looking after individuals, you know, in delivering those care activities directly to -- in a care environment, whether it be residential, supported living, or a ward environment. You know, some social workers have had experience of working in those environments and some haven't. So the experienced nurse alongside an independent person outside of the service area was a good team to actually explore each of those incidents and see, and try and get to the bottom of it.

214 Q. Well, I'm going to come back to some of those issues in a moment. But I just want to ask you about something you say at paragraph 30 of your statement, where you refer to Dr. Milliken's reaction at the time. You say:

"Dr. Milliken, the clinical lead, was shocked at the allegations that were made. He advised that he had personally never witnessed any ill-treatment. He also made the point to me that how could the allegations be so widespread when Ennis Ward was open to family

members who had the door access code and could enter onto the ward at any time without prior appointment."

Can I ask you, was it your impression that Dr. Milliken didn't think the allegations were credible? 12:20

A. He never at any point said they weren't credible, he just said he was shocked. I think he was shocked that allegations of abuse come out of the ward. But, equally, he was shocked when he heard of a patient getting struck in Killead Ward. You know, that member 12:21 of staff had been on the site for eight years who did that. So I think any of us would express shock when we hear of a patient being mistreated. And so, therefore, I mean because he was the RMO he knew the patients, he knew the staff, he would have been in the ward 12:21 regularly and, you know, we all -- I suppose we all have opinions of people who we work with, and if you went to a nursing staff on a ward today and someone told you tomorrow that they assaulted a patient, you know, you think back, you can't imagine that person 12:21 doing it, so you express your emotions at the time in relation to, you know, he found it hard to believe that they did it.

215 Q. Yes.

A. So I think I would -- you know, if it's someone I know 12:22 and somebody told me tomorrow they hurt somebody, I would express shock at that, you know.

216 Q. Now let me ask you then about the report itself. We know now that the report wasn't formally escalated to

the Trust Board at the time when it was produced. Does that surprise you?

A. I was -- I knew the directors knew about it. So these things you would expect directors to make reference to, but I don't know the process for getting those things on to the agenda, so I don't know what you have to do to do that. 12:22

217 Q. So you wouldn't have had any say in a decision of that kind?

A. No. 12:23

DR. MAXWELL: But was it discussed at the Learning Disability Services governance group that you talked about earlier when you talked about the Risk Register for staffing?

A. I don't recall it being discussed there. It was discussed at the core management group. 12:23

DR. MAXWELL: So it didn't get to the Learning Disability Services governance group, which would presumably have been the route through to the Board?

A. I don't recall it being discussed there. 12:23

DR. MAXWELL: Okay. Thank you.

218 Q. MR. DORAN: Now, at paragraphs 32 to 35 you discuss a meeting at which Aine Morrison discussed her findings with the staff. I just wanted to ask you about a specific point that you make at paragraph 33, if you could just scroll down, please, and you say: 12:23

"There was already some negativity from staff based in MAH regarding the resettlement processes being rolled

out and against working on resettlement wards such as Ennis Ward. This meant that some of the staff appeared resistant to change and some feedback from managers previously would have indicated that they were annoyed that patients were leaving the hospital and being resettled, which was putting their jobs in the hospital at risk."

Does that mean that some staff were actually resistant to the whole concept of resettlement, on the basis that reduced patient numbers meant fewer jobs? 12:24

A. There's a variety of responses to that, is some staff, yes, didn't want patients leaving the hospital because they had lived there all their lives and had moved in when they were children and were still there 50-odd years later. So some staff were of the opinion that it was inhumane to ask them to leave somewhere that they viewed as home. 12:24

219 Q. But what about the notion that they were resistant to resettlement on the basis that reduced patient numbers meant fewer jobs? 12:25

A. There was some staff -- oh, reduced patient numbers. We did have a workforce strategy on site that would involve staff being redeployed. There was no -- there was nothing to do with people being made redundant. We would reassure people that they weren't going to be made redundant. But unfortunately because Muckamore is based in Antrim and not Belfast, you use the Belfast Trust for redeployment. So a lot of people who work in 12:25

Muckamore don't have cars and their family are based in Muckamore, or in an around Muckamore and Antrim, and the idea of moving to Belfast to work was something they were very resistant to. There was a lot of staff who were in health care assistant posts at Band 3, who were the most likely people to be redeployed. Registrants were not likely to be redeployed at all because we had a shortage of Registrants on site, and we knew we needed anyone who was qualified to maintain the hospital into the future. So 5s, 6s, 7s. Band 7s, there was one Band 7 redeployed to Belfast to a vacant manager's post after a ward closed, but Band 5s and 6s were not -- were never going to be redeployed off the site. 12:26 12:26

220 Q. But coming back to this idea of negativity towards the idea of resettlement, was that ever -- 12:26

A. Yes, because -- that was there. Yes.

221 Q. Sorry, if you just wait until I ask the question.

A. Oh, sorry.

222 Q. Was that ever specifically addressed by the hospital at the time? 12:26

A. We, we would have held meetings with the staff every three months and talked about the resettlement process, talked about who was going, when they were going, what the stages were, the impact on the ward, the impact on the staff, who was likely to have discussions with senior managers about their positions in the hospital. Staff side and trade unions attended all of those meetings, and those were attended -- we normally had 12:27

three sessions on a given day every three months, and like numbers attending were usually in excess of 400 people over the three sessions. So we had lots and lots of people who would come along to hear about the process, hear how it was happening, which ward was likely to close next. If it went to the next meeting then we would say, 'Well, actually, more people have moved out of this ward than that one, so this ward is going before that one', but we talked about people coming in and doing in-reach into the wards, we talked about the staff having to go out and work in the wards with other people and into the providers, whether they were nursing homes or supported housing. We also talked to staff about the opportunities that were available to them. There was some staff knew that we had supported housing scheme in Greystone in Antrim, and a lot of them opted for it simply because it was local to their homes. 12:27 12:28 12:28

223 Q. But was there any specific education on the purpose of resettlement, and the philosophy behind it, and the aims of improving and enhancing patient -- 12:28

A. Well, we talked about betterment --

224 Q. I'm going to have to say...

A. All right.

225 Q. Unfortunately the transcript can only pick up one voice at a time, so we can't, we can't talk across each other. But what I wanted to ask, was there any education about the philosophy behind resettlement and the objective, hopefully, of enhancing and improving 12:28

patients' lives in the future?

A. There was at ward managers meetings, and there was at the service meetings, and there was -- we talked about -- I know I talked to ward managers and deputies around the role and function of resettlement, and who was getting involved, and what was behind it, and what meetings they could come to, and how they could engage their staff with some of the processes, and some of that was around talking to staff with patients who they knew really well and had a relationship with over a long time that they had cared for them in the hospital, that they could personally visit the homes themselves and pick the most appropriate setting that that person could resettle to. So we tried to engage the staff in that way, so that what we were showing them was, they had a say in where some of the people went to, and then they would talk to some of the relatives to say 'Well, look, I've been out to that home, this is what would be good for your relative because of A, B, and C', and... 12:29 12:29 12:30 12:30

226 Q. But I think you refer later in your statement to some staff being reluctant to actually work with in-reach staff? 12:30

A. Yes. I mean you would have got -- some statements that you got was more about the personal journey of staff as opposed to the personal journey of the patient. 12:30

227 Q. And that's a problem, isn't it?

A. It is a problem.

228 Q. In the context of Muckamore.

A. Mhm-mhm. And, you know, staff would have said 'I've

worked with that patient for the past 20 years, I envisaged that I would retire having looked after that person all my life', and it was about them going out on retirement, fulfilling their wish, as opposed to the patient's need and what was good for them.

DR. MAXWELL: But we did hear from the Ward Sister on Ennis that in October 2012 she had raised concerns that because of the staffing crisis and because the in-reach staff from Bohill had largely not worked with people with learning disabilities before, she had raised concerns about the capacity to supervise them. So was some of the staff's concern about working with in-reach staff about the supervisory capacity?

A. Certainly that was flagged too. We had a person on site who helped coordinate with the providers to link in with the providers to pick up on any issues and bring them back to the team so that the team could sit down and see, well, what would work better? The feedback from Ennis was different to some of the other wards, because some of the other wards felt that the in-reach staff coming in were learning appropriately about the needs of the individuals. So, that was flagged, and equally she was saying, you know, the changes to the environment were making a difference.

DR. MAXWELL: But would you accept that if you have a significant shortage of staff, "dangerously low" as described in one of your exhibits, that bringing new people in who don't know the hospital, don't know the patients, and don't know the field, actually they can't

be supervised if there are aren't enough staff, and that that itself can cause problems?

A. It can cause problems. But equally -- it's a chicken and egg situation, because if you don't discharge people the situation doesn't improve. If you keep, you know, if everyone continues to live in Muckamore, the staffing situation was never going to ease. 12:33

DR. MAXWELL: No, I understand the challenge, but I'm just trying to --

A. It is a challenge. 12:33

DR. MAXWELL: This is part of the motivation for staff being reluctant to work with in-reach staff, it might be because they want to nurse people until they retire, but it might also be that actually it was challenging in -- 12:33

A. It was challenging. It was challenging any time anybody came into the hospital, and it was also challenging for our staff to go out and support people in the community. None of this was easy. And some services managed better than others with it. But, yes, you're right, there was issues raised throughout the process and at different stages. 12:34

DR. MAXWELL: Thank you.

229 Q. MR. DORAN: I want to come back to the disciplinary proceedings. Is it fair to say that you commissioned them but didn't actually conduct them? 12:34

A. Yes.

230 Q. And did you play any role in directing the investigators?

A. No, we set their terms at the beginning and then it was regular check-ins with them to see their progression with the investigation and what additional supports they might need. Certainly at the beginning we had to ask permission of the police to start the investigation, and their proviso was 'You can start gathering information at this point. We will tell you when we can move forward. But anything that you uncover that has significance to the PSNI investigation, you must share with us.' But that they had concluded their investigation, so they were happy for us to explore moving forward. 12:35 12:35

231 Q. Did they share information with you, or with the investigators, I should say?

A. I think the investigation team, from what I recall, had access to the statements that Aine had access to, but not I think beyond that. I think it was they had access to the information in the safeguarding report, and the statements, and the documentation. So they would have used all of that information, plus what they requested to conduct their investigation. 12:35 12:36

DR. MAXWELL: Does that include statements to the police? Did Aine have access to statements the police had taken?

A. Well, I would assume Aine has access to some of that. 12:36

CHAIRPERSON: Well, sorry, but assuming may not help us.

A. Oh, sorry.

CHAIRPERSON: Did you know or not?

A. Well, I don't know for definite.

CHAIRPERSON: Right.

MR. DORAN: That's something we can revisit. I just wanted to ask you about some points that Aine Morrison raised, first of all about the scope of the disciplinary investigation, and you perhaps touched on this earlier. But can we go to Aine Morrison's statement, that's 198 at page 27, please? And if we scroll down, please, paragraph 104: 12:36

12:37

"I had no further involvement in matters until I became aware that Esther Rafferty had requested Rhonda Scott and Geraldine Hamilton to commence an investigation into the November 2012 allegations. Having had the benefit of reviewing the Module 6(b) Ennis Ward Adult Safeguarding Report bundle for witnesses provided to me by the Inquiry at page 580, I note reference to an e-mail on 19th September 2013, whereby I was contacted by Rhonda Scott by e-mail to advise that she and Geraldine Hamilton had been asked to carry out an investigation into the November 2012 allegations. Upon receipt of this e-mail I note from the timeline that I was concerned that it appeared that Esther Rafferty had asked for another investigation into matters that I considered the safeguarding investigation already covered. I queried this by e-mail to Esther Rafferty. Esther responded to advise "A full internal investigation will now take place to look at what action and learning the Trust needs to 12:37 12:37 12:37

undertake in relation to any staffing concerns from the original complaint on 8th November." This is normal practice. I responded asking if this is a disciplinary investigation and Esther confirmed that it was. Having had the benefit of reviewing the documents, which appear at pages 293 to 376 of the bundle, the content of these reports would appear to me to suggest that the investigation carried out by Rhonda Scott and Geraldine Hamilton did cover matters which I believed were already dealt with. The reports note that the interviews they carried out covered induction processes, training, staffing, supervision, the environment, resources, reporting processes, as well as the adult safeguarding allegations." 12:38 12:38

Now I suppose in short form, Aine Morrison was suggesting that the disciplinary investigation appeared to be intruding on issues that had already been effectively explored by her during the safeguarding process. How would you react to that? 12:39

A. Actually in Aine's report she has asked that a disciplinary process was carried out in respect of the individuals who were suspended and accused of the abuse.

232 Q. Yes. 12:39

A. So in commissioning the disciplinary investigation you have to explore it all, as well as provide the evidence at a disciplinary hearing of when you want to go to hearing you have to have the evidence that you're

presenting, and that includes information provided from each of those people that is signed and dated that says "I'm standing over this and I am prepared to come in and be a witness to this hearing and that I will answer questions in relation to this." So, you go -- the safeguarding investigation was complete. There was evidence in it that we had to look at the continued employment of those individuals and whether or not they should still continue to be employed in their roles. So we had to take forward an internal disciplinary process, and that involves getting all of that evidence stacked up so that you can present it to a panel and that the person and their representative have an opportunity to discount it. 12:40 12:40

233 Q. And Aine Morrison also expressed some concerns about the disciplinary process not giving sufficient weight to the safeguarding conclusions. What would you say to that? 12:40

A. Each of them, each of the things we took seriously simply because we actually looked at every one of those things and wanted to get -- you know, even the ones that she said she didn't find evidence for, we went to look for the evidence for it. So the team wanted to find the evidence to back up what the allegation was or to account for it in practice. So every one of them was given weight, as in every one of them was looked at and tried to resolve as in 'Can this be upheld or can it not?'. Where an allegation is upheld, then we would take it to a disciplinary hearing and allow an 12:41 12:41

independent panel to make a judgment on that as to whether or not that person who did it has to have a sanction.

234 Q. But looking back, might it have been appropriate for Aine Morrison to have been consulted earlier in the disciplinary process? 12:42

A. The two people who were appointed to do it were senior staff. They -- I mean I'm not sure why in the timeline they approached the person at this point as opposed to that point. They were asked to go look at all of the allegations to find the evidence for same and to prepare for an outcome, or make a recommendation as to whether these people are disciplined or not, and if there was further evidence to support those that weren't upheld as part of the safeguarding, they would have been addressed as well. 12:42 12:42

235 Q. But are you saying essentially that you left it up to them to conduct their investigation?

A. Yes, I left it to -- I mean there were two senior staff who were conducting it, you know. So you don't tell them. They were told at the beginning they have the right of access to all of the information to conduct their investigation. So they then do their own timeline about who they're going to approach, and when, and in what sequence, including, you know, they agreed the questions, I had no input into what questions people were asked. They agreed what questions they would ask to get to the bottom of the issues, but they're an independent team who go look at it. I 12:43 12:43

should not be influencing their investigation. I should not be telling them 'Well, I want you to find this or I want you find that', they should be providing an independent report that tells me what I need to do next, and that is; do I accept their recommendations based on the evidence they have produced, or do I say that is not conducted appropriately, and go back and finish it?

236 Q. Now ultimately the investigation was unable to substantiate the allegations. Were you surprised at those findings? 12:43 12:44

A. I was surprised at those in relation to the two individuals who were suspended, simply because the PPS had made the decision that there was enough evidence to go forward to a court hearing and, therefore, if it went forward to a court hearing there should have been enough substantive evidence to support a disciplinary hearing. So, yes, I was surprised that there wasn't. 12:44

237 Q. And were you disappointed?

A. You're certainly disappointed in that you are -- you continue to have in employment people who you are not fully satisfied that the process is complete. So, you have to -- and an awful lot of the reason why the information didn't proceed was because some people disengaged with the process and we could not get statements from them. And, therefore, having taken part in disciplinary hearings before, if you do not have the person there who is standing over what they have said, or a signed statement of what they have 12:44 12:45

said, your staff side representation will argue that that is not supported by any evidence and that it is hearsay because they have not come and supported their original allegation, and you are left with the situation of where that person, if they go to hearing, actually receives no sanction at all because the case will just be dismissed. So...

PROFESSOR MURPHY: Can I ask you why you think that the Bohill staff didn't want to --

A. Well, one of them had emigrated to Australia. 12:46

PROFESSOR MURPHY: Yeah. That one is understandable. But there were a lot of others, weren't they?

A. There was a lot of others. A lot of them said it was stress related. This is from what I recall, is the team coming back and saying that people were declining to get involved, and I think on reading the report again it was recorded that some people were annoyed that the original complainant went to Australia. Now, she come back and testified in court, and I know -- I think the PSNI arranged for her to return to testify in court. But from what I recall, she didn't return for the appeal hearing, which then the conviction was overturned.

238 Q. MR. DORAN: Now you had to convey the outcome then to the staff involved? You wrote to them to advise them that the proceedings weren't going to go ahead?

A. Yeah.

239 Q. I just want to draw your attention to a very specific matter that Aine Morrison mentioned in her evidence.

It's at Ennis 1-581. If we could perhaps magnify a little bit, it's the letter of 1st June 2015. Now, unfortunately, this is not the letter itself, but it's a timeline that quotes the letter that was written by you to the staff involved, and I just wanted to ask you very briefly about this. Sorry, can you realign the screen? Thank you. 12:47

"Letter from ER:
Dear H159,
12:48

I am writing to confirm that the allegation of abuse of a vulnerable adult has been fully investigated under the protection from abuse of a vulnerable adult process and there is no evidence to substantiate the event." 12:48

Now, I just want to concentrate on that sentence, because what Aine Morrison said was really that should have referred specifically to the disciplinary investigation, not the adult protection process. Would you accept that the wording is wrong? 12:48

A. I would accept that the wording is wrong, and I would accept -- now, I would have normally sent letters of that nature to HR first to proofread before I sent them, and certainly that should have actually read "fully investigated under the disciplinary process following the vulnerable adult process." 12:48

240 Q. Yes.

A. And, no, that is not worded correctly.

241 Q. Now, there are two specific things I wanted to ask you about briefly. You refer in your statement at paragraphs 41 and 42 to guidance on family members working in the same ward. Was that written guidance?

A. It was written guidance that I developed and shared with HR. It was to do with -- we had the Ennis Investigation of where the Ward Sister's mum worked on the ward with her, but we had other situations on site where large number of family members worked together on wards. So in one ward, it might have been Iveagh, we had eight family members working on the one ward. 12:49 12:49

242 Q. But I wonder had that ever given rise to specific difficulty. For example, let's say a complaint was made, but the only potential witness was a person from the same family -- 12:50

A. That's why the guidance -- that was why the guidance --

243 Q. Just one moment.

A. Oh, sorry.

244 Q. Sorry.

A. Sorry! 12:50

245 Q. We're crossing again. This is all for transcript purposes. So I gave you -- the example I was giving you, let's say you have a complaint made, but the only potential witness was a person from the same family as the person against whom the complaint had been made. Had those sorts of specific issues arisen? 12:50

A. I was not aware of any specific cases where it had arisen, but when the Ennis one was flagged, it allowed us to look across and say, you know, it was -- I'm

trying to remember if there was any that was specific around families. I don't remember one where the witness said 'Well, I'm related to them', but it was something that I perceived as an issue, and when it transpired that the Ward Sister's mum worked on the ward with her and there was a case, and Aine did bring that to our attention, I think at that point we had a discussion between the senior nurse managers where I said is 'I suppose there's lots of people related to each other in here who work together', and that was affirmed, and we looked at it, and that's where I'm saying there was a case where there was eight family members working on a particular ward, and most wards had people who had family members or close family members. 12:51

246 Q. Yes. Well we will hopefully source a copy of the guidance in due course and we can return to this issue later.

DR. MAXWELL: Can I just confirm? You're saying there was a risk that in your experience that hadn't actually been materialised but it remained a risk? 12:51

A. It remained a risk, but I can't recall a specific incident of where...

DR. MAXWELL: It materialised.

A. The person commenting was a relative. But it -- I think there was other people on shift who were relatives, but not the person who was directly present, but there certainly would have been other people on shift who were relatives. 12:52

247 Q. MR. DORAN: As I say, we can return to that matter in due course. I wanted to ask you specifically about a matter that you deal with at paragraph 54, when you say you were contacted to respond to a complaint by Aine Morrison. 12:52

A. Mhm-mhm.

248 Q. Can you remember who contacted you and exactly what you were asked to do?

A. I don't remember who. It was somebody in the Belfast Trust alerted me to 'We've received a complaint and can you respond?'. 12:52

249 Q. And you've provided your response in your statement?

A. I provided a response, or a copy of it, but it just come out of the blue.

250 Q. Were you spoken to at any time by David Bingham in relation to these matters? 12:53

A. Yes, I've spoken to David Bingham about the complaint and I was asked about...

251 Q. Can you remember when that took place and what the circumstances were? 12:53

A. It was around Covid time. I think it was around that time the complaint came in.

252 Q. Was it a remote meeting?

A. Huh?

253 Q. Was it a remote meeting? 12:53

A. Yes. I think it was done over Zoom.

254 Q. Yes. And who did you speak to?

A. It must have been David. But there's something telling me I think there was somebody else linked to it as

well. I'm not sure of another name.

255 Q. And you've exhibited your written response at Exhibit 2, isn't that right?

A. He contacted me. They said they were going to send through the complaint. I received a redacted copy of the complaint and the bits that related to me, and I done a response. I felt Aine's concerns with me were very much in relation to the meeting of where we met with the staff, but it was around the whole Ennis Investigation, but Aine had not raised any of those concerns during my working time with her before she went to the department, so it was just a bolt out of the blue. 12:54 12:54

256 Q. And did you receive the report that David Bingham compiled into the matter? 12:55

A. I got an outcome that told me that, you know, that there was no evidence to substantiate the concern, and I let, I just let it go at that, because I had already left Muckamore at that point and it was one of those things that it was like, you know, I thought to myself is 'Right, that's dealt with' -- 12:55

257 Q. But essentially David Bingham concluded there was no evidence to uphold the matters of complaint that had been made?

A. Yeah. 12:55

258 Q. That Aine Morrison had raised about your role at the time of Ennis?

A. No. But it just was odd, and I think that's it, because it was around the time, you know, there was

discussion about inquiries and possible inquiries and things like that, and then I got the complaint and, you know, as I say, it was just a bolt out of the blue.

259 Q. Chair, for the record, the report is exhibited to the second statement of David Bingham, and the reference is MAHI-STM-238, pages 6 to 7. I'm not going to take the Panel to the document now. 12:56

CHAIRPERSON: We might be looking at that tomorrow afternoon I expect.

260 Q. MR. DORAN: Indeed. 12:56

Now, Ms. Rafferty, you raise, or you give a very full account at paragraphs 47 to 53 of your statement about various challenges that you encountered in your role at the relevant time, and in later paragraphs then, paragraphs 55 to 57, you make the general point that 12:57 it's important not to view the Ennis episode in isolation, and you set out a number of further thoughts about the Ennis process in that part of the statement. I'm not going to ask you about those parts of your statement now. We may return to them at a later stage 12:57 because they raise wider issues of interest to the Inquiry. Can I just ask for your view on this though? Given your opinion that Ennis ought not to be looked at in isolation, do you think it ought to have prompted a wider review of practice within the hospital at the 12:57 relevant time?

A. Certainly with hindsight, yes, it should have, especially given the allegations that came out in 2017, and as I was involved in reporting those and

subsequently looking at some of the evidence, I certainly would have viewed that a broader remit at that time would have been helpful, and looking at Ennis and if areas of concerned have of been highlighted, even as part of the monitoring, yes, it would have helped develop the staff on site to improve the care and protect the patients, and ultimately during that intervening period there has to have been other incidents of abuse that occurred, and the CCTV did help in uncovering that and, you know, at the end of the day those patients did deserve compassionate care, and they did deserve to have good care, and anything that would have helped that happen is of importance. 12:58 12:59

261 Q. As I've said, you will be contributing at a later stage in the Inquiry and we may wish to pick up on some matters at that stage. Those are all my questions, Ms. Rafferty, it may be that the Panel will have some matters to raise with you before your evidence finishes today. 12:59

CHAIRPERSON: I think my colleagues have asked their questions as they've gone along. 12:59

MS. RAFFERTY WAS THEN QUESTIONED BY THE PANEL AS FOLLOWS:

12:59

262 Q. CHAIRPERSON: Can I just ask you this though, at the beginning of your evidence you told us that part of your role would be to go to the ward on occasions and speak to the staff. During the Ennis Investigation

when staff must have been very destabilised, do you remember during that period going to speak to the staff to give them reassurance or to tell them what was going on?

A. I was down on the ward on a number of occasions when the investigation was ongoing, and spent time, especially down in the back part of the ward, talking to staff, working alongside them, you know. 13:00

263 Q. CHAIRPERSON: So that was on a sort of ad hoc basis.

A. For a few hours. And it was very much -- it was sitting in with the staff and talking about, 'Well, you know, yes, the investigation is ongoing. It will take a while to conclude. You know, monitoring still has to happen.' You were reassuring them. You were asking them, well, how things are at the moment? They talked about the stress that they were under. They talked about the support that the new Ward Sister was giving them. 13:00 13:01

264 Q. CHAIRPERSON: Okay.

A. They also did say things like, you know, 'Why was it not reported at the time?', you know. But these were them talking about their feelings out loud, and we, you know, spent time down on the ward with them, walked through. We talked about 'Well, what else do you need down here? What do you think would be helpful?' 13:01 13:01

265 Q. CHAIRPERSON: Okay. And you remember actually doing that, going on to the ward and speaking to the nurses and other staff?

A. Yes. Mhm-mhm.

266 Q. CHAIRPERSON: That's one thing. Were there any meetings, were there any sort of more formal meetings with all the staff on the ward?

A. Myself and Eileen McLarnon did go down to the ward. They asked us to go down. I'm not sure even at what timeline this is within it. But they wanted to tell us about the support that the new Ward Sister was giving, that they felt very supported by her and that they could talk to her, and they asked us to come down just so that they could talk to us about how the ward was at that point. So myself and Eileen McLarnon did attend a meeting with -- and there was quite a large group of them, there probably would have been about 10 or 11 of them that day, you know, that we went down. 13:02 13:02

267 Q. CHAIRPERSON: Yeah. I think was that towards the end of the investigation though? 13:02

A. I'm thinking it was probably around May/June time or something like that. Yes.

CHAIRPERSON: Yeah. Okay. That is all that I want to ask you. 13:03

Can I thank you very much for coming along today. I know it's a bit nerve-wracking sometimes to attend a Public Inquiry, but thank you for your evidence today. I think we are likely to see you again, but after the summer break, so thank you for coming in and helping us. 13:03

All right. We've got quite a long afternoon. So if we

could sit at 2:10?
MR. DORAN: Thank you, Chair. Ms. Kiley will be --
CHAIRPERSON: I think Ms. Kiley is taking her. Yes. Thank you very much indeed.

LUNCH ADJOURNMENT

THE HEARING RESUMED AFTER THE LUNCH ADJOURNMENT AS FOLLOWS: 14:02

MS. KILEY: Good afternoon, Chair, Panel. This afternoon's witness is Moira Mannion.
CHAIRPERSON: I expect we've got a slightly longer afternoon, haven't we? 14:05
MS. KILEY: Yes, and we will need to have a break also in order to change the technology arrangements. The first half of the evidence relating to Ennis will be live-streamed. I have explained it to the witness, but I propose to remind the witness about it and to put it on the public record what our procedure will be just when we get the witness out. 14:05
CHAIRPERSON: Yes, fine. I think there's a little red light to show me we're on air at the moment. 14:05
MS. KILEY: Yes.
CHAIRPERSON: Okay. Thank you.
MS. KILEY: I should say that the witness is going to be accompanied by her husband, who is going to just sit

at the secretary's table for support.

CHAIRPERSON: Okay.

MS. MOIRA MANNION, HAVING BEEN SWORN, WAS EXAMINED BY MS. KILEY AS FOLLOWS: 14:06

CHAIRPERSON: Ms. Mannion, thank you very much for coming along to assist the Inquiry. Thank you for your two statements so far. And if you need a break at any stage, please will you just let me know. I know that 14:06 you're accompanied by your husband for support, and I'll hand you over to Ms. Kiley who is going to take you through your evidence. Thank you.

A. Thank you.

MS. KILEY: Good afternoon, Ms. Mannion. 14:06

A. Good afternoon.

268 Q. We met just a short time ago. As you know, I'm Denise Kiley, one of the counsel team to the Inquiry, and I'll be taking you through your evidence this afternoon. The Chair has already referred to you having made two 14:07 statements to the Inquiry. Isn't that right?

A. That's right.

269 Q. And can I check have you got copies of both of them in front of you?

A. I have. 14:07

270 Q. You do. Well, just for the record, your first statement is dated 19th September 2023?

A. That's correct.

271 Q. And in that statement you detail your experience in

various roles that you had in connection with Muckamore Abbey Hospital between December 2007 and February 2020. Is that right?

A. That's correct.

272 Q. And for the record the reference for that statement is STM-168. And contained within that timeframe was the period that the Ennis Investigation was conducted, but at the time you made your first statement you didn't have access to a number of documents relating to the Ennis Investigation? 14:07

A. That is correct.

273 Q. That's right. So then the Inquiry provided you with a bundle of documents that we're referring to as the Ennis Bundle, and asked you to make a second statement, and you did that, isn't that right? 14:07

A. I did.

274 Q. And that second statement is dated the 19th January 2024, and you make that specifically for the purpose of explaining your recollections of the Ennis Investigation and Report, and you answered a series of questions that were posed to you by the Inquiry in that statement? 14:08

A. I did.

275 Q. And, again, for the record, the reference for that statement is STM-192. The first question I want to ask you, Ms. Mannion, is, do you wish to adopt both of those statements as your evidence before the Inquiry today? 14:08

A. I do.

276 Q. Can I just then say a little bit about the procedure that will be conducted today. I explained a little bit about this to you whenever we met, but as you know, the first thing that I'm going to do is to ask you questions arising from your second statement. So I'm going to focus on the Ennis Investigation and Report first of all. And as has been the case with other witnesses who have given evidence in respect of the Inquiry's examination of this particular module, your evidence will be live streamed. Okay? But then once we finish that, we're going to take a short break, and when we resume I will then ask you some questions arising from your first statement. Okay. 14:08 14:08

A. Okay.

277 Q. And, again, consistently with other staff witnesses that have come to the Inquiry, that evidence will not be streamed live. So after the break there will be no live streaming, but a transcript of your evidence session in the second half will be available on-line afterwards. Okay? 14:09 14:09

A. Okay.

278 Q. So. There will be at least one break, but if you require other breaks throughout your evidence you can let us know, okay?

A. Okay. Thank you. 14:09

279 Q. So can I ask for the second statement to be brought up on screen, please, STM-192. And Ms. Mannion in this statement you describe the role that you had in November 2012, and at that time you were Co-Director

For Nursing, Education and Learning in the Belfast Trust, is that right?

A. That would be right.

280 Q. And can you describe just generally what sort of responsibilities you had in that role? 14:10

A. My key responsibilities would have been looking at educational needs of all nurses across the Trust as a professional group, and also had responsibility for practice education team, who had responsibilities for student population. So at that time there could have 14:10 been anything up to 700 students Year 1, 2, and 3, from the range of Universities in Northern Ireland, availing of placements for their learning towards being a nurse.

281 Q. And you refer to that being a role within the Belfast Trust. So am I right in saying that it involved 14:10 responsibilities in respect of Muckamore, but not solely Muckamore. Is that right?

A. No, not solely Muckamore.

282 Q. Do you come from a professional nursing background yourself, Ms. Mannion? 14:10

A. I do. I am a registered mental health nurse. I also held a registered family therapist role. I was also a registered coach for individuals. I was also a registered supervisor for people who practice family therapy. So I had a range of expertise. And when I 14:11 worked in child psychiatry I would have worked very closely with families and children up to the ages of 18 who experienced learning disability behaviours and diagnosis.

283 Q. And in your professional nursing experience, was that gained in the employment for the Belfast Trust solely or were you employed --

A. Not only Belfast Trust. I would have worked also in the Southern Trust area in child psychiatry. I would have worked in the department as nursing officer on secondment for over a year. I also worked as practice development educator in the Royal College of Nursing in the professional basis of the organisation, and for a period of time I acted as their Head of Education who had a link into the London office looking at professional issues for nurses in education. 14:11 14:11

284 Q. And did you commence employment with the Belfast Trust in 2007 then?

A. I know I was there 10 years. 14:12

285 Q. Okay.

A. So, yes.

286 Q. In and around that time?

A. In and around that time.

287 Q. And before November 2012, would you have had cause in your role to visit the site of Muckamore Abbey Hospital? 14:12

A. I also had a role looking after carers and volunteers. There was a small team of individuals who supported people to act as volunteers in a range of services across the Trust, and under that auspices I would have visited the Muckamore site, because there were a lot of willing volunteers who signed up to accompany people who were there as patients on day trips or going to 14:12

dental appointments. There were individuals who volunteered to come in and read or be present with activities for some of the patients who were in the presence of Muckamore at the time. So I would have went up to meet with them, because the agreement we had with the volunteers is there would have been someone on the ward who was their link supervisor, so if they had any issues they could address those issues at the time on the ward with the staff. But equally that the staff then didn't use volunteers as staff, or supplement to staff, because they were there for a particular role. So I would have gone to hear and to witness what was happening in relation to that. And, again, I had two members of a team for looking after carers, and they would have worked again in Muckamore to work with carers, and again looking to see what their concerns, if any, or indeed their compliments of services that they might have experienced, and they would have worked with them there. And, again, I would have gone with my team on occasions to see what was happening. 14:13 14:13 14:13 14:14

288 Q. And what sort of time period are you talking about there, even roughly?

A. That would have been over probably about three years.

289 Q. And at what point in time? Was that prior to 2012?

A. That would have been prior to 2012. 14:14

290 Q. Yes. Can you put a rough date estimate on it?

A. It would have been during 2008, I would imagine, because when I took up the role there were -- as two small teams they were a little bit of a surprise to me

that I was managing in my portfolio, and the reason I'm saying a surprise, is that the Trust was reorganising their structures, and it was -- it appeared to be a challenge to where these two small teams should be orientated to, and it was decided that it should come into the nursing and user experience section, and I was the person that was nominated to take responsibility for. Now I am only talking about four staff.

291 Q. Yes.

A. But it was the four staff then I was supporting in their activities. 14:14 14:15

292 Q. And it was in that role then that you visited the site?

A. Yes.

293 Q. Yes. Okay. And then going forward then to December 2012, because that is -- at paragraph 3 there you say that it was December 2012 that you were first advised of the allegations that had emerged in respect of Ennis Ward, and you say there that you were advised of the allegations at a meeting with the Executive Director of Nursing, the Director of Muckamore Abbey Hospital, the Deputy Chief Executive and the Director of HR. And you say there that in addition to being advised of the allegations, you were further advised that relationships within staff at Muckamore were difficult as a result of the allegations and the safeguarding investigation, and I just wanted to ask you a little bit more about at that early time what your understanding was about how those relationships were difficult and how that was manifesting itself at 14:15 14:15 14:15

Muckamore?

A. The information that was shared with me by Catherine McNicholl and, indeed, Brenda Creaney at that meeting, was that the staff on the ward, it would have appeared that they were not engaging as they wished them to in the investigative process, and that there seemed to be conflict between the designated officer who appeared to be wishing to manage operationally in the ward as well as manage the investigation, and that seemed to cause a conflict in the area, and that was the information that would have been shared with me by the directors at that point in time. 14:16 14:16

294 Q. And the directors ultimately asked you to go to Muckamore?

A. Yes. 14:16

295 Q. Did you understand that part of the reason for that was to try and lend support or resolve those issues and difficulties that had arisen?

A. Both Catherine McNicholl and Brenda Creaney at that time were actually very clear about what their expectations of me were. Brenda Creaney did say that I was to be her voice on the ground, and that I was representing her, and that her expectation is that I would come back to her with information of what was happening, that they would together put Terms of Reference to guide the activities they would commission me do and engage in, but ultimately their expectation was that staff would adhere to the safeguarding processes and that I was to seek engagement, that I was 14:17 14:17

to support Esther Rafferty in her role, and that I would work closely with John Veitch in the execution of that role, that I would participate in the strategy meetings, and that I would also support Esther with the team of people who were nominated as monitors. I was 14:17
expected to engage in leadership walk-arounds, unannounced, over a range of times. So I did have the opportunity to go there on a weekend, of an evening, at a night-time, early in the morning, for staff, again, just to witness and experience me being there. So, 14:18
yes, they were very clear about what was expected of myself in relation to what my activities would be when I was there.

296 Q. You mentioned your role in attending strategy meetings, and I just wanted to clarify, did you have a particular 14:18
role in the safeguarding investigation or were you doing something separate that was operating in tandem with the safeguarding investigation?

A. Well certainly Brenda and Catherine both wished me to have a separation from the investigation, because the 14:18
policy at that time was very clear about the role and responsibilities that the designated officer had and the investigating team. But what Brenda and Catherine McNicholl wished me to do was, from a professional nursing perspective, to support Esther to assess the 14:19
environment from a professional basis, and if there were any improvements for service delivery, engagement of practice, observation and adherence to policies, that I was to support her to engage with the staff to

expect that to happen.

297 Q. So is it right to say that that was something that was -- the Trust response that was operating in tandem with the safeguarding investigation but was separate to it?

A. Separate in that there were some activities, but I would have reported back into the strategy meeting, as well as Brenda and Catherine, in relation to what we were learning about the environment and what we were proposing needed to change. 14:19

DR. MAXWELL: Can I just ask, is the strategy meeting different from the safeguarding investigation? 14:19

A. It's the one and the same. It's the term that was used at the time, but it was a Joint Protocol meeting where the police, the RQIA, the investigation team, John Veitch and myself, and Esther, would have attended. 14:20

DR. MAXWELL: So attendance at the strategy meeting de facto meant you were part of the safeguarding investigation?

A. Yes, you could say that.

298 Q. MS. KILEY: And you've referred to the designated officer, and that's Aine Morrison. 14:20

A. Yes.

299 Q. And the Inquiry, as you may know, has heard from Ms. Morrison. I want to take you to paragraph 4 of your statement, because you describe an initial meeting there with Aine Morrison. Just scroll down towards the bottom, please? And if you just pause there. You say that on initially meeting Ms. Morrison you were not clear about the other aspects of Aine Morrison's role, 14:20

separate from the investigating officer:

"Ms. Morrison seemed to think that she would be telling me what to do. At my first visit to MAH in December 2012, I did not have Terms of Reference which could reference the role I was commissioned to engage in. My first meeting with Aine Morrison was a difficult one, but we agreed that we would get clarity from Co-Director Joan Veitch, which we did in a subsequent meeting with John Veitch at the Fairview building at the Mater Hospital, which was where John Veitch was based." 14:21 14:21

Now, I just want to pick up on the first part of that extract about you not being clear about what Aine Morrison's role was. You refer to her carrying out roles separate from the investigating officer. What type of role did you see her carrying out? 14:21

A. Prior to me going up to Muckamore I attended a senior HR individual to refresh my understanding of the disciplinary procedures as was currently then. I also read the material that was on the website in relation to what the designated officer and investigative officers would be, and what a Joint Protocol meant, and how the police and the RQIA would be involved in that, and the reason that I took the opportunity to refresh that is, I wished to understand what the purpose and the clarity of that would be on my first engagement, because even before this it wasn't unusual for me to be 14:21 14:22

asked to go into areas where there was areas of concern, and what I have found in my experience is that often people don't wish someone they don't know to engage, and they're a little hesitant and concerned about your engagement and what you might bring to that process. 14:22

And the first meeting I am, with the aid of the evidence bundle I recalled, with support from the evidence, that I and a HR person in that very first meeting, that we were asking Aine not to destroy minutes. She had proposed that she would be destroying the first set of minutes because of names being mentioned, and we brought it to her attention -- 14:23

300 Q. Just to pause you there, Ms. Mannion. When you say "first meeting" are you referring to the first strategy meeting? Is that the first time you met Ms. Morrison? 14:23

A. Yes.

301 Q. Okay. So that's the meeting that took place then in November?

A. There wasn't a one-to-one before that. 14:23

302 Q. Okay. There were meetings in November 2012, but you arrived in December 2012. So I think we know that the strategy meeting in December 2012 was on the 12th December, so that's the meeting that you first met Ms. Morrison? 14:23

A. Yeah.

303 Q. Okay. But just going back to this point about her role separate to the investigating officer, what did you think that she was doing that was not within the role

of the investigating officer?

A. Well, I would have asked her what was her role in the ward, because the staff were saying that she was visiting the ward regularly, and they were talking about being very uncomfortable with tone and attitude, and they believed that the approach that was taken was so different from what they had ever experienced before with a safeguarding investigation, that they wanted to get some clarity, and they were really saying, 'Help us understand why we have to go through this. Why do we have to be monitored?', because it was their understanding that if a member of staff had been -- allegations were made against them, that the act of suspension meant that they were being supported to be not on the environment and then for the investigation to happen. And since that action had happened, they couldn't understand why they then were being monitored 24/7. 14:24 14:24 14:24

304 Q. And is that the issue that you sought clarity from John Veitch on? 14:25

A. Yes.

305 Q. And you refer then to you both agreeing to seek clarity from John Veitch, and you say:

"We did that in a subsequent meeting." 14:25

So are you saying you and Aine Morrison both met separately with John Veitch?

A. We did. Yes.

306 Q. And did you achieve that clarity then?
A. We did. During that meeting, yes.
307 Q. What were you told about that?
A. Well, John clearly said that the manager, i.e. Esther, would be the person that had responsibility over the clinical environment, and he supported Aine that her purpose for visits would be in the investigative capacity but not on the clinical capacity. My understanding then of that would be that was it clarified, and I also thought it was really important that Aine received the Terms of Reference that I was being guided by, because I didn't want her to be confused about why I was there, because I knew I was going to be expected to be there for a period of time, and I was endeavouring to try and strike up a relationship, professional working relationship, so that we actually could have conversations with an outcome. 14:25 14:26 14:26
308 Q. And did Aine Morrison eventually get the Terms of Reference for your role? 14:26
A. My understanding is that she did.
309 Q. And returning to the meeting with John Veitch, you've said that you got clarity on what Ms. Morrison's role was?
A. Yes. 14:26
310 Q. Do you know, did you or anyone else feed that back to the staff on Muckamore so they had that clarity?
A. Well, I actually asked what information was appropriate to share, because initially I was of the impression I

was told 'You cannot share anything with the staff because of the investigation.' So I said 'Is there an opportunity for Esther and myself to have words that are suitable for the staff to know so that we can maintain the integrity of the team?', because the Ward Sister was clearly saying that she was short staffed and there were a number, a small number of staff at that point in time -- please forgive me, I can't remember the exact number -- were off sick, and she believed that the environment was becoming less stable for patients, so to actually provide them with words that were appropriate to share, I believed was a good way of maintaining the staff integrity and engagement in the process, because there was a lot of concern about being blamed in the staff environment. 14:27

311 Q. Who did you seek that guidance from about what you could say to staff?

A. I would have asked Aine and John.

312 Q. Okay.

A. You know, Aine and John, because I would have seen that Aine's key role as a designated officer would be some decision-making processes about the communication strategy you might use, so I would have respected her role in relation to what words were to be used. And I also would be aware from the disciplinary refreshment process that I had gone through, is allegations are allegations until proven, and also the disciplinary process, I didn't want to cause any shadow of a doubt of information that might be produced as evidence, 14:27 14:28

because both processes could have easily been disrupted, so I needed to respect those policies and procedures in relation to how I presented the communication.

313 Q. But ultimately after you got clarity on Aine Morrison's role, did you go back to staff and give them that clarity? 14:28

A. Yes.

314 Q. And is that...

A. Well, I would have done -- sorry for speaking over you. I would have done that with Esther Rafferty. 14:28

315 Q. Yes. You do refer to meeting with staff on Ennis Ward at paragraph 5 of your statement, if we just scroll down. You explain there that after being assigned to the role you wanted to communicate your role clearly and you wanted to establish a relationship, and you say: 14:29

"I met with the staff on Ennis Ward and Esther Rafferty attended this meeting with me." 14:29

So is that the meeting that you're referring to?

A. Yes.

316 Q. And are you saying then at that stage you explained what Aine Morrison's role was? 14:29

A. Yes.

317 Q. And presumably what your role was?

A. Yes.

318 Q. Can you tell the Inquiry what you explained to the

staff about those two roles?

A. Well, I would have, I would have encouraged the staff to go and read the material around the safeguarding process and then look -- because that particular policy, from memory, was actually quite specific on who engages in which activity. And then I also encouraged people who maybe not availed of mandatory training in relation to disciplinary procedures, to refresh their information in relation to that. One thing that the Belfast Trust was really good at is they had a huge database of policies. The only thing that was difficult is if staff hadn't time to access, you know, which link to the policy. So Esther would have printed off the policies for staff to take time during their work experience to refresh the distinction between them so that they might understand that better. Some staff, I won't remember names, and it's maybe not appropriate for me to say names, may have wanted more information about what the allegations were, and we would have explained to them that it was not appropriate for us to share those, that they were under investigation, but to suffice that the members of staff that were not working at present due to that, that that was again about confidentiality and respecting them as individuals while they weren't there. 14:29 14:30 14:30 14:30 14:30

319 Q. You do say in relation to that meeting that some staff were distressed. Can you describe what it was, how they were presenting that made you think that they were distressed?

A. Well, I do remember one person was -- well I actually put it here, because she said: "Oh, the Gods have come to visit us", you know, and I says 'Look, you know, I am a senior member of staff, help me understand why you might be saying that', I says, you know, 'I'm not here to be punitive to you. I'm here to support Esther and yourselves, engage in this process. I can say that there is a clear expectation of the Trust policy and guidance that we do', and I put the "we do", i.e. myself and you have that responsibility to do that, 'and if there is evidence to support the allegations, the individuals concerned need to be guided by the processes that they would have to engage in, whether that's police procedures or whether that was the disciplinary procedures', but that if we just had discussions about it, it may not be helpful and it takes the focus away from the patient care. So 'How can I help you as members of staff to re-focus on patient care, and the delivery of patient care, and take this forward, and that we protect the confidentiality of individuals who are now not present at work.' 14:31 14:31 14:32 14:32

320 Q. But aside from the patient care element, you do say, if we just scroll further down to the end of this paragraph, please, and just pause there, about six lines from the bottom you just say that staff were disengaging from the investigation process, and can you explain in what ways you could see that staff were disengaging at that time? 14:32

A. What I observed were individuals who wanted to have conversations about what was going on. There were -- appeared to be adding to their anxiety or their presentation of anxiety, because there were tears. There were a number of people who were availing of the 14:33
counselling services that were on Muckamore site, and I also felt that they were, even though the colleagues that were monitoring there, they would be avoiding them, not having conversations with them. They would have indicated to ourselves that they were very 14:33
uncomfortable about being watched. I thought significantly some of the comments they made about particularly the group of individuals who were down on the ward, it was like an L-shaped ward, and there was a higher number of patients on this side of the ward. So 14:33
it did appear overcrowded, it did appear less well kept, but you did have individuals who were there as patients who had profound autistic diagnosis, who had loud vocalisations. So it meant that the staff were actually seeing a behavioural difference of the 14:34
patients, and they believed that the patients were being very disturbed by the monitors, and they were being very disturbed by people coming in and out of the ward, including myself. So there was that disquiet, and what I was trying to say to them is 'Look, it's so 14:34
important that you're open to this process and that you engage in this process, because the patients that you are working with know you so well they may pick up your annoyance at us coming in, as well as their annoyance

at new faces at new experiences', and that's the kind of conversation that I would have been engaging with the staff, and then the clear professional 'you must engage'.

321 Q. Yes. In terms of the references to staff being distressed and disengaging with the investigation, are you then saying that the monitoring was one of the causes of that? 14:35

A. Yes.

322 Q. And I'll come on to ask you a little bit more about the monitoring in due course, but there's one particular issue I want to ask you about just while we still have paragraph 5 up, and you can see around four lines from the bottom you say that: 14:35

"The staff advised you that Aine Morrison was aggravating the situation due to her insistence that the staff were being monitored 24-hours a day and that staff who were family members were not to act as a monitor if another family member were on shift." 14:35

And I just want to check that reference to monitors being family members of those who were on shift. The Inquiry has heard evidence about the monitors and the monitoring that happened on Ennis Ward, but the Inquiry has heard that the monitors were external monitors, but the extract I've just read to you there suggests that staff believed that they could be in a position where they could be monitored by a member of their own 14:36

family. Was that the staff understanding at that time?

A. The staff on the ward were very upset at the mention that members of that staff team, and hopefully my memory serves me well, I think there were about 20 individuals on the roster at that time, and they would have had some -- a small number of that would have been sisters, cousins, that type of relationship. And Esther had already communicated with them, and then I had reiterated with Esther that we needed to be as independent as we could possibly be in the monitoring. So, therefore, anyone of a senior level and may have a family member in Ennis could not be part of the monitoring. 14:36 14:36

So when I looked at who the monitors were initially, they were, when I say "independent", or others may have said -- I can't speak for others, but I'll speak for myself -- the independence was that they were not on the roster of Ennis. They were individuals who worked on other wards in Muckamore. 14:37

323 Q. Right. Okay. But they could potentially have still been family members? 14:37

A. Yes. And then it would have been the case that we would have asked them not to be part of the monitoring team.

324 Q. Okay. 14:37

A. That meant that -- apologies.

CHAIRPERSON: Sorry. I just want to understand that. The staff on the ward didn't understand that it was a bad idea that family members should monitor them. Is

that...

A. Yes, they couldn't -- I think they were comfortable in their belief that the family members that were there were professional.

CHAIRPERSON: Sure. 14:37

A. And could have been able to. But when --

CHAIRPERSON: But in terms of the optics of this.

A. Yes. Yes.

CHAIRPERSON: It would have been pretty bad.

A. Initially they didn't seem to understand that. 14:38

CHAIRPERSON: Right.

A. But they did accept that that is what was expected.

CHAIRPERSON: Yes. Thank you.

PROFESSOR MURPHY: Can I just ask one more think thing. Had you been involved in investigations where there was 14:38 24-hour monitoring before?

A. Never.

PROFESSOR MURPHY: Because I can imagine being a member of staff and feeling that I was being watched, so I wondered whether that often happened? 14:38

A. Not in my experience.

PROFESSOR MURPHY: Fine. Okay. Thank you.

325 Q. MS. KILEY: Do you think, thinking about just this early stage of the investigation, do you think staff had a proper understanding about the nature and purpose 14:38 of monitoring?

A. It was my impression they didn't on my first meeting with them and through some conversations with them. So it wasn't unusual for me to be in attendance for the

handover meetings with staff. It wouldn't have been unusual for me, at that time, to go and join their staff meeting, and then I would have encouraged them to ask me to discuss things that I was in a position to discuss. But, again, I would have said to them very clearly if a question did come up -- now no questions did, because my initial thing was saying to them is, 'If you ask me any questions about the allegations, I cannot have a discussion with you about that. But if there is something you wish to clarify about my role, or indeed what we can talk to you about an investigation, I will do my best to provide you that information. If I cannot answer your question, I will have that discussion with the relevant person', and that might have been Catherine McNicholl the Director, it may have been indeed a HR representative and, indeed, it would have been Brenda Creaney from a professional point of view, and then would I have come back to the staff to give them what the conclusive answer was to that question. 14:39

326 Q. But at that stage whenever you first became involved, that was December, so monitoring was already in place for a period of time, and are you saying that at that stage whenever you came in, in December, there had been monitoring in place for a period, but that staff didn't properly understand? 14:40

A. They still didn't properly, no. It was my perspective that they didn't quite understand at that stage.

327 Q. And you prepared two briefing notes as part of your

role, and I just -- they related to monitoring, so I think it's an appropriate time to turn to those. If we could bring those up, please, with the Ennis Bundle at page 86. Do you recognise this document, Ms. Mannion?

A. I do. 14:40

328 Q. So you can see it's entitled "Briefing by M. Mannion 19th December 2012". So this must have been something that was prepared relatively quickly upon your appointment. Is that right?

A. It would have been. 14:40

329 Q. And if we can just scroll back, please? Just pause there. You explained at being commissioned by Catherine McNicholl and Brenda Creaney, and you have set out your role, you've already explained that in evidence. But just looking at the briefing note 14:41 itself, who did you present this to?

A. This would have been shared with Brenda and Catherine, but it also would have been shared at the Joint Protocol strategy.

330 Q. Yes. Okay. 14:41

A. They would have had that too.

331 Q. And just scroll out, please, so we can see the wider document? And if you scroll down to "Actions Completed", please? And just pause there. You can see the third bullet point is that you met with monitors 14:41 and there are a number of issues identified. If we can just scroll then, please, so you can see those four sub-bullet points. So after -- you say you met with monitors:

"Issues that are identified are key concern about the impact of monitoring on patient behaviours. Monitors welcomed the meeting as it was their first. Not aware if there was a timeframe for the monitoring plan, poor information about the investigating process."

Just looking firstly at that first bullet point about the impact of monitoring on patient behaviours, is that something that the monitors were reporting to you or something that you observed? 14:42

A. Certainly the monitors were reporting that to me.

332 Q. What were they saying?

A. It was consistent with what the staff were saying. They would have said that the patients were -- the environment would have been -- very little soft sound protection on the ward, it was a traditional ward. So, therefore, anyone who may have been making loud vocalisations, there was an echo. So there would have been some individuals who, due to their condition may have done that, and then there's others who had a significant sensitivity to noise, and that meant that behaviourally they may have ripped down curtains, certainly it was indicated that the sensory integration room had been damaged by a patient, that some of the staff had been -- had experienced being bitten by individual patients and being hit by individual patients. So there was a range of behaviours that seemed to be on the increase. And certainly 14:42 14:43 14:43

incontinence was another behaviour that had been mentioned in relation to a patient. So you could see that there was a disturbance in the experience of being a patient on the ward by what the monitors were saying and, indeed, what the staff were saying.

333 Q. And the monitoring process, can you tell us a little bit more about how that actually worked? What the monitors, how they recorded what they observed and what you did with that?

A. Well, certainly a couple of refinements that I discussed with Esther at the time is that we needed to have a structured template that would actually, you know, embody staff behaviours towards patients. And, indeed, how staff communicated with patients to engage them in for taking of their medications. To be supported in their hygiene and dignity needs. To engage in meal times. To engage in activities that might have been prescribed for them. Also their dentistry needs in relation to that. So myself and Esther would have expected the monitors to give an account of what they observed in that, but to respect obviously not being in bathrooms with a patient and the client, because that again would be going against the dignity of the individual, but where possible give an overview of how that process worked.
And again, you know, how did the members of staff engage with the patients in the sitting areas? How did staff engage with patients in the -- there was a small green area outside that some of the patients would have

chosen and wanted to be out there. There was one individual who quite liked sitting in the rain, but again, what's the balance, you know? Is the person having the experience of re-regulating themselves in relation to having that wetness, but then being supported to be in clean and dry clothes when they can return, you know. So, again, expecting that people who were doing the reports actually gave us information of how that process happened.

334 Q. How often did they submit the reports? 14:46

A. Weekly.

335 Q. Weekly. Okay.

A. And daily expectation of reporting anything of any concern to Esther, who would have been on site.

336 Q. And by the time you draft this report, you had reviewed the existing monitoring forms? 14:46

A. Yes.

337 Q. And if you scroll down, please, to page 87? I think we can see that. And if we just pause there you say that there were 85 received to date over the five week period and that you thematically reviewed those, and we can see that you set out results from the thematic reviews. 24 forms out of 85 had noted a concern. The three key themes were that staff levels at key times in the day, environmental issues, impact of male monitor of patients who removed clothing. 61 did not identify any concerns. All 85 forms identified many examples of best practice and positive interaction by staff with the patients. There was no indication of any 14:46 14:47

possibility of a culture that may be accepting of behaviours or communications that could be referred to as abusive.

And I'm going to come back to that because you refer to that also in your second report. Just thinking about the thematic review there, you say that the review was conducted using an early indicator of abuse guide and the RCN Dignity Standards. Can you explain a little bit more? Those are two separate things, is that right, an early indicator of abuse standard? So can you say a little bit more about what that was, what tool you used? 14:47 14:47

A. That was a document that was on the Quality Network for Learning Disability website, which from memory would have indicated staff to patient ratio and how that may have a relationship to the nursing activities not being engaged inappropriately, that the quality indicator about restrictive practice and how that was being respected, because it went wider than going into a locked environment or a closed environment. So one of the points I remember asking for clarity is that the door at the front of the ward appeared locked, therefore the -- I think there were six or seven individuals at the front of the ward who were quite close to being resettled, they their freedom was restricted, but the staff were trying to explain to us that the reason that the door was -- now, when I say "locked", it's one of those doors that if you put a badge over it that it opens, but when we explained to 14:48 14:48 14:48

them that they were restricting free movement for the seven individuals at the front and that we needed to think about how we organised the environment in a slightly different way, that the individuals that needed protection and care that they had the appropriate staffing, but also the appropriate environment at the other side of the ward, within the confines of a ward that was meant to be closing down within the next few weeks to months.

338 Q. So are you saying that those are the examples of the type of things that you were looking for. But just focusing on those tools, the Early Indicator of the Abuse Guide and the RCN Dignity Standards, had you used those tools before? 14:49

A. I had. 14:49

339 Q. You have explained in answer to Professor Murphy's question that you hadn't been involved in an investigation that had 24-hour monitoring?

A. Not 24-hour monitoring, no.

340 Q. But whenever you used the tools before then, in what circumstances did you use those? 14:50

A. That would have been in the capacity of trying to look for areas of service improvement needs and practice improvement needs in relation to some care environments that I worked in previously. 14:50

341 Q. And did you get any guidance from anyone about using those tools in this particular environment looking at the monitoring forms?

A. I would have had that professional discussion with

Brenda in my supervision.

342 Q. Following then this first briefing paper, you presented that to the strategy meeting, there was a strategy meeting I think the next day on the 20th December, and is it right to say that at that strategy meeting you advocated for cessation of the 24-hour monitoring? 14:50

A. Yes.

343 Q. And if we could just bring up the minute of that meeting? It starts at page --

A. Sorry for... 14:50

344 Q. Yes.

A. My memory is that I supported the request for the monitoring to be stood down. I wasn't the initial initiator of asking for the monitoring to be stood down. 14:51

345 Q. Okay. Who do you recall?

A. But that that would be -- my understanding was that it was Esther, because there was roughly about five to six weeks of monitoring activities, but I would have supported Esther's request. That's my memory, that it was -- I wasn't actually asking for it to be stood down. But with the information that I had read, there was nothing to indicate concern, or concern for me professionally, that we needed to continue with the monitoring. 14:51 14:51

346 Q. Yes. And we can see discussions of this at the meeting at page 40 of this bundle, please. This is the meeting on the 20th December, and I think the discussion starts at page 48. If we can scroll down there, please? You

can see there reference to the monitoring, and the fourth paragraph down we can see it is said that you voiced your concern in relation to the impact the monitoring was having on patients. Patients are thought to be reacting badly. 14:52

"Aine noted this factor was presumably also exacerbated by the need to use bank and agency staff at present to make up staffing numbers." 14:52

Then if we can just scroll down again, please, you can see reference there:

"Moira said that as the monitoring had shown no signs of a culture of abuse on the ward and indeed indicated 14:52 a lot of good practice, she felt the monitoring arrangements could change and put forward a proposal in relation to this."

And we can see: 14:52

"The plan proposed that 24-hour monitoring would cease and would be replaced by the implementation of the 15 Steps Challenge. This would involve both further monitoring and inspection but also improvements. Moira 14:53 said that she would lead a team of people charged with carrying this out. If any concerns came to light, 24-hour monitoring would be reinstated immediately."

If we just pause there. The proposal then for the replacement, I don't think that we see that within your monitoring report that we have just looked at. Can you explain a little bit more about what you were proposing would take place? 14:53

A. The activity behind 15 Steps is actually a practice development quality improvement tool. It would have come from the Royal College of Nursing activities Kim Manley and Angie Titchen would have been the authors of the practice development practice, and in that practice 14:53 it actually -- so it's not a challenge as such, the word "challenge" is -- because there's a lot of paperwork out in the -- accessible to all of us about the 15 Step Challenge, which is a new model that was introduced in 2017 from colleagues in England. So this 14:54 was actually part of that practice development methodology, where you were looking at the workforce configuration, you were expected to look at what the ward was communicating to and with family members, carers, representative carers, the clients, the 14:54 patients. Some patients preferred not to be named as patients, they preferred to be, you know, the service user. Some people preferred not to be called service users. So it's about preferences. It was also about the environmental environment, was it safe? Was it 14:54 conducive to acceptable, reasonable care? Were there care plans in place for each individual patient? Was each individual patient supported through speech and language or, indeed, a representative, to understand

what the care plan process was? If there was an expectation of activity schedules, were they aware of what they were? Were they having the support from external others to engage in those activities? Were they prevented from doing that because of the staff reduction in the environment? So, like equally the tool would have expected you to look at, well, what are the range of policies that were relevant to that particular ward? Were staff in adherence to those policies? Were they aware of those policies? Were they aware of the intricacies of those policies? Were they availing of supervision? Was that supervision adequate? Were they availing of the mandatory training processes that could be there? Were they supported to go to additional professional training? 14:55 14:55 14:56

So there was -- one of the things that I noted when I was in Muckamore, there was a significant number of health care support workers compared to the Registrant population, and some of them had availed of the particular NVQ qualifications that would support their professionalism, and some of them were supported to be on the CQ Register in relation to the social work practice, and some weren't. So what I would have had a conversation with Esther about is; well, how do we support the individuals who haven't acquired that training opportunity, that they do, so that their actions are in line with expectations in relation to practice? 14:56 14:56

347 Q. Can I just ask you though, that maybe what would have

been looked at had the 15 Step Challenge been brought in.

A. Yes.

348 Q. But who were you proposing would conduct that work? So at this meeting it says that you proposed that it would be replaced by the implementation of the 15 Step Challenge. Who was to carry that out in your proposal? 14:57

A. Well the initial assessment, it was Brenda Creaney and Catherine McNicholl's desire that myself and Esther would do the first initial assessment, that we would then, through the Royal College of Nursing contract do some education for some of the senior staff on site so that they would have an understanding of the perspective of what would be expected of them when they were engaging in and around the service, and, again, that they would then have an opportunity to begin to do those actions on a more regular basis with staff. 14:57

349 Q. But ultimately that wasn't accepted, that proposal at that time, isn't that right?

A. No, it wasn't accepted. 14:57

350 Q. And we can see, if we just scroll down a little bit more towards the end and onto the next page, please, you can see there was discussion about that and it says there:

14:57

"It was agreed that arrangements would remain as they were and that the issue would be discussed again at the next strategy meeting."

A. So when I say it wasn't accepted, very clearly the designated officer, Aine, did say strongly that she had a great preference for the monitoring to continue, and I certainly did not wish to disrespect that opinion, because she had the authority of that opinion. So I respected that I put my case forward, and at that point in time it was rejected, which can happen. And then I gave her my support that I would continue to support the monitor to engage, and I would come back with a report from further monitoring, and that -- but I did indicate that I would come back with that proposal at a later stage. 14:58 14:58

351 Q. Okay. And you did then go on to prepare a further briefing paper, and we see that at page 88. If we could go down there, please? This is a paper then that was a relatively short time later, the 9th January. And this seems to deal with a wider range of issues, so not just monitoring, is that right? It also sets out your briefing report on other actions that you had completed by that stage. Okay. So if we just take some of those, we can see that by that stage you had completed further unannounced leadership walks and you completed a further review of patient notes, medical files, and drug Kardex. A further review of the monitoring form since the 19th December, and a review of the learning environment. 14:58 14:59 14:59

And if you scroll down then to page 89, you give a little bit -- there is reference there that I've passed

over to the improvement plan, and I'm going to come back to that, but just sticking with this issue, those individual issues that we've just looked at are then broken down. So at page 89 you give a bit more detail about the review of patient notes and medical files. 15:00
Now, in your first statement you do say that whenever you conducted this review that you noticed there was a narrow range of professional backgrounds providing care to residents at Muckamore. Do you recall that?

A. I do. 15:00

352 Q. Can you tell the Panel a little bit more about what you observed about that from your review?

A. I didn't see social workers. I am aware there were a small number, but I wouldn't have seen them present on any of the occasions that I was there. I was aware 15:00
that they had access to speech and language therapy, but I think that person was part of a greater team in the Trust. Therefore, it would have been accessed for the individuals to come from whichever team that person was in. So there wasn't a dedicated speech and 15:01
language therapist. There was the beginning of the development of a behavioural support team in Muckamore, but again access to behavioural support expertise was limited. There were -- now, I might get the term wrong so I'm just going to be cautious about this, but there 15:01
was a person who held a MAPA training qualification who had, by the organisation that regulated MAPA, had the authority to train the trainers, type of approach, and forgive me if I haven't got the language correct around

that, but that person was a senior nurse, but held this qualification. So there would have been an expectation of annual re-engagement of all members of staff in the MAPA training process, which was the recognised process at that time. My understanding is that it was for the greater safety of the patient and not for staff to misuse. So, again, staff sometimes would have said to me they were concerned about engaging in the MAPA strategy in case it was believed that they were actioning something on occasions that was not of what their intention was. 15:02 15:02

353 Q. Yes. If we scroll down I think on this we can see that reference. Scroll down a little bit more, please? You refer there to you found your discussion with the MAPA trainer that the moves noted as potential allegations could have been MAPA moves designed to protect both patient and others during perceived challenging behaviour episodes. So as you saying that as part of this review you had discussions with the MAPA trainer?

A. I did, and I went along to one of the training sessions because I personally and professionally had not accessed MAPA training before, so I was professionally curious as to what that training was like and what the staff were actually engaging in. So I spent two days at the training to witness what it was that was being trained, and felt reassured at the end of the two days that the staff were coming out with how to physically engage with an individual who was presenting challenging behaviours. Now I think now there might be 15:02 15:03 15:03

a new term of how to explain behaviours that are perceived to be challenging, but going to the language that I am aware of, it would have been called challenging behaviour then.

354 Q. But the extract that we've just looked at refers to a particular discussion that you appear to have had with the MAPA trainer? 15:04

A. Yes.

355 Q. About the potential allegations. Now do you say allegations were not discussed with the trainer, but can you be more specific about the type of allegations that the MAPA trainer was saying could have been MAPA moves? Do you recall that? 15:04

A. I don't want to speculate.

356 Q. You can't specifically recall? 15:04

A. I can't specifically recall. What I can share with you is I had a great awareness that on such a small site that individuals knew one another so well because they had worked with each other, and on occasions had to go to different wards to work with each other. There was a chit-chat, so I would have constantly be reminding staff that that was not something that we should be doing. 15:04

357 Q. We have digressed to talk about MAPA, but when we first started looking at your review of patient records I had referred you to a section of your first statement where you noted the lack of a full multidisciplinary team. That specific reference to noting a lack of a full multidisciplinary team is made in your first statement, 15:05

but it is not made in this briefing report. So I'm wondering did you ever report that particular observation about the deficits in the multidisciplinary team to anyone at that time?

A. I am certainly aware I would have had that conversation with Catherine McNicholl and Brenda in one of the supervision sessions, in that I had an experience when I worked in child psychiatry that the child development team in the Trusts that I worked at that stage had what they called a one-stop-shop, and in that you would have had access to psychology, speech and language, dentistry. You would have had the medical profession. You would have the social work perspective. You would have the nursing. And as a team of individuals, the family felt -- I think there's a term, not then, but it was a wraparound service, so that you had access to a range of professionals who were expert in their own field, but would contribute together to the greater good of the individual that they worked with. That wasn't obvious in Muckamore. And certainly the medical team that were there, I wasn't expected to have a view on them, as I am a nurse, not a medical practitioner, but they did seem to be busy with community and hospital, and the division of labour did seem to be strenuous for them in relation to the expectation from a work plan. 15:05 15:05 15:06 15:06 15:06

358 Q. I want to return to your report. If we can just scroll down then, please, to page 93? This is the same report and this is where you set out your further analysis of

the monitoring forms, and we can see there again you refer to the thematic review and you would have conducted that using the early indicators of concern and RCN Dignity Standard. At that stage there had been a total of 118 monitoring forms covering 1,519 hours of observed practice, and they had been submitted over an eight week period by independent monitors to observe practice over a 24-hour cycle. 15:07

If we just scroll down then, you can see your results, and you note some positive themes, and I don't need to go through all of these, these are -- the Panel have all of these, as do Core Participants. But if we keep scrolling down, please, just to take an overview of this, and keep going to the next page, please, and if we just pause there, you can see that there is reference to: 15:07 15:08

"From the 118 monitor forms only 67 that had identified concerns. The key themes were staff levels at key times in the day impairing the ability to facilitate the needs of patients for activity based interventions. The challenge of keeping the curtains up with frequency of the patients pulling them down, and the challenge for staff maintaining dignity for some patients with the behaviour of the removal of clothes." 15:08 15:08

And if we scroll down a little bit more, please? We can see that you move on to the review of the nursing

practice placement.

A. Yes.

359 Q. But pausing about monitoring then. You previously, whenever we had talked about your first report, had indicated that you supported the cessation of monitoring in and around that December time, but ultimately we saw there was discussion of that at the December meeting and monitoring continued. After completion of the second report, did you change your view on whether 24-hour monitoring should be continued? 15:09

A. I still had a view at this stage that it could be ceased at this stage, because there was a significant amount of information on all of the forms that clearly indicated that there was nothing of abusive concern or that would indicate abuse, and how I understand that is, I understand when staff are first -- at this stage the staff were more engaged, and facilitative, and open and transparent about what was going on. They were more accommodative of the monitors being present. Therefore, that initial hotspot, if I say those words, you know "I'm being watched", had reduced, so staff were engaged in business as usual. Therefore, if there had of been any behaviours or concerns, they may have crept back into practice, because when you're being watched initially you may be absolutely dedicated to doing it absolutely by the rule, but over a longer period of time the chances are that you revert back to your behaviours as before, and there was none of that evident in any of the information that was coming

forward from the monitors.

360 Q. Okay.

A. Just as another bit of information, and I'm not sure if I have it in there, is, when we first made the refinement to the monitoring process, we had suggested that the monitors should only monitor for a six hour period and that it should be rostered over the week, so that I, as a monitor, wouldn't get fatigue of observing. There's a risk with fatigue that you don't observe behaviours that you need to, so we needed to put in a factor that would take out the risk of observation fatigue, and that would have been something I would have brought from my professional understanding when I worked in child psychiatry, because it wasn't unusual then for me to have to spend time in a school environment or other environment that children worked and lived in for me to be the person observed, and you need to really keep yourself very sharp, you really need to keep focused and you need to be cognisant that you can be distracted and that you can lose focus. So a period of time needed to be adequate enough that you were fresh at the observations. 15:11 15:11 15:12

361 Q. But that particular --

A. And that needed to change.

362 Q. Sorry, Ms. Mannion, I just want to put a time period on that refinement you've described? 15:12

A. That would have been after the six weeks, the first time that I had proposed a change, and it was rejected. I then encouraged a greater diligence around the

timeframe that each person was -- so that it would reduce the risk of observation fatigue.

363 Q. Okay. So that was after the December period but before the second report?

A. Yes. Yes. 15:12

364 Q. Okay.

CHAIRPERSON: Could I just understand, I'm sorry, just to get the dates right. This is dated the 8th January.

A. Yes.

CHAIRPERSON: So by that point how long had monitoring actually been going on? 15:12

A. My understanding is that the monitoring was in place quite soon after the allegations and the members of staff who were precautionary suspended was put in place. So it would have been ongoing from November through to January at that stage. 15:13

CHAIRPERSON: And having reviewed the monitoring forms you were by that stage satisfied, were you, that the monitoring activity could be discontinued?

A. I was. But with the caveat of other activities being in place. 15:13

CHAIRPERSON: Yeah.

A. To give greater assurance about behaviours.

CHAIRPERSON: And you said there's no evidence that there's a cultural tolerance of behaviours that could be defined as abusive? 15:13

A. At that time.

CHAIRPERSON: But this was Aine Morrison's investigation?

A. It was.

CHAIRPERSON: So how does this play in with Aine Morrison's role as leading the investigation?

A. Well, with the monitoring reports and the evidence that was within each document, and the number has been identified there, it clearly indicated much evidence of good practice, which we would have discussed with Aine and Aine would have received these reports. 15:14

CHAIRPERSON: Yeah.

A. And it was my understanding that she was supportive of the monitoring and the reports, but that she still had concerns that this didn't seem to alleviate. But it wouldn't have been, it wouldn't have meant to have been contentious against what she was supporting. It was -- the monitoring was something she asked to happen and we supported it in its process. 15:14 15:14

CHAIRPERSON: Yeah. But by this point you are suggesting it be discontinued?

A. Yes.

CHAIRPERSON: And had you factored into that the fact that the allegations, whatever one makes of them, were that these staff had behaved in the way that they are alleged to have done in front of externals? So they were so comfortable, as it were, in what they were doing, that they were willing to behave in the same way, despite the fact there were people outside the ward watching? Did you factor that in to the length of monitoring that you thought was appropriate? 15:14 15:15

A. I had, because again the comment I made about, you

know, observation fatigue, and the fact that the monitoring went on as long as it did. And even if we just think from the November to January, staff were accommodating 24/7 of being observed, and if I had of reverted back to behaviours that could be perceived to be abusive, I would have done it, I believe, professionally, in that space of time. And my basis for that is I also did a lot of behaviour management work when I worked in child psychiatry, and the theory behind behaviour change would indicate that you need to accommodate a new behaviour at least 12 to 14 weeks for you then to be engaged in that activity persistently again. 15:15 15:16

CHAIRPERSON: So you were factoring in your knowledge, as it were, of child behaviour. 15:16

A. Yes.

CHAIRPERSON: Into this decision.

A. Yes. Yes.

CHAIRPERSON: Yes, I see. Thank you very much. Sorry, Ms. Kiley. 15:16

365 Q. MS. KILEY: Thank you, Chair. In that January template there, and we've looked at your report, and you did then present your view that monitoring should cease again to the strategy meeting that took place on the 9th January, isn't that right? 15:16

A. Mhm-mhm.

366 Q. And the minute of that appears at page 52 of the Ennis Bundle. I don't need to take you through this in detail, but is it right, Ms. Mannion, that again you

presented your view that monitoring could cease for the reasons you've already addressed, but Aine Morrison disagreed with that at that time again, isn't that right?

A. Yes.

367 Q. So this was the second occasion that you had disagreed about it. And, again, the conclusion of the strategy meeting was at that time that monitoring would again continue, isn't that right?

A. Yes.

368 Q. So having presented your view on two occasions, and having Ms. Morrison disagree on two occasions, I just wonder did you consider escalating the matter? Because it was something that you had come to a professional opinion about, and it was something that Ms. Morrison clearly had a different opinion about. So did you just agree to disagree or did you consider escalating that?

A. I did have a conversation with Brenda and Catherine McNicholl about the fact that there was that kind of not acceptance of the second proposal, with the information, because they too would have had the reports that I put together, and I would have also had a conversation with Aine, and indeed John Veitch, about how do we move forward? What needs to happen for you, as a designated officer, respecting the role that you have, for us to consider how things change? So my view was/is, that there's a timeliness for investigation, and then there's a recovery and redevelopment phase where you're looking at the key factors that absolutely

need to be in place to give greater assurance of daily activity so that business as usual might occur, and I was concerned that there was now another small number of staff leaving due to resignations, they were being offered posts in other in places, and we would have had 15:18
conversations with HR looking at what were exit interviews and what staff were saying, and, also, Esther was doing a workforce plan around what the new configuration might need to look like, and there would have been plans on recruitment fairs and advertisements 15:19
for to try and have staff come to Muckamore, and that would have been open discussions between the Co-Director, Service Manager, Brenda, and the Director of the service.

369 Q. But what's that got do with the conversation that you had about the fact that your suggestion of ceasing monitoring had been rejected for the second time? 15:19

A. They advised me to go back and have a conversation with John and Aine and to come to some resolution. Now it was my understanding that we did come to a resolution, 15:19
and Aine was quite forthright in saying that she, as the safeguarding designated officer, didn't wish to stand down the monitoring.

370 Q. So the resolution, as far as you were concerned, was that Aine Morrison had the final word. Is that right? 15:20

A. Yes. Yes.

DR. MAXWELL: Can I just ask, it sounds as though Aine was very focused on the allegations.

A. Yes.

DR. MAXWELL: And what she thought the immediate action to safeguard patients was, and that you were thinking more widely about what impact is this having on the workforce, who are feeling they're not trusted and they're leaving? Do you think that's a fair characterisation, that she was looking at one lens and you were looking at it through a different lens? 15:20

A. Well, certainly, I know I was being -- I was focusing on the safeguarding aspect of it, because that was the key part of what was there. 15:21

DR. MAXWELL: Yes.

A. But I did have the perception that she was so focused on the allegations that she may have been distracted by thinking about how we move to conclusion of an investigation and what we might propose as recommendations for the future. 15:21

DR. MAXWELL: Because presumably if in your eagerness to safeguard patients you denude the ward of staff, that's a risk to safeguarding in itself?

A. It is. It is. 15:21

DR. MAXWELL: That there aren't the staff to supervise patients, stop patient-on-patient abuse, and so actually the very act of being tunnel-visioned, if that then led to staff not wanting to work there and staff leaving, that could have put the patients more at risk? 15:21

A. Well, certainly that was part of why I would have attempted to have the conversations about, well, how do we accommodate safeguarding as its first priority?', absolutely. And how do we maintain the integrity of

the environment that the individuals who are receiving the care, so that they could be cared for in a compassionate manner?

DR. MAXWELL: So did Aine not understand or not accept that actually unintended consequences could do the opposite of safeguarding patients? 15:22

A. It didn't appear so. Because there was one of the discussions that she and I would have had in one of the meetings, where she had -- I won't remember her words perfect, but there was some words that she used about a staff member, and I challenged her about that, about where was the evidence to support the comments that she made? And then I gave an explanation about regulatory activities from an NMC's point of view and a discipline point of view, that absolutely nurses need to be held to account. Absolutely patient safety needs to be paramount. And I probably came across emphatically about that, because I had the sense that she was suggesting I was protective of the nurses and, yes, I may have been, but not to the exclusion of patient care. Absolutely not. 15:22 15:23 15:23

DR. MAXWELL: Thank you.

371 Q. MS. KILEY: Just while you reference that conversation, Ms. Mannion, I think you have seen Aine Morrison's statement to the Inquiry? 15:23

A. I have.

372 Q. Or statements, isn't that right?

A. I have.

373 Q. And you may know that Ms. Morrison gave evidence last

week, and I just want to ask you to look at a particular point that she makes. Can we bring up Ms. Morrison's statement STM-198-24, please? I think what Ms. Morrison says here is linked to what you have just been describing, and you can tell me if I am wrong about that, but if we can scroll down to page 95, please, or paragraph 95, sorry? Around halfway down "I also recall" - can you see that? You can see that Ms. Morrison said: 15:24

"I also recall that Moira Mannion berated me in a meeting for daring to suggest that nurses could be involved in abuse, pointing to their professional registration, their professional codes of conduct, their duty to uphold their code of conduct, and accountability for their own practice." 15:24

Ms. Mannion, just seeing that, it seemed to me that that might be the conversation that you were alluding to there. Is that right? 15:24

A. It may be. Sorry. Just a moment. [Witness is upset]

CHAIRPERSON: Just take a moment. Have a glass of water. If you want to stop, we can. We're probably coming to a break quite soon.

A. No, I'll keep going. Sorry. My apologies. Sorry. 15:25

CHAIRPERSON: Just take a moment.

374 Q. MS. KILEY: You said there Ms. Mannion that it might have been suggested that you were protective of nurses, but you can see there that it may be the same

conversation, it may have been a different one, but Ms. Morrison felt that there was something more that you were suggesting that nurses couldn't be involved in abuse, and I just want to give you an opportunity to comment on that. Do you accept that? 15:25

A. No, I cannot accept that. Throughout my career at different times I have been extremely unpopular when I brought forward reports about behaviours that other nurses/colleagues engaged in, that I believed stood outside practice. And that would have been as early as 15:26 in my 20s when I was an Acting Sister in ward environment, where on the first week of being there I noticed that patient's property didn't seem to be there, financially, and sweets and cigarettes and bits and pieces. It was an in-patient mental health unit. 15:26 And I reported it directly to the Service Manager, or the title they would have been then. The outcome of that was that they did find that stealing had taken place. As a person, I did experience my tyres being slashed by an unknown person, and staff would have not 15:26 wished to speak to me. So as early as in my 20s, and I'm not 20 now, if I came -- if it came to my attention that behaviours were incorrect, I would have brought it forward. I had the experience of contributing to the historical institutional abuse, and that was when I 15:27 worked as -- I had worked in residential child psychiatry services, and I participated in the Inquiry for that. So it is not unknown to me to bring things forward. So I find that quite difficult.

375 Q. And if anyone was to read that and think that it might be suggesting that you were communicating a view that you don't think that nurses could be involved in abuse, is that your view?

A. I believe nurses can, like others, contribute to abuse, and certainly I have worked with adults and children who have been abused, and it happens. It needs to be reported, it needs to be managed, and the individual, no matter what age they are, needs to be protected and supported. So, no, I wouldn't have said that a nurse that did wrong or abuse could continue to work. He/she needs to be held to account, taken through the appropriate procedures, whether that be the PSNI, whether that be disciplinary, whether that be experience in being asked to leave the workplace, absolutely needs to happen. 15:27 15:28 15:28

376 Q. Chair, it may be a suitable time for a short break. I'm in your hands, but I have around 20 minutes I think left of Ennis and then we'll move on.

CHAIRPERSON: I think it would be good for the witness if we do take a short break. 15:28

A. Thank you.

CHAIRPERSON: And it may be that we can take a very short break just to switch over the machinery, as it were afterwards. 15:29

MS. KILEY: Yes.

CHAIRPERSON: Okay, we'll take just ten or so minutes now. Thank you very much. Thank you.

SHORT ADJOURNMENT

THE INQUIRY RESUMED AFTER THE SHORT ADJOURNMENT AS FOLLOWS:

15:49

CHAIRPERSON: Thank you.

377 Q. MS. KILEY: Ms. Mannion, when you returned to the witness table you just indicated briefly to me that there's something else that you want to add to your, what we were discussing just before the break. So if 15:50 you'd like to, I'll give you the opportunity to do that now.

A. Thank you. There was just one comment that I would like to make, in that Ms. Morrison's allegations towards myself in that they came forth many years after 15:50 Ennis, and I find that hard. But as a nurse I would know that the voracity of the allegation, if a nurse had waited seven years to bring that forward, that would have been perceived to have been unprofessional, and it needs to be brought up in a timely fashion at 15:50 the time. So when I was working with the Trust, at that stage I had been invited by the Trust to be the senior nurse on the investigation team, and when the senior director brought it to my attention that these allegations had come forth, I stood down from the 15:51 investigation as there may have been a question over my behaviour. But I did ask the question: How come now? And, equally, if you are concerned about someone's behaviour, when I was first asked to go back to

Muckamore in 2018, why not then? And when subsequently I was being invited to be part of the investigation team with the PSNI in November of 2019, why not then? Why now?

CHAIRPERSON: Right.

A. So it was quite concerning to me, and I can't make judgments on other professional backgrounds, but from a nursing background that is not acceptable.

CHAIRPERSON: Okay. Thank you. Yes, Ms. Kiley.

378 Q. MS. KILEY: Ms. Mannion, you have touched on the allegations that Aine Morrison made against you. We touched on them a little bit before the break, but since you've referred to them now I just want to spend a little bit more time on them because -- and I can see that it's a difficult issue, but in fairness I want to give you a full opportunity to respond to those allegations. So there was one other particular allegation that I wanted to put to you, and that was, and you will have seen from Ms. Morrison's statement how she describes your behaviour during the investigation, and you will have seen, I need not bring it up, but at paragraph 101 of Ms. Morrison's second statement she describes your behaviour as bullying, and that is a particularly serious allegation, so I want to give you an opportunity to particularly comment on that?

A. The initial allegations that I'm speaking about did not mention bullying in 2019, and that was approximately February/March when I stood down from the investigation

team at the Trust. My first knowledge that the allegation of bullying came forth was when the statements went up on the website. That had not been shared with me before that.

379 Q. Okay. And to be clear, do you accept or reject that as a characterisation? 15:53

A. I completely reject that.

380 Q. Okay. And just before we move away from this topic, you refer to the allegations that were made in 2020, and you do address this at paragraph 14 of your statement, and we need not go through it, but in fairness just to highlight that you made a written response to the allegations and you've provided that to the Inquiry. It's at page 15 to 27 of your second statement. And you then also make reference to a report which was authored by David Bingham in respect of the allegations. That too is in the materials that the Inquiry has, and that's at page 802 of the Ennis Bundle. Again, I won't bring that up. But I just wanted to check, as part of that process, Mr. Bingham's adjudication on the issues that Ms. Morrison raised, were you particularly interviewed by Mr. Bingham before he drafted his report? 15:53 15:53 15:54

A. For many hours, and he certainly made it known to me that they also spoke to other individuals in relation to his exploration of the allegations. 15:54

381 Q. And was that just particularly in relation to the allegations? Because we know that David Bingham and others were at the, along the same time, conducting a

review of the leadership and governance of the Belfast Trust, but were you only spoken to by David Bingham about these particular investigations?

A. Moira Devlin was present and, forgive me, but I can't remember the social work lady who was part of the team, but they were present, and as it was during the Covid restrictions period it would have been over the Teams. 15:54

382 Q. And what did you understand about what David Bingham was doing in respect of those allegations and what he was considering? 15:55

A. He was -- well the indications to the team, I won't get this word perfect, but he was indicating to me that they were investigating this on behalf of the Trust and it was outside the remit of the leadership and governance review that he had, but since it had been brought into this, they needed to clarify was there anything to substantiate the allegations that were made, and may the allegations have caused disruption to the investigation and the outcome of the investigation. 15:55

CHAIRPERSON: Ms. Mannion, I don't think you quite answered the earlier question. You told us you were interviewed for many hours. Was that all about the allegations? 15:55

A. Allegations, yes.

CHAIRPERSON: And not about the leadership and governance report? Or was it a mixture of the two? 15:55

A. It may have been a mixture of the two.

CHAIRPERSON: Because it sounds a bit odd to spend many hours talking about these allegations.

A. Well, when I say many, it was maybe two hours, maybe. I don't want to sound as if I'm exaggerating. It might have been two hours on the -- and forgive me, I lack clarity on -- I think it may have been on both.

CHAIRPERSON: Yeah. Okay. 15:56

383 Q. MS. KILEY: And then finally to complete this picture, you have provided the Inquiry with an outcome letter that you received from the Belfast Trust on 27th August 2020 and, again, you've exhibited that to your second statement. But in broad summary that provided you with 15:56 the report that Mr. Bingham had made in respect of the allegations, isn't that right?

A. Yes, there was a report, yeah.

384 Q. And it's right to say that ultimately his report found that he did not substantiate the allegations that 15:56 Ms. Morrison made against you?

A. That's what I believe.

385 Q. Were you satisfied with that outcome?

A. I was satisfied.

386 Q. And by that time you didn't work for the Trust anymore? 15:57

A. I wasn't, no. No, I had retired.

387 Q. Okay. I want to move on from that episode but back in time to the Ennis Investigation. We talked beforehand about monitoring and strategy meetings, and I want to take you particularly to a strategy meeting that took 15:57 place after the Ennis Report was finalised, and that was on 28th October 2013, so it's at page 70 of the Ennis Bundle, please. So, the Inquiry has looked at this meeting before, and this was the meeting at which

the final Ennis Report was presented to the strategy meeting. But there was some discussion at this meeting about what the monitoring showed, and if we could move down to page 75, please, and if we can just Zoom in on the final three paragraphs. Yes, just pause there, please, where it says "Mr. Veitch". So it says here:

"Mr. Veitch acknowledged a very thorough investigation carried out and highlighted the very intense monitoring process which showed no evidence of institutional abuse. Ms. Mannion noted that the monitoring process had been stepped down as there was no concern about institutional abuse. Ms. Morrison stated that while the monitoring reports confirmed no evidence of institutional abuse post the allegations being made, she did not feel that this could be necessarily generalised to the period before the allegations were made."

15:58

15:58

15:58

Just pausing there, we can see that there was discussion at that meeting about institutional abuse. Do you recall that?

A. Yes.

388 Q. And when you were engaging in that discussion at the time, did you understand "institutional abuse" and that phrase to refer to abuse at the wider hospital or abuse on Ennis Ward itself?

15:58

A. It was about Ennis.

389 Q. It was about Ennis. And we can see there that

Mr. Veitch expressed his view, and it appears, and you can correct me if I'm wrong, that Mr. Veitch and you had similar views, but Ms. Morrison had a different view to both of you about whether there was evidence of institutional abuse. Is that right? 15:59

A. Yes.

390 Q. And can you just confirm for the Inquiry what your view was about whether institutional abuse had taken place at Ennis?

A. I believed that there were some behaviours by the individuals who had been managed not to work in the environment, had engaged in behaviours that were not appropriately professionally. However, I would not have deemed that to have been institutional abuse. For my understanding of institutional abuse is that there was a level of malaise and others would have been engaging in behaviours that were not appropriate, and this was potentially with and allegedly with the two individuals and a student at that time who was exonerated, but just those three individuals, but two staff members. 15:59 16:00

391 Q. And as you know the Inquiry has heard from Ms. Morrison, and she has given evidence about this issue too and about whether she believed there was institutional abuse, and in summary what she says is that she didn't feel that there was enough evidence to satisfy her that there was not institutional abuse, so that's slightly more nuanced to the position that you have described. And it appears when one reads the 16:00

minute that I've taken you to, that there was disagreement between you and Mr. Veitch on the one hand and Ms. Morrison on the other hand about that issue, is that fair?

A. I'm not sure I would have described it as a disagreement, but we did hold two views, and when we -- when I -- I can't speak for another person, when I was asking questions of Ms. Morrison I was hoping that she would give me greater clarity as to how come she was still suspicious, because when you read the report it didn't have a coordinated approach of what the evidence might be to substantiate that suspicion. So if you have a suspicion but you find it challenging to articulate what that suspicion is based on, it's very difficult then to provide that person with assurances with a range of activities that you might engage in from a professional point of view, how you can allay that concern that that person might have. 16:00 16:01 16:01

392 Q. Did you get that clarity in those discussions?

A. She was very adamant not to accept the challenges that myself, now Mr. Veitch can speak for himself, but she was adamant that her suspicion was still there. 16:01

393 Q. And having come to two different opinions about that, did you consider escalating the issue to someone more senior to try and resolve the point? 16:02

A. The conversation did happen with Catherine McNicholl and Brenda in the supervision sessions.

394 Q. Sorry, just to set this in context. Was that between you and Brenda and Catherine only?

A. Me. Yes. Yes. Because I would have been going to them on a regular basis for mostly the Director of Nursing, because that is who my reporting officer was, but there were occasions that Catherine McNicholl, the Director who had commissioned the joint commission of myself to be engaged in that activity, would have been there, and it was my memory that Catherine McNicholl and John Veitch, as having the authority of the service profile, that they would engage in the completion of the resolution of that, and at a similar timeframe Ms. Esther Rafferty had been promoted to Associate Director of Nursing, who was Brenda's key person on the ground responsible for professional issues and, likewise, that she would have then taken on that portfolio as I was moving on to other activities. 16:02 16:03 16:03

395 Q. Okay. So you thought actually that there was going to be a professional resolution of that?

A. Yes.

396 Q. And did you ever understand that to happen?

A. The resolution, as I seen it, Ms. Creaney had significant governance meetings from a nursing perspective, so she would have had a Nurses in Difficulty process, which is related to regulatory activities, and supporting staff either from health, ill-health, behaviours such as addictive behaviours and/or indeed malpractice from nursing, and there was a support framework for nurses in that. So I would have attended that meeting as her deputy at that point in time, as would Esther Rafferty and other Associate 16:03 16:03

Director of Nursing from across the Trust. The expectation from the Executive Director of Nursing was that they needed to take professional responsibility of professional matters, and if there was risks, that they needed to be raised in line with the governance 16:04
expectation of the organisation, but then professionally raised with Brenda Creaney at that meeting, and the expectation is then that you as an Associate Director of Nursing would have went back with the action plan and put in place what was expected to 16:04
happen in relation to that issue.

There was also an Education and Workforce Governance meeting, and there was also Infection Control and Prevention, again senior meeting. So there were at 16:04
least three regular governance meetings with the expectation that all Associate Directors of Nursing and Brenda's senior nursing team would attend, and the agenda was set that all of those matters related to each of those subjects would then be discussed, and the 16:05
expectation is that the Associate Director of Nursing would have taken the action plan back.

There would have been occasions that Brenda, as the Executive Director of Nursing with her statutory 16:05
responsibilities, would have expected myself or my colleague, who was her other deputy and, indeed, the teams that we managed, to engage in supportive activities, in-reach to the areas of concern, be that

education, be that workforce, be that about behaviours that are unacceptable, be that about infection control, and then the supplementary teams would have worked in those sites, whether that was Muckamore, whether that was in the Royal, whether that was on the City site, whether that was in Knockbracken.

397 Q. But thinking particularly about this difference of opinion that there was at this stage of the investigation. So, October 2013, when the final report had been produced to you, and the difference of opinion between you and John Veitch on one hand and Ms. Morrison on the other hand about whether or not there was evidence of institutional abuse. Did you understand that disagreement to ever have been resolved? 16:05 16:06 16:06

A. My understanding was that it was resolved in that -- well John Veitch was to go back and review all of the minutes and to do a timeline of how we might resolve the modification of a final report. I have no recollection of receiving a final report, so I could not say definitively that it was resolved. However, in the meetings with the Associate Director of Nursing and Brenda, because of all of the actions, the adherence to the audit activities around policy adherence, the presentation of a new workforce plan, the update of actions around improvement that Esther would have brought to those meetings, the fact that Esther engaged vehemently and encouraged her colleagues to engage with my team around nursing assessment 16:06 16:07

standards, meant that students returned to work in Muckamore. I do recall that Esther then began to look at whether CCTV needed to be implemented across the site to give greater assurance around safeguarding, and I am aware that there was opposition from our trade union colleagues at that point in time. 16:07

398 Q. What point in time are you referring to?

A. I'm talking about post, it would have been after 2000, probably 2014 approximately. But I know that she began those conversations, so I am -- 16:08

399 Q. And are you connecting them back to the Ennis Report and this consideration of institutional abuse?

A. Yes.

400 Q. Okay.

A. So there was an ongoing need for Esther to give assurances to a wide range of individuals that abuse had not happened in Ennis. 16:08

401 Q. And, finally, just on the discussions that you were engaged in at the time that the Ennis Report was delivered, this is October 2013 time, the Inquiry has heard evidence from Aine Morrison who said that John Veitch put considerable pressure on her to state that she found no evidence of institutional abuse. Do you recall Mr. Veitch putting that sort of pressure on Ms. Morrison? 16:08

A. I honestly can say to you that in each of those meetings there can be a need for greater clarity, therefore, you focus on seeking the clarity with the questions that you do. I would not have said he put

pressure on. At that senior level there is an understanding that a greater opportunity for clarity and transparency is really important, and I would have heard what he was saying as seeking that clarity, because it would have assisted the disciplinary process and it also would have assisted the PSNI approach being separate from the safeguarding factors.

402 Q. Yes. And the Inquiry is due to hear from Mr. Veitch tomorrow in fact. But I want to just move on now.

DR. MAXWELL: Sorry, just before you go. Where was your expectation about where this report would go? Because most reports go through a governance process.

A. Yes.

DR. MAXWELL: So...

A. My understanding is that the report, when it would have been finalised, because my memory has it that I seen a final draft, but I never received a final copy. But my understanding is since it was the ownership of that Directorate that John Veitch would have taken it to his senior management directorate team, and that indeed Catherine McNicholl would potentially share that with --

DR. MAXWELL: So do you think it would have gone to the Directorate of Clinical Governance Committee?

A. Well, that is where other reports --

DR. MAXWELL: Is that were safeguarding reports normally go? And we've asked --

A. My -- sorry, my apologies. Sorry.

DR. MAXWELL: It's okay. I've asked a number of times

and nobody has been able to tell me what Belfast Trust's policy for where safeguarding reports go, is?

A. My understanding is, there was an extremely professional gentlemen called John Grocott, he was a very senior social work, and he would have collated the statutory document for social work to go in to the Health and Social Care Board, and my understanding is that safeguarding and other professional matters would have been reported through that remit. 16:10

DR. MAXWELL: So they would have gone to the Health and Social Care Board? 16:11

A. My understanding is yes.

DR. MAXWELL: Okay. Thank you.

CHAIRPERSON: Sorry.

A. But, sorry, equally to the Executive. 16:11

DR. MAXWELL: Yes, to both.

A. Yes.

DR. MAXWELL: But there's a safeguarding governance route and there's a clinical governance route.

A. Yes. 16:11

CHAIRPERSON: And within the Trust, just explain to me as a civilian, where does it end up in the Trust? What's the last stop?

A. My recollection is when you are with the Directorate, with their decision to take it to Trust Executive Team and potentially to the attention of the Board members. 16:11

CHAIRPERSON: Yes. Okay.

DR. MAXWELL: But they make that decision about whether to do that, because not all safeguarding reports would

go to the Executive Team?

A. No, no. It's the Director would have the responsibility of making that decision.

CHAIRPERSON: Fine. Thank you.

403 Q. MS. KILEY: I said I was going to move on, but just before I do leave this issue of the final report, or the final draft as you have been referring to it as, in your statement at paragraph 10 you do say that you felt that the report was poorly constructed. 16:12

16:12

"I recall John Veitch discussing this with me and he was concerned about the vagueness of the report and how this would be perceived by the families of patients. Mr. Veitch wanted to be open and clear with the families but the report didn't assist him with this." 16:12

Did you consider that the report was vague?

A. I thought parts of the report were clear and other parts of the report were conversational, and having a list of sentences that don't give you really a concept of its 'don't worry about your loved one', is unhelpful. So, yes, that was poorly written. 16:12

404 Q. Did you raise any concerns of that nature at the time when you saw the draft report in October?

A. I did. 16:13

405 Q. Who did you raise those with?

A. It was in the room with Aine and John, and encouraged, I felt, refocussing of how that was presented.

406 Q. What was the response to that?

A. I won't remember the words exactly, but it did seem to be rejected, in that 'this is my report', this is, you know, the conclusions of the report. And I wouldn't have been the only person saying is there an opportunity for us to re-word some of these? Because some of them -- and, again, I'm going back to memory here, some of them appeared to be allegations and some of them appeared to be comments. So when the two are mixed its difficult to see which are definitively the areas that needed to be addressed, and whether or not the other issues were day-to-day business that could be resolved without being in a safeguarding report. 16:13 16:13

407 Q. You then, I think, finished your role, or had by then finished your role in Muckamore, isn't that right? You left the particular role that you were tasked to do in Muckamore in and around June and July '13, is that right? 16:14

A. That would be right.

408 Q. So were you involved in the implementation of the recommendations in the Ennis Report? 16:14

A. Some of the activity that had been reported here, we were beginning to do the improvements before a recommendation was made, but Esther Rafferty would have been commissioned to continue with the progress.

409 Q. There is one action that you explain taking after the report was received, at paragraph 11, if we can scroll down there? You describe meeting staff after the report was prepared. You say you think that was some time in and around November '13. 16:14

"The staff on the Ennis Ward advised me that they felt there was still an element of suspicion around their conduct. I met the staff by way of a farewell meeting. The staff advised me that the experience of the investigation was negative. The staff said that Aine Morrison was very vocal during her investigation about staff members working with each other. Esther and I..." 16:15

CHAIRPERSON: "Staff family members", sorry, just for the transcript.

MS. KILEY: Oh, I beg your pardon. Yes.

"...working with each other. Esther and I felt that the staff should have been better supported. Staff needed support through counselling and Human Resources to mitigate perceived harm." 16:15

Do you know if ultimately the staff did receive that support that you're referring to at the end there? 16:15

A. Staff were offered help through Occupational Health, and also there's a counselling service that goes with that, and I know that Esther did commission a counsellor on site for staff to refer them -- self-referral to the counselling. And, again, it wouldn't be unusual for staff to have a period of time afterwards of still feeling discomfort/distress after the experience. But one of the -- well -- and one of 16:16

my attempts about trying to support staff is, and again it goes back to the comment that I made about 'Oh here come the Gods', is that, yes, I can be commissioned to go in to do a piece of work and then I am taken out of the environment and I am gone, and one of the things 16:16
that I endeavoured on a personal and professional level, was to go back and conclude that so that staff knew that I was now not engaged in that, and I would have explained to staff what the purpose of my role was in future. So at that time I would have been saying to 16:16
staff 'I now have a responsibility for education, I will be doing work to ensure that you achieve your mandatory training, I will be working with my HR colleagues to ensure that people get an opportunity to go for their NVQ training', and I would have made that 16:17
commitment to staff. So they would have understood there was a delineation of what I had been doing, but that I would be back but in a different role. And I have found in my experience that's a very important activity to do. But, again, it's not unusual for staff 16:17
to regurgitate and say all of the emotional concerns that they have with something during that. And how I would have termed that, because I do not want to be disrespectful by even using the word "regurgitate", is, I would I have called it that a listening time for the 16:17
staff to actually just say what their emotional experience was, and then advise them of the support mechanisms that are there for them to then privately and confidentially have an opportunity to be supported,

but for them to know that Moira now is not here on a monitoring role, 'I may be back to do a leadership walk-around, I am willing to hear what you have to said, I will raise issues on your behalf, I will bring issues to your attention if I see them', but my key role is X, Y, and Z.

410 Q. But was part of your role at that meeting to explain the outcomes of the Ennis Report to staff?

A. No.

411 Q. No? Do you know if anyone else undertook that role of explaining -- 16:18

A. My understanding is that Esther was to do that.

412 Q. Okay. There's one document that I said we would come back to when we were looking at the briefing reports. The briefing reports made reference to a Draft Improvement Plan. Do you recall that? 16:18

A. I do.

413 Q. And I just want to check with you, we have an improvement plan in the papers, and if we could bring up page 99 of the Ennis Bundle, please? You can see it's marked "Service Improvement Plan". Is this -- do you recognise this document? 16:18

A. I do.

414 Q. Did you draft this, Ms. Mannion?

A. Myself and Esther Rafferty would have completed this together. 16:19

415 Q. So this was -- at what stage of the investigation was this drafted?

A. It probably was fairly early on, because the --

CHAIRPERSON: It's got a date stamp on it if we go down a bit, hasn't it?

416 Q. MS. KILEY: Yeah. You can see there, there's a date stamp 8th January '13, and that's the social services.

A. It is early on. The idea, certainly the hope and expectation of the Director was that I would have a rapid assessment of the situation and with Esther identify key areas that needed improvement in the short-term, and what I mean by that is if tomorrow can happen, i.e. regarding curtains, it needs to happen, or really within the first four weeks. So there would be an expectation that the electricians were there to make sure that any of the electrical equipment was safe. That if there was any damage, for example, in the sensory integration room, that it needed to be altered and made safe so that patients could actually use it as a safe place to regulate themselves. 16:19 16:20 16:20

417 Q. So was the focus of this on recommending improvements to the ward environment?

A. Yes. 16:20

418 Q. And was it concerned with issues such as potential improvements that were needed to staffing?

A. Oh, yes, I think there's one comment there about the rostering.

419 Q. Yes. If we scroll down I think? 16:20

A. Yes. The Trust, and I won't remember the dates, but we had a traditional way of writing up your roster which the Ward Sister normally looked at the configuration of staff, thought about the skill set she needed across

the spectrum of care in the week, and she made determinations of the ratios of registered staff to health care support staff across the shifts. But with her clinical understanding, and Telford was one of the tools that would have been used then, at that time there wasn't a researched workforce tool that was suitable just for learning disability, but one needed to think about the needs of the patient. So if there was a high impact time, meal times being one, getting up in the morning another, going to bed at night, and again some individuals with autism don't necessarily see day and night-time as we might, and they might be alive and awake and very active at 2:00 o'clock in the morning. But the clinical team would know what behaviours would happen by patients, and they were there to determine nurse to patient ratios and try and equate that across the week. 16:21 16:21 16:21

The expectation was that you would have that for a minimum of a month so that you can have anticipatory care rosters, and one of the things we noticed is that that wasn't as apparent as it could have been and, equally, the Trust at that stage was beginning to engage in a new electronic rostering system, and staff not only in Muckamore were really concerned about how that was impacting on shifts from a family friendly perspective, because again you wouldn't have always had, you know, 'I'll work night duty and I'll only work night duty' or 'I'll have every weekend off' or, you know, such requests as we as human beings wish to have 16:22 16:22

to accommodate our family needs. So the new electronic rostering system would definitely have looked at the permanency of keeping the patients safe and keeping the environment safe for the patient. So there was a reluctance for staff to move to that, and we had to do some work with staff to engage that. 16:23

420 Q. I just wanted to move down to page 102, because you list some possible adjustments. If you just scroll down to the next page, please? Keep scrolling down to the bottom of that, please. We can see there, there are also some possible adjustments to staffing, and I don't need to go through them all there, but you can see about particular times of day care pickup, and observations of particular patients, and they were designed to adjust and make the balance of staff on ward at particular times better, or to increase the number of staff who were available generally; is that right? 16:23

A. That's right.

421 Q. And if we keep scrolling down then to page 103, keep going, we can just see, and I'm not going to go through them all, but there are a number of little bullet points about recommendations that were made there. And just keeping scrolling down. Just pause there at the final paragraph we can see, for example: 16:24

"It has recommended an option for future staffing on Ennis based on a model that required a ward or unit to be self-sufficient in terms of staff."

It doesn't appear then from this document itself as to whether the recommendations in it were accepted. Can you say anything more about that?

A. Well, my understanding is that they were accepted, because I remember Esther being very excited at getting additional funding from the Health and Social Care Board to fund additional staff, and certainly Brenda Creaney made an executive representation that in relation to the savings plans that the moratorium that was there on recruitment of staff was lifted for Muckamore, and there was an active recruitment campaign in relation to learning disability nurses, and the bank staff were required, where possible, to only engage in contacts in the early stages that people with learning disability qualifications would come to work in Muckamore if there was agency. And we also appealed to other staff on the bank. Now, let me clarify that for you. There were members of staff in Muckamore who were on the bank and would have come back in to Muckamore to Ennis and other wards to provide supplementary shifts to the shifts that they would have been rostered do, and then we would have had access to mental health practitioners in Belfast Trust who were on the bank who may have joined the team in -- so they would have known the Belfast Trust processes and systems, and the expectation from the bank office was that there was an introductory period, now that may only have been for the first shift, that the person did have a supervisor

16:24 16:25 16:25 16:25 16:26

and professional person who was buddying them through the experience and the routine, you know, 'where is? How come? What time is medications? What time is medicines? What time? Where is the medication Kardex? Where are the notes?' So, again, orientation. 16:26

422 Q. And are you saying all those things were the outworking of this improvement plan?

A. Yes. Yes.

423 Q. And just to clarify then, you refer to working with Esther Rafferty I think on this. Who was it ultimately presented to? 16:26

A. This would have been presented to Brenda Creaney.

424 Q. And was it --

A. And, indeed, John Veitch, who was Esther's reporting officer, and then through to Catherine McNicholl. 16:27

425 Q. Was it also presented to Aine Morrison as part of the safeguarding investigation or was this something different?

A. I'm not sure about that.

426 Q. There's just one final thing that I want to clarify with you, and that is a comment that you make at paragraph 17 of your statement. If we could turn to that, please? Paragraph 17 of the second statement. Just while we're waiting for that to load, this is the place, Ms. Mannion, were you describe a particular tension at Muckamore. There it is there. On the second paragraph you say: 16:27

"The perception at departmental level was and continues

to be that MAH is more of a social care environment, but it is in fact a hospital environment, and this creates tension. It also feeds down to staff ratios, because the ratios in a social care environment are different to ratios in a hospital environment. Social care requires care workers to have a social care background and social care workers are paid more than health care support workers. Health care support workers, however, require more supervision by registered nurses. All of this leads to staffing problems, which has been a real concern at MAH for a long time." 16:28 16:28

Now I think is it fair to say that this is a more general comment and not just related to the Ennis time, is that right? 16:28

A. It's not just Ennis times. That's -- it's a longer...

427 Q. What are you saying --

A. I would have found that in mental health environments as well within the Trust. And what I mean by that is, it would have been known that the RQIA measured Muckamore by the standards of the hospital standards when they came into review and indicate what they might have been concerned about, and then they changed their processes over the years to a more fulsome approach, because they may have come in to do the infection control matters on a separate issue and then the practice issues on a separate issue. And would have also looked at the Mental Health Order in case there 16:28 16:28

were any patients there who needed to be supported through the Mental Health Order in relation to Muckamore care.

Staff would have made it known to us, people have conversations over lunch, people have conversations to get to know one another, and they were, some of the health care support workers were actively seeking positions in independent establishments of a social care background because the wages were improved, the environment had less individuals to care for, and you may have been partnered with one individual where there was one or two of you supporting that individual in supported living environments. 16:29 16:29

In the hospital environment there was an opportunity for what I would describe as 'role creep', and this would be something I would have had conversations with individuals before, and what I mean by that is, if I have worked with you for four years as a perceived senior health care support worker, there is a level of Trust that has grown about my abilities to engage in activities. And for myself, from a professional nursing point of view, I supported individuals to delineate that which was nursing, registrant, regulatory, and that which was assisting the nurse in his regulatory or her regulatory activities. So those would have been conversations that I would have engaged staff with. 16:30 16:30

428 Q. But just if I may, Ms. Mannion, just focusing on the impact of that for Muckamore. Are you saying that Muckamore was a less desirable place to work for the reasons --

A. It became that very rapidly. Because of the moratorium some positions were temporary filled. Now my understanding, I'm not a HR practitioner, but my understanding that my HR colleagues shared with me is that temporary really should be six to nine months, with then substantive employment opportunity. In other words, that you get an interview and you are then in a substantive position. As a person I understand that when you're in a temporary role if you were applying for a mortgage you are not in a substantive role, therefore, you wouldn't get an opportunity to be getting a mortgage. So the idea of having a team that is stable requires you to have permanency, congruity, transparency, and for a team to get the opportunity to gel as a team that focuses on your strengths, addresses your weaknesses, supports your education, but ultimately that you are delivering patient care, prioritising the individuals that are there in your care. 16:30 16:31 16:31 16:31

429 Q. And are you saying that that didn't exist in Muckamore in your experience? 16:32

A. I think that the staff did their very best to do the very best they could. Staff indicated they were very concerned about the mix of individuals that were coming to Ennis, because as the retraction of the hospital

environment happened, and the resettlement, those who were fortunate to be complex, but not too complex, were being successfully integrated into the support environments that they could be, but that meant that ultimately individuals who were incredibly complex in their presentation seemed not to get the opportunity to have a favourable environment that would be adequate in their professional standing to support them with all of the needs that they had. That meant that the team, that was the medical team and the team who engaged in those case conferences around patients, were making decisions to move individual X into Ennis, but not always -- it didn't appear as though they were always considering the combination of patients. 16:32 16:33

And the reason that I bring that up is when I worked in an environment called Lisieux which was a residential children's psychiatry unit, if we had the balance of young people who came in who were demonstrating behaviours that placed them at risk, or others at risk, if the balance is that we had more of those individuals, it was very disruptive and quite challenging to provide a therapeutic environment for all of the patients who were there. So I had some insight into how that balance of needs, and the balance of staff, and the coordination of that, to actually put that forward into the Trust equation when I was working with them. 16:33 16:33 16:34

430 Q. I think, Ms. Mannion, we're starting to stray on to your wider experience of Muckamore.

A. Sorry.

431 Q. So I'm going to pause you there, because as you know we're going to have a break. I have no more questions for you on your Ennis experience.

CHAIRPERSON: I think we're going to have to have more than a break. It's twenty to five, a quarter to five now. We would need to break for 10 minutes. How long do you think the second part of your examination is going to be? An hour? 16:34

MS. KILEY: I think 30 minutes, I think, if I can pick out salient episodes, Chair. But I'm in your hands as to the issues that the Panel are interested in too. I think the stenographer... 16:34

CHAIRPERSON: Well, partly that's -- I mean genuinely I don't want to put any pressure on the stenographer at all, and it's not fair. Can I ask Jacqlyn the secretary to have a private word. If we need to break completely, we will break now and, if necessary, have the witness back after the summer. Would you prefer to carry on? 16:34 16:35

A. I would be willing to do that, yeah.

CHAIRPERSON: Sorry?

A. If that is your desire I'm very willing to come back.

CHAIRPERSON: Okay. Well I think that may be the better thing. 16:35

MS. KILEY: I think we need a break anyway, Chair, to sort out the technology, if we are going to continue.

CHAIRPERSON: We would if we're going to continue. There's no pressure at all to continue if you feel you

can't do it. Yes. Okay. All right. Thank you. Sorry, first of all I should ask my colleagues if they have got any questions? We are going to have to ask you to come back. We'll notify you. What we'll do is we'll look at the, it's actually not the second statement, it's the first statement, and decide if we do need you back at all, and if you are needed back it will be very short. But I am afraid it will be after the summer. 16:36

A. Okay. That's okay. 16:36

CHAIRPERSON: But can I thank you in the meantime very much for your evidence this afternoon, and we will be in touch with you. All right. Thank you very much.

A. Okay. Thank you for the opportunity. Thank you.

CHAIRPERSON: Okay. We'll rise now until tomorrow at 10:00 o'clock. Thank you. 16:36

THE INQUIRY ADJOURNED UNTIL TUESDAY, 18TH JUNE 2024, AT 10:00 A.M.