MUCKAMORE ABBEY HOSPITAL INQUIRY

SITTING AT CORN EXCHANGE, CATHEDRAL QUARTER, BELFAST

HEARD BEFORE THE INQUIRY PANEL

ON WEDNESDAY, 19TH JUNE 2024 - DAY 94

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THE INQUIRY RESUMED ON WEDNESDAY, 19TH JUNE 2024, AS FOLLOWS:

CHAIRPERSON: Good morning. Thank you. Yes, Ms. Briggs.

MS. BRIGGS: Good morning, Panel. This morning you'll be hearing evidence from Owen Barr, Professor Barr, who has given evidence to the Inquiry previously, that was in April last year, and that was in relation to Evidence Module 4, that was staffing. The evidence today is in relation to Evidence Module 6E, which is Other Reports Concerning Muckamore, and the statement reference is STM-242. And unless there's anything further, we can call in the witness, Panel.

CHAIRPERSON: Okay. Let's call him in. Thank you very much.

PROFESSOR OWEN BARR, HAVING BEEN SWORN, WAS EXAMINED BY MS. BRIGGS AS FOLLOWS:

CHAIRPERSON: Professor Barr, can I welcome you back to the Inquiry, you were last here I think on 26th April last year, and so some time since we saw you, but thank you for your new statement, and for coming and giving your time this morning. Okay. Ms. Briggs.

1 Q. MS. BRIGGS: Thank you, Professor Barr. We're here today about your second statement, okay, to the Inquiry, and that's in relation to Module 6E of the Inquiry's Evidence Modules, that's "Other Reports in

Relation to Muckamore". I think you have a copy of your statement in front of you. It's dated 25th April 2024. It runs to 64 pages, and it has three exhibits, being three reports that you were involved in. Do you wish to adopt the contents of your statement as your evidence to the Panel this morning? 09:56

A. Yes.

2 Q. Okay. And we've got the statement on the screen there, and if we can go down to paragraph 1, that sets out the three reports that you've been involved in. Exhibit 1 then is a first draft report of the Independent Assurance Team dated April 2018, and you say you co-authored that report with Frances Cannon of NIPEC and Yvonne McKnight of the Belfast Trust. Exhibit 2 is a final report of that team, dated September 2018, co-authored with the same people. And Exhibit 3 is Muckamore Abbey Hospital Adult Safeguarding File Review September 2021, and you co-authored that and you say there who that was with. Okay. One person from QUB and two from the HSE Leadership Centre. 09:56 09:56 09:57

Over the page then at page 2, you give a little bit more information about the 2018 report, if we call it that, that's the Assurance Team report, you say that you were: 09:57

"...one of three people requested to undertake an independent assurance review of decisions taken by senior Belfast Trust staff following the identification

of safeguarding concerns at Muckamore."

And you go on at paragraph 4 to say that you were the lead author on that report, is that right? Okay. Then at paragraph 5 you describe the 2021 Safeguarding File Review, and you say that you were one of four people asked to participate in that exercise and that was to review safeguarding files relating to people cared for at Muckamore, and you say you worked alongside the other people involved to review paper and electronic record files on the Muckamore Abbey site. And you say that you weren't the lead author on that report, and alongside the other people you contributed to the development of the report by providing comments on areas that you felt needed to be addressed and by providing feedback on drafts, and you read the final report before it was submitted. 09:57 09:57 09:58

All right. I'm going to start by asking you then about the 2018 Assurance Team Report, that's the 2018 report, and it starts at Exhibit 1. Can I ask you what led to you being involved in that Assurance Team Report? 09:58

A. So the -- we became aware, I -- my clinical practice and clinical involvement is very much with people with learning disabilities. I became aware through discussions with colleagues and people in the Belfast Trust that some concerns had been raised about Muckamore. I was asked by Brenda Creaney, who was then the Executive Director of Nursing in the Belfast Trust 09:58

if I would contribute to the report, along with Frances and Yvonne. There are, as I am sure youse have heard by now, very few registered nurses in learning disability who did not undergo their initial training at Muckamore Abbey Hospital, I'm one of them, I undertook my training in Devon, and after my general nurse education and then worked in the Western Trust and worked as a community nurse in the Northern Trust. So apart from having taught for two years at the School of Nursing in Antrim, I had no clinical involvement with Muckamore, so that gave me a certain distance from a lot of the people who worked at the hospital. 09:59 09:59

3 Q. Okay. All right. And the questions I'm going to ask you about really focus about the final report rather than the draft at Exhibit 1? 09:59

A. Yeah.

4 Q. Is it fair to summarise that the draft is, for all intents and purposes, very similar to the final report that was produced?

A. Yes. 10:00

5 Q. Can you describe how the draft report was used and shared before the final report came into existence?

A. The draft report was shared with the Belfast Trust initially on 5th April, and it went to Brenda Creaney and Marie Heaney, with a request for feedback. So we had, as we developed -- as we undertook the work, we had regular meetings with Brenda and with Marie, a report was drafted and it was sent on 5th April. Requested feedback for the 19th April. We didn't have 10:00

any feedback. We went back on 6th July and said 'Well, given we haven't had feedback, everything appears to be okay', so on 6th July we issued what was our final draft. Requested further feedback on 20th August, and then on 20th August Marie Heaney came back with a few aspects that she wanted clarified, and then there was a meeting on 18th September online to discuss the -- any of the changes, and the changes very much were that we removed the draft, we changed the date of the report, and what was Appendix 1 was integrated into page 5, Appendix 2 was retitled "Appendix 1", although I did notice in there in this report that it wasn't changed in all places, it was just changed at the end. So the changes between the draft report and the final report were editorial more than substance. 10:01

6 Q. Okay.

DR. MAXWELL: Can I just ask, you were invited to do this because you are a learning disability registered nurse, but with less contact with Muckamore than others. 10:01

A. Yeah.

DR. MAXWELL: And Frances Cannon is from NIPEC.

A. Yeah.

DR. MAXWELL: Yvonne McKnight works for the Belfast Trust and was quite intimately involved with the investigation. 10:02

A. She was their safeguarding lead.

DR. MAXWELL: So were you getting your information from her because she was actively involved in investigating

incidents or --

A. No, we -- we met at -- on the Hospital site. When we met we had access to some of the limited access before the police inquiry started, and some initial videos, and then we decided we didn't need to be seeing those. 10:02
We had access to any policy documents we requested. We had access to the Charge Nurses and Sisters in the Department when we requested it. So Yvonne was one of the three of us, but our -- the information we requested come directly from the Trust. 10:02

DR. MAXWELL: I'm just wondering if you and Frances were chosen because you had minimal contact, why do you think Yvonne, who was quite intimately involved, was selected?

A. That, I think, you'd need to ask the Belfast Trust. I 10:03
didn't at any sense or at any time get a sense that it was obstructing anything we were trying to do.

7 Q. MS. BRIGGS: Picking up on Dr. Maxwell's point there, do you feel it was possible to achieve a fully independent review in light of Ms. McKnight's 10:03
involvement in the report?

A. Yeah, I don't think her involvement caused us any difficulties.

8 Q. Okay. All right. If we can go to page 24, then. That's the cover page of the final report dated 19th 10:03
September 2018, and then over the page, page 25, that's the contents page, and then into page 26, please, sections 1 and 2 give the background to the report, and by way of summary, it's a Trust report that was asked

for by the Belfast Trust, and it was provided for the Belfast Trust, isn't that right?

A. Yeah.

9 Q. And Section 2 is the objectives, and that goes on into the next page. So there's four objectives there, (i) through (iv). Is it fair -- can we pull those up on to the screen so that they can all be seen at the same time? Thank you very much. Is it fair to say that those are really the Terms of Reference for the report? 10:04

A. Yeah, yeah. 10:04

10 Q. And who set those?

A. They were initially set by the Belfast Trust. This is what they wanted us to look at. We had some discussions with them on the wording of them, but they were -- initially this was the request what we were asked to look at. 10:04

11 Q. Okay. And resulting from your conversations about the wording, were there many changes made?

A. They weren't substantial changes, no, I think from the start I mean it was -- when we were asked, we were asked to very much review the decision that had been made and give a view on what we thought of those decisions. We were aware by this stage that a serious adverse incident and a report, a further report would be done, so we weren't getting into the detail of what it was going to do, we were asked to look at the period of time very much around when the allegations became knowledge to the decisions that were made in the few months after. 10:05 10:05

12 Q. And that further report that was going to be done, is that a reference to Margaret Flynn's report?
A. That's Margaret Flynn's report, yes.
13 Q. Okay. There are three things that this report focuses on then, and that's at Table 1, page 27, it's just down slightly. Okay. Under the "Area" heading, we can see the three matters that the report focused on. Okay? The first one is to: 10:05

"Review interim decisions regarding named staff who were subject to precautionary suspension or restricted duties." 10:06

The second one is to:

"Review Belfast Trust policies related to agreed areas." 10:06

And the third one is to:

"Review the draft workforce paper." 10:06

I'm going to go through each of those in turn, okay? So Professor Barr, the first thing I want to look at is the review of the decisions by the Trust to suspend staff or place staff on restricted duties, and the report's Section 4 on pages 28 through to 36, using the Inquiry's numbering, deals with that issue. Is it fair to say, Professor Barr, that the methodology for that

part was to look at various documents, including e-mails, policies, and meeting with staff?

A. Yeah.

14 Q. And the team also looked at CCTV, isn't that right?

A. Yes. 10:06

15 Q. Was that CCTV in relation to all of the incidents where staff had been suspended or placed on restricted duties?

A. It was in relation to the majority of the initial incidents at that time. 10:07

16 Q. If we go to page 29, Section 4.2, Section 4.2 there describes staff who were suspended on a precautionary basis, and then over the page at 30, there's the types of staff that were placed, or what they were involved in, that were placed on restricted duties, and isn't it 10:07 right to say that there were six staff that you looked at who were suspended and six who were placed on restricted duties?

A. Six who were suspended. I haven't written down the number of the number who were on restricted duties, but 10:07 six sounds about right, yeah.

17 Q. I think it might be page 28 on the third paragraph, it says six staff were suspended.

A. Okay.

18 Q. So you can see on the screen there -- 10:07

A. Yeah, a further six. Yeah.

19 Q. In response. And then it says:

"Six staff were placed on precautionary suspension and

a further six were placed on restricted duties."

Does that sound about right?

A. Yeah. Yes. Yes.

20 Q. Okay. If we can go back to where we were then, 4.2, 29. Page 29. Okay. So these are the staff that were suspended, and we can see the types of incidents that they're alleged to have been involved in. Okay? And the first and last bullet points relate to staff who seemed to have been directly involved in safeguarding incidents, that's the wording that's used in the first and last bullet point? 10:08 10:08

A. Yes.

21 Q. Does that mean those staff were actually involved in the abuse of patients? 10:08

A. It means that there was allegations made against those staff and the -- we were exploring how the decisions were made, and the view of the Trust at that stage was that the CCTV showed them directly involved, whereas the other people were people who had failed to report concerns or had discouraged somebody from reporting concerns, but weren't actively involved in contact with the individual. 10:09

22 Q. Okay.

A. -- with learning disabilities. 10:09

23 Q. Thank you very much. Over the page then at 4.3 --

DR. MAXWELL: Sorry, can I just add on that? So you were looking at these as allegations and whether there was an appropriate response to the allegation, rather

than making a judgment about whether the allegation was true?

A. Yes, but the -- the Serious Adverse Incident Report was going to deal with the allegations, yeah.

DR. MAXWELL: Yes. No, I understand that. So did you -- obviously the actions that are taken in response to allegations, which are without prejudice, do depend to some degree on the level of risk identified in the allegation? 10:09

A. Yeah. 10:10

DR. MAXWELL: So did you categorise them in that way? So, one of them might be if proved, this would be gross professional misconduct; did you actually -- had they been categorised by the Trust and, if not, did you as a team categorise them or did you just take them as a generic set of allegations? 10:10

A. The only distinction drawn was the distinction between people who were directly involved in an incident and may have been in physical contact with a person with learning disabilities and people who may have been overseeing. 10:10

DR. MAXWELL: Okay. So those who were directly involved with some action, that wasn't broken down according to the degree of risk or the potential consequence if the allegation was proved to be true? 10:10

A. No.

DR. MAXWELL: Okay. Thank you.

CHAIRPERSON: And while we've paused, can I just ask, what was the purpose of you watching CCTV? Because you

were -- the questions just asked by Dr. Maxwell make clear that actually you were focusing on an allegation being made, rather than, as it were, the strength of the allegation. So why were you looking at CCTV at all? 10:11

A. So at the very early stages it was felt by Belfast that it would have been useful for us to see where we were trying to distinguish, though there could have been a number of people, for example, sitting around a table when there was an interaction with somebody with 10:11 learning disabilities, and some of those people had been placed on suspension, some of them hadn't, and when we said 'Well, how come?'.

CHAIRPERSON: Oh, I see.

A. If they were all there, how come some were on 10:11 suspension and some weren't? Then we were shown some video...

CHAIRPERSON: Yes.

A. We seen a small amount of video relating to these particular things. We didn't watch extensive video. 10:12

CHAIRPERSON: Well that's what I was going to ask next.

A. It was very -- it was quite a small amount of video, very specific to when we queried 'Well, how come there were multiple people there?'...

CHAIRPERSON: So they were specific to the allegations 10:12 that you were, that you were watching.

A. Yeah.

CHAIRPERSON: So that you could assess whether a response was reasonable or not.

A. Specific to decisions that were made, I would say. We were asking 'How come if there were several people there, you made a distinction between some of these people?'

CHAIRPERSON: Yeah. 10:12

A. And the -- we were shown some of the early footage. We felt after a few days we didn't need to be seeing it, it wasn't really for us, there was going to be an adverse inquiry, there was going to be a number of other investigations, so we -- it wasn't within our 10:12 brief to make a decision as to whether abuse had occurred or, indeed, to rate that abuse.

CHAIRPERSON: Quite. So you saw some of this as samples, as it were, and then you stopped?

A. Yes. Yeah. 10:13

CHAIRPERSON: Okay.

DR. MAXWELL: Can I just go back then. So was the distinction between supervision and suspension, whether somebody was directly involved as opposed to being in the vicinity and not reporting it or dissuading people 10:13 from it?

A. That was the initial -- or that was the distinction drawn by the Belfast Trust. So when we asked --

DR. MAXWELL: So that's the actions they had taken? If you were directly -- 10:13

A. -- when we asked 'How come you made a difference?', that was the answer we were given.

DR. MAXWELL: Okay. Thank you.

CHAIRPERSON: Ms. Briggs.

24 Q. MS. BRIGGS: Thank you. We can see then over the page at 4.3 those staff that were placed on restricted duties, and you've drawn a distinction there really, you were looking at whether it was right to suspend or whether a suspension should have been put in place, and that was really the focus of the team, is that fair to say? 10:13

A. Well, it wasn't so much whether it was right or wrong, but was there a -- what was the rationale? How was the decision made? What matters were considered when that decision was made? So we were asked to give an opinion on the decision-making process. We were not there to second-guess whether a decision was right or wrong by the person who made it, but what we were trying to understand was, how was that decision made? Why was it made? How come people who could, on the face of it, appear to be in very similar circumstances, were treated differently? 10:13 10:14

DR. MAXWELL: So you were looking at consistency of decision-making? 10:14

A. Yeah.

25 Q. MS. BRIGGS: All right. If we can go to Section 4.4, it's the bottom of page 30? The report describes there the information that was reviewed by the team.

A. Yeah. 10:14

26 Q. And there's reference there to the "Nurses in Difficulties Policy". Are you aware whether there were meetings for the nurses in difficulty?

A. Sorry?

27 Q. Are you aware whether there was meetings for the nurses in difficulty?

A. I know there were meetings - and we had asked for some records - with the staff who were placed on precautionary suspension and those who were placed on restricted duties, but I take it they were in line with that policy, but we didn't --

DR. MAXWELL: So the Inquiry has heard that Belfast Trust has a committee called "Nurses in Difficulty", where senior nurses discuss nurses in difficulty, but the nurse themself isn't there. Were you ever shown the minutes of that meeting as they related to Muckamore? 10:15

A. No.

28 Q. MS. BRIGGS: All right. There's a distinction in this report made overall between the interim, the immediate decisions that were made at the time, and then the ongoing review of those decisions as time passed, isn't that right? 10:15

A. Yes. 10:15

29 Q. Okay. And you came to the view as a team that the interim decisions, that is those decisions taken at the time to suspend staff, the conclusion was that those decisions were appropriate?

A. They appeared appropriate at the time, yes, as initial decisions. 10:16

30 Q. Okay. Can you describe how exactly the Assurance Team came to that conclusion, given that it wasn't privy to the decision-making process at the time and as it

happened?

A. Well, given the information that we had been provided with, and the people we had spoken to, we arrived at the view that it was appropriate at the time that decisions were taken to -- that if there was concerns about actions that had occurred with staff, that it was appropriate at that time, under the policy, to put people on precautionary suspension, and we weren't there to -- we weren't there on the day the decisions needed to be made, we didn't know all of the other factors, but we felt that the decisions - that the policies that existed were applied and precautionary suspension could have been put in place on those policies, and we felt that that was an appropriate thing to do at that time, as distinct from not taking any action, you know, and allow the staff to continue to work until a later date. 10:16 10:16 10:16

DR. MAXWELL: Can I ask, did you look at each incident in isolation? So what I'm thinking is, if the decision was suspend, if they were actively involved in an incident, put on restricted duties if they failed to intervene or to report, hypothetically, if there was somebody who wasn't actively involved but was repeatedly present when somebody else was actively involved, would that have nudged them over to a suspension, because they were creating a culture where this was permissible? 10:17 10:17

A. We didn't get into the detail of how many times people were involved. One of the distinctions that stood out

for us, and it's in the report, where there was a member of staff who was in charge and was not actively involved but was put on a precautionary suspension, the view being they were in charge and they should have escalated the situation, but they weren't actively involved. And that, for us, stood as a difference from how other people who weren't actually involved were treated. The rationale given to us at the time was that the person was in overall charge and, therefore, should have escalated situations. 10:18

DR. MAXWELL: In overall charge of the shift or of the ward?

A. Of the unit.

DR. MAXWELL: Of the unit?

A. Yeah. Yeah. 10:18

DR. MAXWELL: So because they were in overall charge of the unit and had a wider responsibility for standards. But if it was a registered nurse in charge of the shift who was a Band 5, that wouldn't necessarily have led to a suspension? 10:18

A. The challenge we had, and it's documented in the report as it goes on, is that we, as a -- as a group, or as a team, decided or reached the conclusion that the detail of how the decisions were made was not well -recorded, and we couldn't see exactly what was taken into consideration in each of the decisions. 10:19

CHAIRPERSON: And that's in your report?

A. Yes. So it wasn't clear -- the detail of exactly what was being considered in relation to each person wasn't

clear in any of the documentation we were shown.
DR. MAXWELL: So potentially there was some inconsistencies?
A. Yeah. Or lack of clarity at the least, yeah.
31 Q. MS. BRIGGS: Was there evidence within the information that you reviewed that those people taking the decisions to suspend staff, considered the impact that it would have or might have on patients and staff? 10:19
A. In relation to the suspension?
32 Q. Suspension. 10:19
A. So one of the things that we reached a conclusion on is that decisions were taken about suspending staff. We could find no evidence that there was any consideration of if we had suspend this staff what impact this might have on the activities that the ward will be able to 10:20
provide, or what impact it may have the activities that were planned for people with learning disabilities, we didn't find anything. And we did ask that question, but we didn't find anything that said 'Here were the number of factors that were considered.' So we became 10:20
aware through our discussions with members of staff that the movement of staff to other wards on restricted duties, and the suspension of staff, had an impact on the activities of people with learning disabilities who were able to undertake, but that wasn't in any of the 10:20
decision-making information we have.
33 Q. And what was that impact on activities that patients could undertake?
A. It was around -- I mean examples that we were given

were around planned day activities that people were going to go, different outings that people were going to go on, activities that could have occurred on a unit if they had of had the full staffing complement or if they had of had those staff present. That didn't appear to be a factor.

34 Q. And what about when those initial decisions were then reviewed as time went on, and those consequences may have become more apparent and more obvious, was there evidence then within the decision-making that those issues were being considered? 10:21

A. As we have said in the report, the considerations when decisions were reviewed appeared to be more focused on staff, and how staff felt, and representations made by and about staff, than they did about people with learning disability. 10:21

35 Q. Okay. All right. Thank you, Professor Barr. And it's fair to say, isn't it, that if staff are suspended, as opposed to being placed on supervision, that wards can suffer from a lack of, for example, learning disability trained nurses on the ward? 10:21

A. It would reduce the number of people that would be available, yeah, and require other staff to work extra time or they'd be coming through other agency type services. 10:22

36 Q. Okay. We've touched on it a little bit there and I want to look a little bit more about what the report says about the Trust's ongoing review of their decisions to suspend staff or place them on restricted

duties. If we can go to page 31? And it's the second paragraph down, I'm just going to read that in:

"As noted, interim decisions around precautionary suspension and restricted duties needed to be made in real time and it would be expected these would have been initially reviewed within an agreed timeframe and four-weekly thereafter, in keeping with the Belfast Trust HR disciplinary procedures and Nurses in Difficulties Policy." 10:22

Then towards the bottom of that page, there's mention there that:

"Interim decisions should have a clear calendar date set for review. This date was not provided or clearly stated in any documentation provided to the Independent Assurance Team." 10:23

That can't have been very reassuring? 10:23

A. No.

37 Q. Did the Assurance Team look to the governance process within the Trust for overseeing that the reviews were being conducted initially within an appropriate timeframe and then four-weekly after that? 10:23

A. We asked for evidence of communication with the staff who had been suspended and put on precaution. We were shown e-mail correspondence, we were shown notes of some meetings. There were a number of limitations on

those, particularly in the initial suspension, it may have said "review in four weeks", but it didn't give a date. I, and those people who have been taught by me, will be very familiar with the idea that a date is a date, it's not a -- it's a calendar date, and that way you know you've achieved or haven't achieved, if it's not in four weeks' time. So there was no date, which was surprising, because it should have had a date. The notes that we were shown were very light, they were more of an update, there was very little information in there to indicate that the decisions were being actively reviewed. It was more a communication of a continuing suspension than 'We have now considered new evidence, we have now gone and looked at something and so we are now reaching a decision based on the following criteria to continue the suspension' or 'we are now reaching a decision that that precautionary suspension should become restricted duties.' I would have expected to see very clear information as to how those decisions were made. 10:24 10:24 10:24 10:25

DR. MAXWELL: Who would have been responsible for reviewing those suspension decisions?

A. My understanding, and the person that we linked most closely with at that stage was Esther Rafferty, as the Hospital manager at the time, and I think her -- Esther, working along with Brenda Creaney. I'm sure there were other people within the Trust from a HR point of view were involved, but... 10:25

DR. MAXWELL: And presumably the same process applied

to supervised practice?

A. Yes.

DR. MAXWELL: Because at some point you would hope that the supervision have been effective?

A. Yeah. 10:25

DR. MAXWELL: And you could remove it.

A. Yeah.

DR. MAXWELL: So that would have been primarily the responsibility of the Service Manager?

A. Yeah. So each of the people on supervised practice had a named person that was supervising them, and they were to meet with them on a weekly basis and there was to be notes of those meetings, if the policy was being followed. 10:25

DR. MAXWELL: But presumably the supervisor would have to notify somebody they thought they had now reached a level of practice that no longer needed supervision, and that would have been Esther Rafferty, you think? 10:26

A. Whether Esther made the final decision or Esther had a discussion with Brenda or Marie. 10:26

DR. MAXWELL: Yes.

A. But Esther would have been involved, yeah.

DR. MAXWELL: Yes. So Esther Rafferty should have been the person monitoring that there were dates and that reviews were happening appropriately? 10:26

A. I would have thought it would have been the hospital manager would have done that. I wasn't aware that somebody else had been delegated that.

DR. MAXWELL: Okay.

38 Q. MS. BRIGGS: Professor Barr, I'm just going to read in another little bit about reviews and how those were looked at by your team, it's page 31, it's the same page that we're on, up the page, paragraph just above that one, the second sentence there says that: 10:26

"The Independent Assurance Team were provided very limited written material in relation to the review of the decisions. The documents provided focused on communicating or reinforcing the decisions that had been made and were limited formal notes of meetings." 10:27

And it goes on to say that there was a lack of factors considered, there was no outline of those factors, how they were weighed up, or the range of options for the decision-making considered. 10:27

Focusing on the point that the Assurance Team say they were provided very limited written material in relation to review, why was that information not provided? 10:27

A. It wasn't available. We were provided with what information --

39 Q. Does that mean that that information --

A. -- that they felt was available. So the information that we were provided, when we asked, we were given 10:27 information saying 'Here is the information in relation to the communication', and my understanding was, we were provided with what -- with what was available. That information was very limited.

40 Q. Does that mean that there was nothing else out there to be considered?

A. We weren't aware of anything else, and when we asked for the information and notes of meetings and correspondence and e-mails with people, we were provided with them, and when we reviewed those, there was very limited information. 10:28

41 Q. Some of the recommendations in the report related to the review of the initial decisions, and I'm going to ask to go to page 36. (iv), first of all, says: 10:28

"There should be a standardised approach to the review of decisions which proactively considers the relevant factors with a recognition of the possibility of amending the interim decisions." 10:28

Are you aware whether the Trust changed their practice in this regard?

A. This report was submitted to the Trust and there has been no correspondence from the Trust after the report. 10:28 I'm not aware if any of these recommendations were implemented.

42 Q. You weren't whether any of them were?

A. Any of them have been implemented.

43 Q. Implemented. 10:29

A. Or if any changes have been made after this report was written.

44 Q. Okay. So there was no response whatsoever to the report?

A. They acknowledged the receipt of the final report.

45 Q. And that was it?

A. That was it, yeah.

46 Q. Okay. Number (v) it says:

10:29

"When decisions are being reviewed, both the intended and unintended consequences of interim decisions for people with learning disability, service delivery and staff members should be actively considered and reflected in the notes of the review of the decision." 10:29

Did the Assurance Team receive specific information about what those unintended consequences were?

A. Not written information. We received information when we spoke with ward managers and when we spoke with 10:29 people who were supervising people on restricted practices, but we didn't receive written information on it, which is one of the reasons we highlighted it. We also, in writing that recommendation, deliberately put people with learning disability first, followed by 10:30 service delivery, followed by staff, and that was a purposeful decision, that the impact on people with learning disabilities should be considered when these decisions are made.

47 Q. Okay. Just finally on the topic of staff suspensions 10:30 and staff being placed on restriction, I'm going to ask to go to Appendix 1 of the report, and that's page 46. This is a document titled "Themed feedback from interviews with staff at Muckamore Abbey Hospital on

28th March 2018", it says there that:

"Five staff were interviewed..."

And it gives the job title of those that were interviewed. The first topic is titled "Staff in Difficulty Policy", and a number of the comments, and I'm summarising this, made there, include that staff weren't aware of that policy, and that they needed more support in their role as a designated contact person for staff who had been suspended or placed on restricted duties. But I want to look specifically at the last bullet point. There are a number of quotes there. It says: 10:30 10:31 10:31

"The persons on precautionary suspension only want to hear about what is happening in relation to their situation..."

- and there's quotes to include: 10:31

"We don't have that level of information, in fact we know very little; expected to have conversations out of context." 10:31

And it's this last one:

"Fear of reprisal if you say anything wrong."

Can you tell the Inquiry a little bit what that was about?

A. These are a number of quotes that were taken directly from comments that were made by the people we interviewed, and one of them, it's the example you referred to, was expressed by a member of staff who was -- they were worried that if they said something wrong to the people that they were supervising, that that would have consequences for them, that, you know, they were aware at this stage that there was a serious adverse incident, Margaret's Flynn's report was ongoing, they were aware there was going to be police investigations ongoing, they thought this was very high stakes for them and they were being put in a position where they felt very vulnerable, and that if they said something wrong, it would come back to them, and that they would then get called into a situation where 'explain why you done what you done, explain why you said what you said.' So their feeling was that there was more to the supervision of staff, and there was potential consequences for them if they didn't do, do it well. And this was added, and I think compounded by the situation that many of the staff were not -- did not feel well prepared for the role that they were asked to undertake, and were not that familiar with the policy.

10:31 10:32 10:32 10:32 10:33

CHAIRPERSON: So I can perhaps understand the sensitivities, because they would have been aware that there was going to be another report potentially, there

were disciplinary proceedings, there were PSNI allegations.

A. Yeah.

CHAIRPERSON: And so it comes down to they were concerned if they said something out of place and -- 10:33

A. It could have consequences for them.

CHAIRPERSON: It could have consequences.

A. Or they could be brought into wider discussions that they were not expecting to be involved in.

CHAIRPERSON: Yeah. Yeah. Okay. 10:33

DR. MAXWELL: We have heard from some witnesses that it was very hard to be a supervisor because you often weren't told what the allegations were. Somebody was put on supervision, but you didn't know what you were supervising them to do. Did you hear that? 10:33

A. Yeah, and this was -- this is again reflected, we didn't know the level, we didn't have that level of information, and in fact we knew very little, and they were expected to have conversations out of context. They weren't aware of why the person had been 10:33 suspended, they weren't aware of the detail of the allegation against the person, that the person is now going to your ward and you are supervising them.

DR. MAXWELL: But you didn't know what you were supervising them on? 10:34

A. That was the feedback we got.

PROFESSOR MURPHY: Sorry, did you get an impression of how much information these designated persons had had from HR, for example, about what they should be doing

and how they should be doing it?

A. Our impression was it was very limited. From speaking with the nurses who were in those roles, they didn't appear to have clear information on what the allegation was and what they should be necessarily watching out for, or what they should be planning. So if in other circumstances where you're supervising someone and you know this person has made an error with medication, therefore you need to focus on this and, you know, that's where your supervising will focus. So this person has made -- that didn't appear to be the level of discussion that had been had with these people. 10:34 10:34

DR. MAXWELL: So did you, as a team, form an opinion about how effective being on supervision was, if nobody knew how to do it and what they were supervising? Was it a useful action? 10:35

A. We were very much focusing on how the decisions were made and why the distinctions were made.

DR. MAXWELL: Okay.

A. But as we spoke with the staff who were involved in that role, it became clear that there were definitely gaps in what could have been done, and they reported to us that they didn't feel well prepared for the role they had been asked to do. 10:35

48 Q. MS. BRIGGS: Okay. Professor Barr, the next issue I want to move on to then is the Assurance Team's review of policies, and that's at Section 5 of the report, it's the bottom of page 36, it starts. The policies that were reviewed by your team are listed there, and 10:35

they go into the next page. The first one is the levels of supervision/observations within learning disability inpatient services, November 2013, and the brackets there say "(should have been reviewed 2016)", and then we've got three more over the page, which I'll use short terms for them; we've got a seclusion procedure from 2016, we've got a Restrictive Interventions Policy from 2015, and we've got a CCTV policy from 2016. And it says at Section 5.1, just below that list, it explains that three of them have an asterisk beside them and they were due to be updated, and it says there that the seclusion policy, that's the 2016 Policy on Seclusion, should have been reviewed in November 2016, and this was not completed. And then at the final bullet point on page 37, it also says there that the supervision November 2013 policy was not reviewed in November 2016, and it should have been. 10:36 10:36 10:37

So, it looks as if there are actually two policies that should have been reviewed in 2016, but weren't. Is that right? 10:37

A. Let me just...

49 Q. And take your time if you want to reread that. I've gone through it fairly quickly.

A. Level of Supervisions Policy is the one that was dated 2013, and should have been reviewed in 2016. So it's the first policy, level of supervisions and observations. 10:37

50 Q. Yes, it's that policy that should have been reviewed in

'16?

A. Yes.

51 Q. So, the seclusion policy that's referred to at 5.1, just below the title "5.1" and halfway through page 37, when the seclusion policy is said that it needed reviewed? 10:38

A. Yes, yes. So it's the second one that should have been -- yeah, so there's two policies that should have been reviewed --

52 Q. Two policies that should have been reviewed that weren't? 10:38

A. Yes.

53 Q. Okay. Thank you for clarifying that. Why were those reviews not completed?

A. I'm not aware why they weren't. We just noted that they hadn't been, that the policies that were being followed were, in essence, out of date, and hadn't been reviewed when they should have been reviewed. And we took the date for when they should have been reviewed from the front of the policy, so on the policy there was a review date, and that that date had passed. 10:38

CHAIRPERSON: Does that demonstrate some sort of lacking in governance of some sort?

A. I think those timescales are quite considerable past the review date, so they are. So I would have expected them to have been reviewed, even if it was simply to note that they had been reviewed, unchanged, and extended, and a new review date had been set. We were surprised to see a policy that had a review date from a 10:39

year earlier that hadn't been updated.

CHAIRPERSON: Yeah.

DR. MAXWELL: Did you look at the content? So, clearly it should have been reviewed, and a good governance system would review it, as you say, if only to say 'no changes is need', as a positive assurance that the evidence base has been reviewed. But did you look at the policy, and if you did, did you feel that it reflected current best evidence? 10:39

A. I think the evidence in that area is changing, so it definitely can -- and if it was -- initially written -- the one that was 2013, it should have been reviewed in 2016, we were sitting in 2017, that 2013 policy would have been written earlier in 2013. So to me -- 10:39

DR. MAXWELL: So you think the evidence base would have changed over that time? 10:40

A. We're four years later. It's -- yes --

DR. MAXWELL: And so it wasn't reflecting current best practice?

A. Yeah, I think it was important for that to be -- for it to be considered, and if there wasn't new practice, that to be noted. But we didn't get -- we don't do a review of what new evidence was there, but I think a timeframe of a policy which had continued four years after it should have been reviewed, was of concern. 10:40 10:40

54 Q. MS. BRIGGS: I think the words "major concern" are used in the report. I want to touch upon another policy that the Assurance Team looked at, and that's the Restrictive Intervention Policy from 2013. If we can

go to page 39, (iv), it says there that:

"The Belfast Trust Management of Aggression Team are not involved in training within Muckamore and the Muckamore staff had their training given by the MAPA training team within Muckamore."

A. Yes.

55 Q. So it's two different teams, is that right?

A. Yes, there's an overall Belfast Management of Aggression Team that we were told of, and they're for the entire Trust. We were also told there was -- the team that undertook the training at Muckamore were the MAPA training team at Muckamore, and not the overall Belfast Trust team. 10:41

56 Q. And the MAPA training team at Muckamore, they were based in Muckamore and only Muckamore?

A. My understanding was, yes, only Muckamore.

57 Q. And there was no overlap between the two teams?

A. No. 10:42

58 Q. Okay.

A. Or the -- so just to clarify, what we were being told was that the training that had been done at Muckamore was done by the team at Muckamore. We weren't getting any information that people from outside of Muckamore, from other parts of the Belfast Trust, were contributing to that training. 10:42

59 Q. And the report recommends integrating the MAPA team in Muckamore into the Belfast Trust Management of

Aggression Team. Why would that have been better?
A. I have -- I've quite an interest in why do things go wrong in services? And actually wrote my, one of my very early papers in 1993 about micro-institutionalisation, where Community Homes For Institutions in Waiting. So it's an area that I've had quite an interest in and teach quite a bit of content on, and one of the things that comes out quite clearly in a lot of the work that has been done, is that when inquiries occur, services are often geographically or organisationally isolated. We were concerned that Muckamore was both. It was geographically isolated from the Belfast Trust, it wasn't in the Belfast Trust, it was several miles outside it, and we were concerned that it was organisationally isolated, and this was an example of where it had a self-contained team and, therefore, may not have been benefitting from the wider discussions around how to support people who are distressed, that were occurring elsewhere in the Trust.
CHAIRPERSON: And I'm sorry, just so that I understand what you mean, when you say about your '93 report, Community Homes For Institutions in Waiting, do you mean in waiting for problems?
A. In waiting to become institutions, yes. So there was a lot of discussion at the time around whether moving people from hospital was of itself a good thing, and there was a lot of belief that if we moved people from hospital into community, into smaller units, we would solve the problem of institutionalisation.

CHAIRPERSON: But then they could become institutions themselves.

A. I didn't share the view that it was as clean as move people to hospitals.

CHAIRPERSON: Yes. Thank you. 10:44

A. I -- personally, when I talk on these topics, I tend to use the term "organisational abuse" rather than "institutional abuse", because I think that the risk is, we will associate institutional abuse with large buildings and large hospitals, whereas actually abuse 10:44 can occur in very small units, and we have many, many examples across the UK of when that's occurred. So that was part of, part of this discussion about the idea of potential organisational isolation of the MAPA team at Muckamore from the wider discussions that are 10:45 going -- occurring in the Trust.

CHAIRPERSON: Presumably, if you're right about that, that should have wider implications than just the MAPA team, because what you're talking about is a cross-fertilisation, as it were, of ideas. 10:45

A. Yes.

CHAIRPERSON: A fresh breeze, as it were?

A. Yes.

CHAIRPERSON: Yes.

DR. MAXWELL: So it wasn't that you had any concrete 10:45 concerns about the MAPA training; it was the fact that it was another example of the isolation of the service?

A. Yeah, we didn't review the MAPA training, we didn't review what the team done, and we didn't review how

they worked. We felt that it wasn't a good idea that they stood alone.

DR. MAXWELL: Yes.

60 Q. MS. BRIGGS: What were other examples of organisational isolation that your team saw? 10:45

A. It's not an area that we got into detail, but I mean -- and it's not contained within the report, so I need to sort of restrict myself to it, but, I mean, I got a sense from people that we spoke with that the presence of senior management from Belfast Trust on the 10:46 Muckamore Abbey site was limited.

61 Q. Okay.

A. And their familiarity with the site was limited.

62 Q. The final of the three issues that the Assurance Team looked at was the review of staffing and workforce in 10:46 Muckamore, and that's Section 6, starting at page 40. If we can just scroll down to Section 6? It says there that the team were asked to review a draft paper on staffing levels in Muckamore Abbey Hospital.

10:47

"This paper provided figures for the funded, actual and required number of staff for each ward within Muckamore Abbey Hospital. It also provided information on the number of 'bank hours' used within each ward as well as information on specific levels of enhanced 10:47 supervision that were being provided in specific wards."

And it says that the figures provided related to

November 2017.

Thinking about the figures for the funded, actual, and required levels of staff, did the paper that you reviewed, did it consider whether staff were registrants or not, or whether they were LD registrants or not? 10:47

A. So this was a paper developed by, was being developed by the Trust, and we were undertaking this review and we were asked to give an opinion on it, so we didn't get into it in -- we weren't involved in its development, we were just asked to give a review on it. My recollection of that was that the reference was to registered nurses. 10:47

63 Q. Rather than LD nurse? 10:48

A. Rather than registered nurses in learning disability.

64 Q. Okay. In relation to bank hours, the report goes on to say that large numbers of bank hours were being used, and that's page 41, point B. What was your view, or what was the team's view, on the amount of bank hours that were being used? 10:48

A. There was considerable hours being used. There seemed to be differences in patterns across different areas of the Hospital, that was potentially due to staffing and challenges that the Hospital have already made youse aware of in relation to filling posts, so we thought there was a large number of them. We couldn't get a clear handle on which grades of staff were being called on more often. It appeared to be, from what limited 10:48

information we had, the nursing assistants and registered nurses, and less of the more senior people were being used for bank hours, but we couldn't get detail on that.

The other thing that it was difficult for us to get a handle on, and we asked this as we went through some of our discussions, was how many hours, for staff who held contracts at Muckamore, how many additional bank hours were they working? How many hours were they working in a week? And that was information that we couldn't get a definitive figure on. 10:49 10:49

DR. MAXWELL: Can I just ask, because when you say you're not clear what grades of staff, did you actually know whether they were registered or not? Did the banks -- 10:49

A. Yes, that was the distinction that was -- the bandings --

DR. MAXWELL: But not the grades within that.

A. -- weren't as clear.

DR. MAXWELL: And could you determine from that the whole time equivalents that were employed, even if you couldn't say whether that was over, essentially overtime by existing staff or bank only staff? 10:49

A. No, we didn't. This report that we were asked to look at didn't get into that detail. 10:50

DR. MAXWELL: Didn't look at that.

A. This was a paper that was being drafted as to -- to a response to a challenge they were having with bank hours -- or, sorry, with staffing numbers. The point

that we were making, as it's detailed in this report, was that the numbers that were being suggested didn't appear to be enough, the number of absences were, a large number of them would be covered by bank hours, and that didn't appear to be adequately addressed in the paper. So our concern was that this work -- the challenge would continue even after this paper, and the paper needed some more detailing.

65 Q. MS. BRIGGS: Thank you, Professor Barr. We're going to go down to page 42, the third paragraph down. Yes, that paragraph refers to short term workforce planning, and the fact that a significant number of staff in Muckamore had been offered temporary contracts. Did the Assurance Team find out at what level the decision to offer temporary contracts had been made within Muckamore? 10:50 10:50 10:51

A. No.

66 Q. I'm going to go now to the recommendations about staffing, page 44, Section 6.5. The first one says: 10:51

"The Independent Assurance Team recommended the need for clear processes for escalating concerns about staffing levels and am ability to provide safe nursing care directly to the Director of Nursing and Director of Social and Primary Care." 10:52

Hadn't the issue of staffing levels previously been escalated? It had been on the Risk Register for the Belfast Trust since 2014, isn't that right?

A. Yeah.

67 Q. So was the difficulty not really then the escalation process, but the lack of action once the issue with staffing had been identified?

A. The review team were of the view that there were some inconsistencies in how things were being escalated to the Director of Nursing in particular, and the Director for Social and Primary Care, and we felt that it should have been escalated to both. 10:52

DR. MAXWELL: This is escalating outside the Risk Register and the Datix system? 10:52

A. Yes. Yes. That these should have been raised as priority matters. So, yes, it was in the Risk Register, but as you say it had been on the Risk Register for a very long time, and continued to be on the Risk Register, and our view was that the staff in the Hospital should be escalating directly to the Director of Nursing, as the senior nurse within the Trust. And, yes, they followed the procedures that were there. But it wasn't clear to us how that message got from the Nurse Manager in the Hospital directly to the Executive Director of Nursing in the Trust. There was a process by which it got escalated, which youse are familiar with, and went through a series of channels. We felt that there should have been a way that it went directly to the Director of Nursing as well. 10:53 10:53 10:53

CHAIRPERSON: Can you just help me? The Director of Nursing obviously sits within the Trust.

A. Yes.

CHAIRPERSON: The Director of Social and Primary Care also sits within the Trust?

A. Also sits within the Trust. And we felt that both of them should have been made aware, because the Director of Social and Primary Care seemed to have a role for Muckamore Abbey Hospital as well, but our view was, if the shortage related to nursing, then that also should have been raised directly with the Executive Director of Nursing. 10:53 10:54

CHAIRPERSON: And I understand the importance of escalation, but if there's a fundamental problem with recruiting, partly because you're only offering people short-term contracts, it needs a pretty granular look, doesn't it, as well, as to what's going on? 10:54

A. Yes, yes. There are many factors that contribute to the recruitment. In a previous role I was seconded from the University of Ulster to the Department of Health as the nursing officer for mental health and learning disability, and at that stage led on a recruitment campaign back in 2006 -- sorry, 2007, for registered nurses in learning disability - this has been long-established. We did have three training sites for nurses in Northern Ireland, many years ago we had one, some of the -- some of now -- some of the challenges, I would dare say, were predictable. We used to have one, then we developed the three to solve problems, and then we went back to one. 10:54 10:54

DR. MAXWELL: But surely only offering temporary

contracts isn't a great incentive for the small number of LD nurses. It's not just about supply.

A. It's not just about supply, and those people -- some people who didn't -- some people were -- could have got a temporary contract within the Belfast Trust, or could have got a permanent contract within a range of other independent providers. So the people were choosing to go and take -- these were people who had, you know, wanted some, I would expect, security in their employment. So -- 10:55

PROFESSOR MURPHY: Presumably that was a financial decision really at base, somewhere in BHSCT, that you don't want --

A. Yeah, I suspect it was, and it was a decision taken probably down about recurrent funding, or slippage funding, or various other. So -- but the -- the information we were provided with is the Hospital was retracting, numbers were reducing, they weren't going to keep appointing. Now at that time. I know that subsequently changed later, but at that time. 10:56

DR. MAXWELL: We've heard quite a lot about although the number of patients was reducing, the case mix and the acuity was going up, and so the simplistic logic that less patients requires less staff wasn't actually true; they were cohorting patients with complex conditions and behavioural challenges in distress, and actually, assuming that you could cut the number of posts, particularly registered nurses, was a false logic. Did that get reflected in this paper? 10:56

A. No, because that wasn't really what we were looking at, but I agree with the logic. I mean, as hospitals close or reduce in size, the complexity of the people who continue to live there increases. The people who will leave hospital earliest will be people who are more able and more able to use community facilities. So by default, the complexity of the people who remain in hospital will increase.

DR. MAXWELL: And that wasn't reflected in the paper you were asked to review? 10:57

A. In the briefing paper, the staffing paper, it wasn't --

DR. MAXWELL: That wasn't reflected in the briefing paper?

68 Q. MS. BRIGGS: The final question I have about this report is page 46. It's back on Appendix 1, which we've looked at earlier, and it's on the point of staffing. If we go down the page to the second heading. There's a number of bullet points based on your interviews with staff about the topic of staffing, and the second from last bullet point says this: 10:57

"RNLDs [Registered Nurses in Learning Disabilities] who have completed their NMC recorded Specialist Practice Programmes are not supported to practise as specialist practitioners." 10:58

What did that mean?

A. So, I lead the Specialist Practice Programme in learning disabilities, and it was my experience, and my

recent experience at the time we were running this report, is that people who were being commissioned on to the Specialist Practice Programme, and successfully completing the Specialist Practice Programme, were then returning to posts that did not require them to be a specialist practitioner. So the logic was -- the commissioning was, we've identified a need for a post, we need a specialist practitioner, we're going to educate people into that role and they're coming back to do that job. That wasn't the case. People who were completing NMC Specialist Practice qualification were returning to potentially previous roles that they had before the qualification, and were not being -- were not then being -- their knowledge and skills and expertise as a specialist practitioner was not being utilised as a specialist practitioner. 10:58 10:58 10:59

CHAIRPERSON: Why?

69 Q. MS. BRIGGS: Were there specialist roles for those staff in Muckamore available?

A. At the time people that returned from the course, no, they went back to the roles that they had. 10:59

CHAIRPERSON: So, why?

DR. MAXWELL: But what role would you expect them --

CHAIRPERSON: Sorry.

A. Why? 10:59

DR. MAXWELL: What role would you expect them to have had?

A. I would have expected that at the time they were commissioned that that was part of a larger plan that

we need to increase the number of specialist practitioners we have.

DR. MAXWELL: But can you give us an example of what a specialist practitioner could do that an RNLD couldn't?

A. Well, the people that I am thinking on who completed the course at the time, were both undertaking a specialist practice course with a focusing on working with people who had behaviours that were challenging and people with mental health problems. That's what the focus of their practice was, and that's what the focus of their course was. 10:59 10:59

CHAIRPERSON: So why weren't they going on then to take up roles that required those specialties? You don't know.

A. I don't know. 11:00

CHAIRPERSON: The witness shrugged his shoulders.

A. It was a decision by the Belfast Trust.

CHAIRPERSON: Okay.

A. Some of those people subsequently left and went to work in other services. 11:00

DR. MAXWELL: So they did leave to find posts where their skills could be used, but Belfast Trust, having supported them to do the course, did not create the post in the service when they finished?

MS. BRIGGS: Chair, that's all my questions about the 2018 report. I wonder at this point, the Panel might have questions about that report before we move on to the other report, and perhaps with a break, but I'm in the Panel's hands. 11:00

CHAIRPERSON: Yeah, I think we might take -- because you'll -- if we take a break now, after Panel questions, you'll still comfortably finish this morning, won't you?

MS. BRIGGS: Yes.

CHAIRPERSON: No, I think we've asked the questions as we've gone along. So I think what we'll do is we'll take our 15-minute break now, and you'll be offered a cup of tea or something, I hope, and we'll reconvene at 25 minutes past. Thank you very much. 11:01

THE INQUIRY ADJOURNED BRIEFLY AND RESUMED AS FOLLOWS:

CHAIRPERSON: Thank you. Right, Ms. Briggs.

MS. BRIGGS: Thank you, Chair. 11:17

70 Q. Professor Barr, I'm going to go now to the 2021 Safeguarding File Review, and that starts at page 47. Just as a recap, this was a Safeguarding File Review commissioned by the Department of Health, isn't that right? 11:18

A. Yes.

71 Q. And you weren't the lead author, but you were involved in the review of the files themselves and the report that was produced?

A. Yes. There had -- my understanding was this was being done at the request and for Aine Morrison at the Department of Health, and there had been three people identified to be involved, all of who come from a social work background, and I had a request from the 11:18

nursing office in the Department of Health to be involved as a nurse, they wanted a nurse as part of their review team as well.

72 Q. And the report is dated September 2021, isn't that right? 11:18

A. Yes.

73 Q. Okay. I'm going to read in the first paragraph, it's over the page.

"The purpose of this file review was to provide an external opinion and analysis of adult safeguarding referrals involving staff-on-patient interactions in Muckamore Abbey Hospital between 1 January 2020 and 30th April 2021. The review was commissioned by the Department of Health in response to concerns about the numbers of referrals implicating staff in alleged abuse of patients." 11:19 11:19

So is it fair to say then, Professor Barr, that this was a desktop exercise? It was a review of existing referrals. 11:19

A. Yes.

74 Q. Rather than, say, interviewing staff or patients?

A. No, this was a review. It was undertaken in the Muckamore Abbey Hospital site because some of the files that we were being asked to look at were only available on their electronic system, and there were also some of them that were available hard copy, so it was all done on the Muckamore Abbey site, because that's where the 11:19

information was, and it was desktop review, yeah.

75 Q. Why were some available in hard copy and some available only electronically?

A. There was I think a transition that deals with the PARIS system, and some of the older information related back. So there was different sources of information that we were able to look at. 11:20

76 Q. Okay. And then the files that you looked at, they would obviously come into existence only where a concern had been raised and a safeguarding referral made, is that fair to say? 11:20

A. Yeah.

77 Q. Okay. If we can go down to the methodology section, the second paragraph. It says there that:

11:20

"In total, there were 116 relevant adult safeguarding referrals for this period. The file review examined a sample of 60 adult safeguarding referrals made within the timeframe."

11:21

How were the 60 files selected?

A. So as it details here, we had 116, we had very outline information on them, we then looked through to say 'Okay, can we make sure that we cover a range of referral sources?', we look at different types of abuse, we look at the different outcomes of the screening process. So some of them went on to further investigation and some of them didn't proceed to further investigation. One of the things that we were 11:21

being asked about was the appropriateness of the threshold for the referrals, so we wanted to be able to compare those that were screened out, although that's not the language -- that didn't progress -- and those that went on to subsequent further safeguarding discussions. So it really was a sift through all of the ones we had on the first day to say 'Okay, do we feel we've got a good mixture of different people referring different types of abuse and different levels of safeguarding referrals that are being made?' 11:21 11:22

78 Q. So that's a system of a selection of -- of selecting 60, was undertaken by the team?

A. Yes.

79 Q. And it was done in order to give a broad range of different types of incident and referral, is that fair? 11:22

A. Yes, and sources of referral. We had -- we only had -- this was done within a week, so we only had a few days to go through these.

DR. MAXWELL: So was 116 the total number of referrals that had been received in that year where there was an allegation of staff action or staff abuse of a patient? 11:22

A. I think they were -- the 116, we understood to be the number of referrals between 1st January 2020 and 30th April 2021.

DR. MAXWELL: More than a year. But -- so that would have been the total population, that would have been all the referrals at the allegations of staff abuse of patients. 11:22

A. Yeah.

DR. MAXWELL: And you say that you stratified it according to the source of referrals. What are the range of sources of referrals? Where could they have come from?

A. Well, they would have come from different levels of staff. They may have come from different groups of staff within the Hospital, they may have come from staff on the ward, or staff in day services. So there was -- they were all largely -- my memory of them is that they were all relating to -- and I would need to go back to familiarise myself with the appendix of them, but primarily they related to referrals made by staff within the Hospital. 11:23 11:23

DR. MAXWELL: And so were some of these from viewing of CCTV? 11:23

A. Sorry, were some of them?

DR. MAXWELL: Were some of the referrals made as a result of viewing CCTV prior to there being any concern? Because we know at one point there was a sample of CCTV being viewed almost contemporaneously. 11:24

A. From memory, the reviews that we looked at didn't relate to CCTV. That was being done at a -- the investigation of allegations based on CCTV was being done --

DR. MAXWELL: Well, there were two separate things, weren't there? There was the historic viewing of the CCTV from March '17 to November, but there was also -- well it was called "contemporaneous", but I think it was a few weeks out of date, random sample of CCTV was 11:24

being viewed, and are you saying that none of these referrals you looked at had been thrown up from the contemporaneous viewing of CCTV?

A. I'm not definite, to be honest. We were more focusing on who made the referrals as opposed to where they had come from -- 11:25

DR. MAXWELL: Okay. Okay.

CHAIRPERSON: I understand you can't remember now, but you had the files there, so presumably the file would have told you at the time? 11:25

A. Yeah, and that's something that we've noted. So my feeling is that the majority of these referrals were not involving the review of CCTV.

DR. MAXWELL: Okay. So it was largely not contemporaneous -- it was not the 2017, it was not the contemporaneous CCTV, and you said only a small number came from the staff, the ward staff? 11:25

A. No, the majority of them came from -- one of the challenges that we had, and it's in one of the appendix tables, is that the recording of detail on the referral was poor, and of the 60 files that we looked at, there were 34 of those that had a named member of staff, but no role. So unless you knew who that person was and what their role was, then it wasn't possible for us to determine exactly who -- 11:25 11:26

DR. MAXWELL: Okay. But they weren't coming from outside? They weren't coming from families making a referral?

A. There was two that came from the DAPO, there was one

came from an OT, there were five that went through the adult safeguarding team, that my understanding were people who had contacted the safeguarding team in the Trust, and then they then brought those back to the Hospital. So I suspect -- 11:26

DR. MAXWELL: So non-staff had contacted --

A. Yes. My understanding was that they were family members who went to the safeguarding team, rather than going to the Hospital, because of the situation.

DR. MAXWELL: Okay. Okay. 11:26

PROFESSOR MURPHY: Can I ask just one more about the methodology. Am I right in understanding you weren't selecting by ward?

A. No. No, we --

PROFESSOR MURPHY: The reason I ask is that I'm 11:27 wondering if somebody said 'Oh, well you've got an awful lot from Cranfield, were you specifically selecting Cranfield?', your answer would be "no"?

A. No. No.

PROFESSOR MURPHY: But why did you not decide to do a 11:27 proper random sample?

A. I suppose at the time we felt that if we had half of them, then we -- and we looked at the particular areas that we identified -- then we would get a spread, whereas a random sample may not have given us, and that 11:27 may have. We weren't treating it as a research project as such, where we would be more likely to do that. We felt that if we looked at -- we knew we had 116, we had four people, we had a number of days to do this, what's

the number we feel we can manage? How do we make sure that we don't just take the first 60 we come across? Let's make sure we get a spread. And that was the level of the stratification within it.

PROFESSOR MURPHY: Okay. 11:28

80 Q. MS. BRIGGS: And as you were giving your earlier answer, you were referring to a table in the appendix, and that's page 60, isn't that right? That was the table that you were looking at when you were saying that there's 34 named members of staff with no role 11:28 provided?

A. Yeah.

81 Q. Et cetera. And you said two were the DAPO, and that's where that information is from. It's on the screen now. 11:28

DR. MAXWELL: Can I ask what "DWS female" means? Is that Deputy Ward Sister?

A. Deputy Ward Sister was my understanding, yeah. We wrote it down as it appeared. My understanding was it was Deputy Ward Sister, yes. 11:28

CHAIRPERSON: I had better ask, ASW.

A. Approved Social Worker.

CHAIRPERSON: Approved Social Worker. Okay. Thank you.

82 Q. MS. BRIGGS: So I want to go to some of the findings of 11:29 the report, it's page 49. So these are really statistical outcomes of the review, and they relate to the 60 files that were selected by the team, and you've said already that it wasn't a random sample, but of the

60 files that were selected, the findings section says that:

"The majority of incidents occurred on Cranfield 1 and Erne" 11:29

A. Yes.

83 Q. Was any consideration given to the profile of the patients on those wards, or the staffing on those wards, for example? 11:29

A. No, we were just -- we were reviewing -- the question was around thresholds, and the question was around the safeguarding process. So we didn't get into further analysis on the number of people, or staffing, or the level of ability of people on the ward. 11:30

84 Q. Okay.

DR. MAXWELL: Did the files contain any information about the patient? So, you know, potentially these wards where patients were -- had patients who were particularly distressed and, therefore, managing a 11:30 situation was more complex than maybe on what we've come to know as the resettlement wards.

A. Yeah.

DR. MAXWELL: When -- when considering the management of the referral, was there risk of a safeguarding 11:30 incident with this patient considered?

A. The information provided in the safeguarding referral related to more descriptive aspects like age and gender and level of ability. It didn't get into --

DR. MAXWELL: So it wouldn't have anything about their behaviours and triggers and --

A. No.

DR. MAXWELL: And the context of why this situation might have arisen? 11:31

A. Any context that was there, was the context about a particular incident that was the subject of the safeguarding.

DR. MAXWELL: Thanks.

85 Q. MS. BRIGGS: Just picking up that the majority of incidents were found to have occurred on Cranfield 1 and Erne. Might it have been the case if 116 were considered that that might not have been the case, it might have been skewed towards a different ward, for example? 11:31

A. No, our initial impressions as we went across the files was that those were the wards that highest numbers of referrals were coming from.

86 Q. Okay. Page 58 is a table setting out some information about the referrals that were looked at in relation to the nature of patients' disability, and this is what your team would have seen on the safeguarding referrals, isn't that right? 11:31

A. Yes.

87 Q. And we can see there lots of different types of disability listed, and beside it the number of referrals, and we can see from the asterisk at the bottom that although the total is 81, that's because a patient may have more than one type of disability? 11:32

A. Yes.

88 Q. Okay. And we can see there that 40 referrals are marked that the patient has learning disability?

A. Yes.

89 Q. We can see that one says mild learning disability, two says moderate learning disability, and eleven say severe learning disability. Is the 40 within learning disability simply because the person who filled out the referral hasn't specified the level of that learning disability? 11:32

A. Yes.

90 Q. Okay.

A. So these were --

PROFESSOR MURPHY: So these weren't categories?

A. This is the information reported on the file. 11:32

PROFESSOR MURPHY: There weren't categories already provided that people ticked, they named them themselves?

A. No, this was how the staff filling in the form noted the level -- 11:33

DR. MAXWELL: So it's just a free text into --

A. Yeah.

DR. MAXWELL: They could put anything they wanted?

A. Yeah.

91 Q. MS. BRIGGS: Okay. Back to page 49, Professor Barr. It's the last paragraph of the findings section, and the very last sentence there says: 11:33

"When an investigation was undertaken, this was

conducted as a single agency investigation by the DAPO in 62% of cases, by police in 10% of cases, and as a joint agency investigation with the DAPO and police, sometimes in conjunction with other professionals in 8% of cases." 11:33

So this is safeguarding referrals that have gone on to investigation?

A. Yes.

92 Q. That wouldn't have been the case with all of the safeguarding referrals, or would it have been? 11:33

A. Well, no, because some of the -- the referrals were made, but the decision would then have been taken that some of these don't need to proceed, and that was part of the question was that was -- the question being asked of us about the appropriateness of the threshold for the referral was very much around a belief that the numbers were high because there was a very low threshold being applied and referrals were being made that maybe didn't necessarily warrant a safeguarding referral, but -- so, therefore, when those were considered, they were not progressed with as investigations and they were dealt with through other means. 11:34 11:34

93 Q. Okay. And we'll go to the threshold findings in a moment. Would you have expected, just focusing on that bit that I read out, more investigations to be joint investigations as opposed to single; what might you have expected to see? 11:34

A. We didn't have a figure or a ratio as to what we expected, because we were just reporting this as the figures for these particular, but we didn't have a figure in mind that we would have expected to see more in one category than in others.

DR. MAXWELL: Did you see any -- because I understand the decision about whether to investigate and whether it's single or multiple agency, depends on the nature of the allegations, so you can't set a benchmark. But did you see any file where you thought, oh, we would have expected that to be managed under the Joint Protocol, and it wasn't?

A. No. No. So there was no files that we looked at that we then went back to the Trust and escalated it or said 'We feel that that should have been dealt with differently.'

DR. MAXWELL: Conversely, were there any where you said, 'Oh, I'm not sure why this went to the Joint Protocol'?

A. No.

DR. MAXWELL: So the Joint Protocol seems to have been used appropriately?

A. Yes.

94 Q. MS. BRIGGS: I'm going to go now to the thresholds, the appropriateness of the thresholds, because that's one of the issues looked at in the analysis section, which starts at page 49, but it mostly appears on pages 50 through 51. And I want to go to page 50, in particular. We can see there the heading:

"The appropriateness of the thresholds in operation for initial referral and screening outcomes."

The review says this:

"Arguably a number of the incidents triggering a safeguarding referral related to minor concerns and could have been dealt with in other ways, for example, clarifying information, through governance arrangements, or staff training."

Moving on to the next sentence after that:

"Context is important here and the low referral threshold may be understood in the context of current public scrutiny and the ongoing formal Safeguarding Investigation in relation to services provided at Muckamore Abbey Hospital."

I appreciate it was some time ago, and I also appreciate that you weren't the lead author on the report, but are you able to say how many files were minor incidents that could have been dealt with in other ways?

A. We didn't reach a figure on it, because we hadn't looked at all 16. It was a general impression that there were some areas that were completed as safeguarding referrals that could, at another time may

not have led to a safeguarding referral. So we were really trying to answer the question of, had the position moved to, if there was a concern, make it a safeguarding referral and let somebody else decide as to what should be done about this? So our answer to that question was, yes, there was some evidence that within the ward environments, and within the services, that people were making safeguarding referrals and passing that on for the Designated Adult Protection Officer to make a decision as to whether that should be investigated or not, and there was a reluctance to say 'Well, that's okay, we don't need to worry about that.' 11:37 11:37

DR. MAXWELL: Was it your impression though that the DAPOs were appropriately screening those out?

A. Yes, there didn't appear to be -- there wasn't anything that we read as not proceeded with that we thought that should have been proceeded with. 11:38

DR. MAXWELL: Well I'm asking the reverse, actually.

A. Right.

DR. MAXWELL: Did more things get investigated than was warranted under the policy on safeguarding regionally? 11:38

A. No, I feel that what was investigated was appropriate.

DR. MAXWELL: So the DAPOs were screening appropriately, both making sure things that should have been were proceeding to investigation, and things that didn't need the regional policy were sent back to presumably be managed by these other -- 11:38

A. Yes. We were content with the level of screening out that the -- and it comes up later on in the report --

we had some concerns, and I personally had particular concerns about the lack of involvement of people with learning disability in the investigation.

DR. MAXWELL: Okay.

A. I'm sure that might come up. 11:39

95 Q. MS. BRIGGS: We'll go there, Professor Barr. You've said then, just to top off what you've said there, the report on the screen says that:

"Notwithstanding the low threshold for referral in some instances, to a large extent screening thresholds were appropriate." 11:39

And that's your evidence today. But does that mean it was appropriate in the specific circumstances of Muckamore, or does that mean it would have been appropriate in any hospital? 11:39

A. We felt that it was appropriate that the referrals were made, and the other people I -- when we had discussions -- were of the view that there was no referrals that were -- that just shouldn't have been made, there was no referrals that we felt absolutely warranted no one to look at them. At another time it may have been dealt with by discussion and clarified and not needed to proceed to safeguarding, but we felt, no. And my view is that if a registered professional has a concern about safeguarding, they should make a referral, and there is a process by which that referral is investigated and, therefore, I maybe am an advocate of 11:39 11:40

a low threshold.

DR. MAXWELL: We have heard, though, that prior to the discovery of CCTV, there was a twofold safeguarding process; one was that the issue could be reported to the ward manager, who could decide that, actually, it didn't need to go to the DAPO. So it wasn't ignored, a concern was raised and it was being managed. But then once the scale of the concerns in 2017 became apparent, that threshold changed -- or that process changed. It's described by a lot of witnesses as a lowering of the threshold, and a decision was made that any concern from anybody would go straight to the DAPO, and the ward manager's role in assessing things would be removed. Did you feel that some of these could have been managed by the ward managers in general? Because the question you're asked is, was this appropriate in general or was this appropriate for Muckamore, because of the specific concerns there? 11:40 11:40 11:41 11:41 11:41

A. I think it was appropriate in general, and I think it was consistent with the safeguarding policy that was in place at the time, the 2015 policy. I would need to go back and examine it, but my understanding of it is that there isn't an opportunity to screen out at unit level, but if there's concerns about a referral, or there had been an incident, that referral should be made. There was in a previous policy what was referred to as "screening out", and my understanding is that that was removed in the 2015 policy. So if there was -- if it existed after 2015, my understanding is that wouldn't

have been consistent with the 2015 policy.

CHAIRPERSON: So to a large extent, I mean, you were ignoring what one might call the Muckamore factor.

A. Yeah, the referrals -- the referrals that were made for safeguarding we considered to be appropriate. 11:42

CHAIRPERSON: Yeah.

96 Q. MS. BRIGGS: Another thing that the review team looked at was the levels of harm caused to patients, and that's just down the page slightly on the screen, and the review team gave a very detailed analysis about 11:42 this, and I'm not going to go through it all, everyone has read the statement and it's on the Inquiry's website as well, but I do want to go to the last paragraph of page 50, it says there about halfway through that paragraph: 11:42

"Whilst acknowledging that physical abuse of a minor nature was the dominant issue noted, there was very limited attention to the potential for emotional distress or harm, with an emphasis in reporting 11:43 relating to physical examination."

It goes on to say:

"Moreover, some of the staff behaviours in the 11:43 screened-in referrals were for responses to patients that should have been very obviously inappropriate, thus raising concerns about the knowledge, skills and experience of the staff involved. Where relevant

information was provided, agency staff appeared to be disproportionately involved in incidents of concern."

What is meant by "agency staff" in that context?

A. So these -- at this stage, in Muckamore, many of the staff that were on the wards were employed through an agency. They were not core staff from Muckamore. 11:43

97 Q. Were they nurses or...

A. Many of them were nurses, yes, but my understanding is that the majority of them were not nurses in learning disability. So they were nurses from mental health or other qualifications, but they weren't RNLDs. 11:44

CHAIRPERSON: Can I just ask, because you are very experienced, as it were, in this; were you able to perceive that it was because they were not nurses trained in LD that these events were happening, or would they have been wrong in any circumstances? Do you see what I'm trying to ask? 11:44

A. Yes. I think they would have been wrong in any circumstances. I would have expected that somebody who was -- so they were wrong in any circumstances. I was surprised to see them. I was of the view that an RNLD would not have behaved in this way in some of these circumstances. But had they had behaved in that way, it also would have been wrong, and I think that some of the comments made to people with learning disabilities, some of the comments made about people with learning disabilities, some of the interactions with people with learning disabilities that were focused within the 11:44 11:45

safeguarding, an RNLD would have addressed in a different way.

DR. MAXWELL: We have heard some evidence that some of the incidents were a result of a failure to de-escalate situations and, whilst always wrong, somebody without the skills to understand what was happening and how their response was triggering, can escalate things; were you seeing that sort of example? 11:45

A. Yeah, situations that could have been managed much more appropriately, much quicker, in a very different way, which would not have escalated. When you read some of the stuff you think that that could have been dealt with in a different way, that didn't have to become the incident that led to the safeguarding. So the safeguarding then focused on the next interaction that occurred, or the way the situation was managed, but it shouldn't have progressed to that. 11:45 11:46

DR. MAXWELL: Did the safeguarding files actually look at the events that led to the safeguarding incident, or did they just look at the incident? 11:46

A. Some provided a bit of a history as to, you know, a more recent history of what happened, and earlier that morning, or earlier that day, or what the person's mood appeared to be. Others didn't. They were very succinct that 'At this time the following thing happened', and... 11:46

DR. MAXWELL: So that's one of the inconsistencies in the file that you talk about?

A. Yes.

PROFESSOR MURPHY: Can I ask you about your table on page 59, which unless I'm misunderstanding it, says you didn't know whether people were agency staff or not in an awful lot of cases; have I misunderstood that?

A. So, which table? Yes. So it wasn't clear. But what we -- we did see agency staff named or we did -- so when -- in the sample that we looked at, yes, there's a large number, it wasn't known if they were agency or not, but where the people were named as agency or Trust, then agency was named more often. So there's only 16 people where it was identified what their employment status was, but if we compare -- so the numbers of people who were identified as agency and non-agency, then there was a higher number of agency staff being identified. 11:47

PROFESSOR MURPHY: Yes. Yes.

A. If all 60 had of been listed, then we don't know what that would have come out of, but on the observations of the ones where we had the information, so one of the things that is detailed in the report is that the quality of the information provided in the safeguarding referrals was lacking in a number of ways. 11:48

PROFESSOR MURPHY: And, again, was this pre-defined categories provided or was it...

A. It's whether it was noted in free text that this person was agency... 11:48

PROFESSOR MURPHY: Yes.

DR. MAXWELL: So the safeguarding files, by the sound of it, don't have a minimum dataset of things that need

to be collected?

A. Given a minimum dataset, but that's not one of the things, from memory, that they were --

DR. MAXWELL: There seems to be quite a few things that you have highlighted that you thought would have been important that weren't in the minimum dataset for the file? 11:48

A. Yeah. Or on occasions the box was there, but it hadn't been answered.

DR. MAXWELL: Okay. 11:48

CHAIRPERSON: And finally before we go back to Ms. Briggs, and I certainly don't want to put words in your mouth, but is the effect of what you're saying that the high rate, or the relatively high rate of referrals, seems effectively to be linked to the fact that there were -- there was an increase in non-learning disability trained staff? 11:49

A. Whether that caused it? But we had a concern about the number of agency staff who were being mentioned, and we'll see later in the report we also had a concern that when some of those staff were mentioned in a referral, it was unclear to us the degree to which that was escalated; so for example, to a professional regulator like the Nursing Midwifery Council, or to the -- the barring service that would have been required within Northern Ireland, and part of our concern was that there appeared to be communicated to the agency that the Trust didn't want that person back, and that's where it appeared to stop; we couldn't find any 11:49

evidence that that then progressed to the other expectations that would be within the safeguarding policy.

DR. MAXWELL: And this was an agency based in England?

A. Yes, a lot of these people travelled into Northern Ireland, worked shifts, and left again. 11:50

CHAIRPERSON: And I'm sorry, it may be somewhere in data, but did you have an assessment of how many of the agency staff were LD trained and how many weren't?

A. No. No, we couldn't -- we asked for that information, but we couldn't get definitive figures on it. 11:50

CHAIRPERSON: No.

98 Q. MS. BRIGGS: Just to put this review in context. It was obviously after the 2017 abuse was uncovered, alleged abuse, and then this is in 2021 when agency staff had come into Muckamore, and this was a report asked for you to do by the Department of Health? 11:50

A. Yes.

99 Q. Was the review team shocked by what it had seen in terms of the numbers of staff-on-patient allegations at that time? 11:51

A. We were concerned that even after a major review and a major inquiry, that there appeared to be still things in safeguarding referrals, which is behaviour that we would have considered unacceptable at any stage, but it was surprising that that behaviour continued and was still being reported after there had been the Margaret Flynn report. 11:51

DR. MAXWELL: So your report was after Margaret Flynn's

"A Way to Go"?

A. Yes.

DR. MAXWELL: It was after the RQIA improvement notice on safeguarding processes, which I think was 2019. So it seems you've got two issues: One is the number of allegations, but, also, you've got a number of queries about the safeguarding processes, the way the documents are kept, the amount of information? 11:51

A. Yeah. I mean we had observed, and among the team had different levels of concern, but there was a general concern, or an expectation maybe is another way to put it, when we arrived to do this, that we would have thought having, all those things having had occurred, that we would have seen a set of files that were exemplary, that a lot of -- you know, the detail that we would have had, the involvement of people with learning disabilities, all of the processes would have been absolutely complete. So it was a surprise to the members that looked at the files that, after all of those things happened, we still appeared to have limitations in the recording of safeguarding. 11:52 11:52

100 Q. Just to draw that out, what the teams say about the quality of the files that they're looking at, and that's on page 51, from the second paragraph down. Yes, that first paragraph there that's now on the screen under the heading "Positive and negative aspects of the safeguarding process", the review team there are referring to the difficulties accessing information from safeguarding files, they talk about the 11:53

duplication of paper and electronic files, missing information is mentioned, it's mentioned that the pro formas were not user-friendly, and there's a lack of narrative, and so on and so forth. Overall, was the team of the view that, based on what they saw, that the recording system, even at this time, was insufficient? 11:53

A. Yeah. Yes, we would have expected it to be better.

101 Q. Was there any evidence of the files being overseen by senior management, or audited in any way, other than the review that you come in to do externally? 11:54
Internally within Muckamore is there evidence of that type of process?

A. Not to the extent that we weren't made aware of any reports that said 'No, we have internal audits and we've looked at files.' There were people that were present on the day, and people we spoke to, that appeared to have an overview of what was being done, but we didn't see any -- we weren't provided with anything that said 'We have audited X number of files over the last number of months and this is what we' -- 11:54 11:54

DR. MAXWELL: So were these people with oversight line managers?

A. Yes.

DR. MAXWELL: There was no separate quality assurance process that you were aware of? 11:54

A. Well, they were people who had a line management function, or, sorry, a quality assurance function within their line management.

DR. MAXWELL: Yes. But no separate.

A. It didn't appear. I wasn't aware --

DR. MAXWELL: So in most clinical governance systems there's an entirely separate quality assurance.

A. Yeah. Yes.

DR. MAXWELL: And as far as you're aware there wasn't one? 11:55

A. We didn't meet anybody that I'm aware of who introduced themselves in that way in that time.

PROFESSOR MURPHY: So even after "A Way to Go", and all sorts of other things, there was nobody doing a regular review of this kind in the Belfast Trust? 11:55

A. Well, my understanding was that Belfast Trust were doing reviews and they were reporting information to the Department. We were asked to look at this to some extent because of the numbers that were being reported to the Department. In the days that we were there, we weren't furnished with a report that says 'Here's the audits we've done and we specifically looked at these files.' The wider discussion as to how that was being audited and what ongoing reports were being provided to the Department, would be for the Department to answer, but we weren't made aware of them on that day. 11:55

CHAIRPERSON: Just so that I understand, when you refer to "line managers", what sort of level are we talking about? Somebody would write the report and... 11:56

A. Yeah, we're talking about -- the terminology has changed, so I tend to go back to old terms like "nursing officers" or "hospital managers". There were people there who had a responsibility, or appeared to

have within their role a responsibility for safeguarding, there were people there who were that the DAPO reported to, we didn't list the names of the people, and I can't remember them now at this stage. So there were some people present who were the people that provided us with files, who were the people who helped us navigate the system when we couldn't, and they have had an oversight of safeguarding among a number of other things. My understanding was that they were, you know, involved in line managing the DAPO and the overall process. They may well have had a governance remit, and that's not an area we get into exploring in detail. 11:56 11:56

DR. MAXWELL: So were the files the responsibility of the DAPOs? 11:57

A. The referrals were made either in hard copy or on the electronic system, and that then went to the DAPO.

DR. MAXWELL: Yeah. So once the DAPO had received the referral, was it the DAPO that then was the responsible person for the file, and for the investigation, or the decision not to investigate? 11:57

A. My understanding was they then made the next decisions around --

DR. MAXWELL: So the files are primarily -- the referral is made by anybody. Once the referral is received, it's a DAPO-led thing? 11:57

A. I'm not 100%. And that was part of our confusion; who contributed to these files? Who has added the notes in them? Who made the entries in them? It wasn't always

clear. The DAPO had an oversight and made decisions around 'we're proceeding with this to investigation', or not proceeding with this.

DR. MAXWELL: So the challenge is, though, if everybody is responsible, nobody is responsible. 11:58

A. Nobody is responsible, yes. Yes.

DR. MAXWELL: And you're not sure that there was -- whether there was a responsible person for each case?

A. I didn't leave getting a real sense of this goes from A to B to C and this is how it works. 11:58

102 Q. MS. BRIGGS: I'm going to go now to the overall conclusion of the report. It's at the bottom of page 51 and into page 52, and I'm going to read a section towards the top of page 52. It says there, the second sentence: 11:58

"On receiving a referral, good practice was evident in what appeared to be thorough initial responses, initial communication with families and referrals to PSNI. However, there appeared to be less attention to ongoing 11:58 and timely review of protection plans, the restrictions these may place on patients' activities, and time frames for completing investigations."

So similar to the earlier report I was asking you about, it seems that the problems really arise in a large part in the ongoing review of safeguarding? 11:59

A. I think there were problems in two areas; one was the involvement of people with learning disabilities. I

was bothered, for the want of a better word, by the fact that I could find very little evidence that people with learning disabilities were interviewed, and there was often written "severe learning disability". The safeguarding policy is very clear about the need to 11:59
make reasonable adjustments, the need to try and involve people, and even if the person doesn't have capacity, how you keep them abreast of. I was bothered that that wasn't happening and, to me, that was a major omission. I don't know how could you reach a decision 12:00
about where you go with safeguarding without having spoken to the person, and I was bothered that if that person didn't have a learning disability they probably would have been spoken to. I can't prove that, but the requirement in the safeguarding policy is very clear 12:00
about being consent-driven, and about involving people and making reasonable adjustments, and I didn't see any evidence of that.

DR. MAXWELL: Not in any of the 60 files?

A. Not in the ones that I looked at. 12:00

DR. MAXWELL: Not one?

A. No. And that -- so that was of concern. Sorry.

103 Q. MS. BRIGGS: No, go ahead. Please.

A. And take me back to your initial question, I may have gone off the track, slightly. 12:00

104 Q. I had read out that portion on the page, and I had asked you was the difficulty really in relation to ongoing review or the initial decisions?

A. There was a difficulty with ongoing review and, again,

following the safeguarding policy, it makes very specific comments about things shouldn't be allowed to drift and there should be active follow-up, and often the answer we were given is 'Oh, we haven't heard back from the police', but when we asked the question was, when -- like for Joint Protocol, when was the last time they were contacted? Where is the evidence of them being contacted? What did they say when you contacted them? It seemed to be being left almost for the police to come back and say, 'Right, we've reached this stage. This is what we're doing', and that had a potential consequence for people with learning disability if there was an interim safeguarding plan in place that placed restrictions on the activities that the person with learning disabilities could do, or places they could go. And that was our concern, you know, that these restrictions were -- that were there to protect the person with learning disability, may be having an adverse effect. 12:01 12:01 12:01

105 Q. What would those restrictions have looked like for a patient? 12:01

A. Only being able to be worked with with two members of staff present, only being able to undertake activities in particular areas of the Hospital, maybe limits on - if they needed two members of staff present, then it might not be possible for that person to undertake activities outside of the Hospital. There were, at times, the safeguarding plan, and I don't think I'm overstepping it to say that I think there were times 12:02

that the safeguarding plan appeared to be more focused on the protection of staff from further accusations, so, therefore, staff shouldn't work with this person on their own.

106 Q. And there was less of a consideration, is your evidence, to how that impacted the patients? 12:02

A. We had concerns that there wasn't a timely review and that the restrictions, while they were put in as interim, and may have been appropriate at the time, that the continuing restrictions on the activities of people with learning disabilities could have been addressed more consistently. 12:02

CHAIRPERSON: And the response to why these restrictions were in place for so long, was very often because 'We haven't heard back from the PSNI'? 12:03

A. Yeah.

CHAIRPERSON: So that was having a direct effect --

A. Or "we're looking at CCTV" or "we're doing something else", so there was a number of reasons as to why -- sorry, I interrupted. 12:03

CHAIRPERSON: No, not at all.

A. It was having a direct effect on the activities that some people with learning disabilities could undertake, and it just seemed ironic that a plan in place to protect the person with learning disabilities could have been having a detrimental effect on their opportunities to do things. 12:03

CHAIRPERSON: Well, on their lives generally?

A. Yeah. Over an extended period. In the short term, you

can see why that -- why that's there. And the safeguarding policy in Northern Ireland is quite clear about the need for timely follow-up.

CHAIRPERSON: Yes, thank you.

107 Q. MS. BRIGGS: And then the next sentence I am just going to read in as well: 12:03

"The potential for harm was however evident in the findings that new safeguarding incidents are continuing to occur and involving staff recently working at Muckamore. The file review indicated the likelihood that there was substance to a significant proportion of these referrals." 12:04

So this report obviously went back to the Department? 12:04

A. Yes.

108 Q. What was done about it?

A. I don't know. I had no further communication with the Department on the report when it was submitted.

109 Q. Did any of your co-authors have any communication with the Department? 12:04

A. That, I don't know, but I am not aware. They didn't communicate to me that they had.

DR. MAXWELL: Can I ask, I think you have done a number of pieces of work for the Department of Health and, in fact, you said you had worked within the Department of Health at one point. Would it be normal to have an ongoing dialogue with somebody who had done a report? 12:04

A. Yes, I would have thought. No, my experience

elsewhere, particularly when I have done stuff with Trusts, is that continues; "okay, this is what we think you need to do". No, there would be a discussion about recommendations, whether the recommendations they felt were supported, not supported, what they might do about it, there would be a discussion about, you know, further work that might be able to be undertaken or there's been occasions where I have done work with Trusts, not on safeguarding but on slightly different matters, where they would come back and say, "Well, can you give us a hand doing this? You have recommended this. Can you come along and help us do this?" This report was submitted and I don't know what happened after that. 12:05 12:05

DR. MAXWELL: And who was the sponsor for this? 12:05

A. Aine Morrison is the --

DR. MAXWELL: Aine Morrison was the sponsor for this, because she was the chief social worker at the time?

A. The chief social worker, yeah.

CHAIRPERSON: So, just so I understand, the report went to the Department of Health. Did it also go to the Trust, or not? 12:05

A. My understanding is, it went directly to the Department of Health. Whether the Trust -- I don't know, is the quick answer. I would have expected the Department shared it with the Trust. The Trust were aware it was being done, but we didn't send it to the Trust. 12:05

CHAIRPERSON: No. And then you didn't hear back from anybody?

A. I personally didn't. That doesn't mean that they didn't do something with it. I just don't know what they did.

CHAIRPERSON: No, sure. Yes, okay.

110 Q. MS. BRIGGS: How do you know that the Trust was aware that the report was being done? 12:06

A. Because we were on Trust premises working with Trust staff, undertaking --

111 Q. Staff on the ground were aware, but I am talking about higher levels within the Trust? 12:06

A. My understanding was, this had been agreed by Belfast Trust that the Department of Health wanted this review done and they were going to send people in to do the file review and that it was people from outside the Belfast Trust that wanted to do the file review, so my 12:06 understanding is, those discussions had all occurred before we arrived.

112 Q. The final thing I want to ask you about, it's the last sentence of the conclusion, it says there: 12:06

"Finally, consideration should be given to the wider protection issues in terms of staff no longer employed in Muckamore Abbey Hospital, but who were subject to an active safeguarding referral." 12:07

Were there staff still working with LD patients outside of Muckamore who were subject to one of the safeguarding referrals that you have considered?

A. What that attempts to point to, is that there were

staff who were subject to safeguarding referrals within Belfast Trust that the -- we couldn't find any evidence that that had been escalated to a regulator or to a barring service, and the explanation, when we asked about it, there was a discussion that there was some people of the view that that wasn't the responsibility of the Belfast Trust; they reported it to the agency.

DR. MAXWELL: Are you talking about agency staff?

A. Yes, and particular --

DR. MAXWELL: So they weren't employees of Belfast Trust?

A. They weren't employees, and that was part of the defence, "They are not our employees, we don't need to deal with it". My answer was, "Well, you are paying them and it occurred on your premises in front of your staff". So there was a difference of opinion as to who was responsible for escalating that. Our concern was that members of staff, agency staff, may well be working with other people who could be vulnerable in other services and there was no way of closing that loop to say this person -- this has now been escalated, that person has been suspended by the agency or that person is not -- there was no -- there didn't seem to be any loop that dealt with that whatsoever, so, potentially, the person could have been working in another service with somebody else who was vulnerable, while being investigated for safeguarding during the time they had been at Muckamore Abbey Hospital.

CHAIRPERSON: And there was a time - Dr. Maxwell will

probably correct me - when a sort of alert letter could be sent out; even if somebody wasn't registered, you could send out an alert letter to --

A. Alert letters would have come from the chief nursing officer's office at one stage, yeah. 12:09

CHAIRPERSON: Yes. Were those relevant to this period of time?

A. My understanding was that they had stopped by this period of time, but there is provision within the safeguarding policy about alerting the barring service 12:09 or raising concerns, so the challenge here is that some of these concerns won't be raised until the outcome of the --

CHAIRPERSON: No, you have got to wait for the whole thing, yeah. 12:09

A. -- investigation. But equally so, as we dealt with in evidence earlier on, where referrals are made with safeguarding incidents, that may lead to the suspension of a member of staff or restricted duties of a member of staff, and we have seen examples of where that has 12:09 happened with staff who were employed by Belfast Trust in Muckamore. Our concern here was, we couldn't see what happened if these staff came from an agency and how that loop was closed.

CHAIRPERSON: Yes. 12:10

DR. MAXWELL: So, given that they came from an agency in England and many of them were resident in England, are you aware of any process for linking between the two countries? Because Northern Ireland has its own

processes which wouldn't apply in England. The only common regulator is the NMC. But do you know if there's a process for communicating staff who are subject to safeguarding concerns across the four countries of the UK? 12:10

A. I think that -- I am not 100 percent. I think that may occur at the level of the barring services in the different jurisdictions, but our concern here was based on the file review. We couldn't see any way in which that process was completed or that loop was closed, and 12:10 that was really what we were highlighting. There are people who are subject to a safeguarding referral at Muckamore Abbey Hospital and we couldn't see who that -- there was nothing in the safeguarding notes that we were looking at to say this had been reported to a 12:11 named agency who employed that person.

DR. MAXWELL: So there was no evidence that their agency had been informed?

A. Not in the safeguarding files that we looked at.

CHAIRPERSON: So they were just sent home, as far as -- 12:11

A. The answer we received was that the agency would have been told not to send them back to Muckamore.

CHAIRPERSON: Right.

MS. BRIGGS: Professor Barr, that's all the questions I have. The Panel might have some more. 12:11

CHAIRPERSON: Professor Barr, I think that will be the last time that we hear from you, so can I thank you very much indeed. We have asked our questions as we have gone along, obviously, and it's been very

informative, a very informative morning, so can I thank you very much indeed.

A. Thank you.

CHAIRPERSON: All right. I think we can sit a little early, and it might be sensible to do so, so we will break until 1:45 and we will sit again at 1:45. Thank you again. 12:12

THE WITNESS THEN WITHDREW

12:12

THE INQUIRY ADJOURNED FOR LUNCH

THE INQUIRY CONTINUED AFTER LUNCH AS FOLLOWS:

CHAIRPERSON: Thank you very much. 13:44

INTRODUCTION TO MODULE 5 BY MS. BERGIN

MS. BERGIN: Good afternoon, Chair and Panel. We now come to Organisational Module 5, RQIA and the Mental Health Commission. The purpose of this module is to examine the mechanics and effectiveness of RQIA inspection, including an RQIA corporate response to the Inquiry and evidence from frontline inspectors. The module will also consider the prior role and effectiveness of the Mental Health Commission. 13:44 13:45

This module is of particular relevance to paragraph 13 of the Terms of Reference, which requires the Inquiry

to examine the response of other relevant agencies, including the PSNI, PCC, HSE, and the RQIA, when allegations of abuse of patients at Muckamore were reported to them.

13:45

The Panel requested statements in relation to RQIA from four individuals for the purposes of this module.

First, Lynn Long, Director within RQIA, with responsibility for mental health, learning disability, children services, and prison healthcare; secondly, Wendy McGregor, former RQIA Inspector and, since 2020, Assistant Director of Mental Health Learning Disability and Prison Healthcare in RQIA; thirdly, Alan Guthrie, former RQIA Inspector; and, fourthly, Margaret Cullen, former RQIA Inspector.

13:46

13:46

I should say that the Panel also requested statements from two former members of the Mental Health Commission. Those individuals were unfortunately not in a position to assist with the range of organisational issues that the Inquiry would wish to address in this module.

13:46

The Inquiry is, however, making renewed efforts to trace other former members of the Mental Health Commission who will be able to assist the Panel with this aspect of the Inquiry's work.

13:46

The evidence the Panel will hear today and tomorrow in relation to Module 5, will therefore focus on the role of the RQIA, and we will keep Core Participants updated on the position concerning the evidence sought in respect of the Mental Health Commission. 13:47

It is worth recalling, Panel, that the RQIA also made a significant contribution to the evidence modules last year. Evidence Module 5 dealt with regulation and other agencies, topic 5A was specifically dedicated to 13:47
the RQIA, along with the Mental Health Commission, and included consideration of the RQIA's history, statutory remit, objectives, inspection procedures and methodology, procedures for ensuring improvement, and its roles and responsibilities in respect of the 13:48
Hospital.

The Inquiry received three statements from Briege Donaghy, Chief Executive of the RQIA. Her first statement, dated 24th February 2023, reference STM-096, 13:48
provided information on a range of issues, including an introduction to the work of the RQIA, an outline of the governing legislation provisions, inspection procedure and methodology, the means of encouraging improvement, the training of Inspectors, the means by which RQIA is 13:48
alerted to safeguarding concerns, and the organisation's review programme.

Ms. Donaghy gave oral evidence to the Inquiry for a

full day on 3rd May 2023. Following on from the evidence modules, the Inquiry directed a number of follow-up inquiries to the RQIA, which were addressed in an additional statement of 15th November 2023, reference STM-185.

Now, that statement included extensive detail on multiple issues, including RQIA monitoring of PRN medication and attentions at MAH, patient experience reviews and the assessment of culture, and Ms. Donaghy also provided a third short statement dated 8th December 2023, reference STM-187, to correct a couple of matters in the second statement.

I am drawing this material to the attention of the Panel and Core Participants as a reminder that the evidence in this Organisational Module should not be considered in isolation.

The Inquiry has already received a significant body of evidence relating to the history, practice and procedure of the RQIA, which will serve as an important backdrop to the evidence of Ms. Long, Ms. McGregor and Mr. Guthrie.

CHAIRPERSON: Yes. It's worth noting all that material is available on the website.

MS. BERGIN: Yes, Chair. Thank you.

Having considered the statements in relation to the

RQIA, the Panel wished to hear oral evidence from Lynn Long, Wendy McGregor, and Alan Guthrie. Lynn Long will be called to give evidence shortly, and the Inquiry will hear from Ms. McGregor and Mr. Guthrie tomorrow.

13:50

As I have mentioned, Ms. Long is a Director within RQIA, whose field of responsibility includes learning disability. She will be in a position to give evidence from a broad organisational perspective. Ms. Long provided this statement with the assistance of previous 13:51
and current RQIA employees, and having undertaken a review of documentation from 2012 and 2013.

Alan Guthrie and Margaret Cullen are former Inspectors who visited the Hospital in that capacity and they, 13:51
therefore, will be in a position to assist with how inspections were conducted in practice.

CHAIRPERSON: Do you mean McGregor, Ms. McGregor?

MS. BERGIN: Yes.

CHAIRPERSON: Yes. 13:51

MS. BERGIN: Thank you, Chair. Before we hear from the witness, it would be perhaps helpful if I highlight perhaps some of the salient features of the written statement of Margaret Cullen, former RQIA Inspector, from whom we will not be hearing oral evidence. 13:51

Ms. Cullen has provided a statement to the Inquiry dated 19th April 2024. She outlines her qualifications and professional experience as a mental health social

worker. She was an Inspector for RQIA between 2009 and 2013. She has indicated that her statement is based on her review of inspection reports. In the body of her statement, she outlines:

13:52

"The role and function of the Mental Health Commission was taken over by the Mental Health and Learning Disability Directorate of RQIA in 2009, and there are four full-time Inspectors with specific responsibilities." 13:52

She was the mental health social worker on the team, and there was another social worker who specialised in learning disability.

13:52

Ms. Cullen was involved in six patient experience reviews, nine announced inspections, and four unannounced inspections, and Ms. Cullen has exhibited a schedule of the inspections and PERs that she was involved in between 2010 and 2013, and she states that 13:53 she does not recall having any concerns over culture at Muckamore.

Ms. Cullen outlines her experience of the pre, during, and post inspection process, and notes that: 13:53

"Inspectors were provided with a range of information, including previous inspection reports and recommendations in advance of inspections. For

announced inspections questionnaires were sent to the ward manager to distribute to patients and relatives. For unannounced inspections, RQIA notified a Belfast Trust manager on the morning of the inspection. There were a minimum of two Inspectors per inspection, and announced inspections would typically last two days. Inspectors explained the process to the ward manager and arranged interviews with staff and patients. If concerns were highlighted on the first day, they reported back to RQIA management. 13:53 13:54

Day one would involve touring the wards, reviewing patient files and a range of documents, and day two typically would include a discussion of outcomes and a summary of inspection findings with the multidisciplinary team, ward manager, and responsible medical officer." 13:54

And Ms. Cullen states that she would have spent around a half day speaking to staff, half a day speaking to patients and relatives, and over half a day reviewing records, with the last few hours spent preparing her report, and Ms. Cullen states that she felt as though she was always rushing and there was never really enough time. 13:54 13:54

She states that:

"Unannounced inspections, particularly in response to a

significant allegation, tended to be completed within one day, and, therefore, required more Inspectors."

She states that:

"Communication with Muckamore and others varied, depending on the findings, and after inspections, ward managers were given a timeframe to provide updated quality improvement plans and recommendations were reviewed at the next inspection." 13:55

Ms. Cullen outlines her role then inspecting the Ennis Ward. Ms. Cullen was involved in and inspected the Ennis Ward following the allegations of abuse in 2012, but her memory is limited in relation to this, and she states she would likely have been the lead Inspector. She was involved in the unannounced Ennis inspections on 13th November 2012, 20th December 2012, and 29th January 2013, and she outlines the purpose of each inspection, but cannot recall the inspections. 13:55 13:56

After the January 2013 inspection, Ms. Cullen does not recall being involved in any further way in relation to Ennis.

So that concludes the summary of Ms. Cullen's statement, and it is available on the Inquiry website. 13:56

Now, turning back to Ms. Long's evidence today, Chair,

you will note that there are two statements from Ms. Long that we will be considering in the evidence today. Before Ms. Long gives her evidence, I would like to set those statements in context, briefly.

13:56

While the primary focus of Ms. Long's evidence will be on the general role and responsibilities of the RQIA for the purposes of this Organisational Module 5, she will also address issues relating to the RQIA's role in respect of the issues that arose in the Ennis Ward in 2012. The Panel will recall that when senior counsel to the Inquiry introduced Evidence Module 6 on 10th June, which has addressed the Ennis process, he indicated that requests to certain organisations for corporate statements had also included discrete questions about Ennis. Such questions were included in the letter of request for a statement from Ms. Long. Those questions were as follows:

13:56

13:57

13:57

"1. What role did RQIA have in the investigation into the allegations in November 2012 arising from Ennis Ward?

2. When and how did RQIA receive the Ennis Report? Please provide details.

13:57

3. What was RQIA's response to the Ennis Report?

4. What role did RQIA have in the oversight of the

implementation of recommendations arising from Ennis?

5. What steps, if any, did RQIA take to investigate other wards following the situation that arose at Ennis Ward? What actions were taken following any such investigations?" 13:58

So, rather than call upon an RQIA witness to participate directly in Evidence Module 6, the Inquiry has asked that Ennis-related issues be addressed in organisational statements, where appropriate. A similar approach has been adopted to the PSNI, Public Health Agency, and the Health and Social Care Board. 13:58

This, of course, is in keeping with the Inquiry's approach to Ennis. Rather than examining the granular details of the various processes that resulted from Ennis, the Inquiry has focused its attention on matters such as the nature and effectiveness of the approach adopted to the issues arising; whether the matter ought to have been dealt with differently; the lessons to be learned; and whether the issues arising in Ennis should have prompted a wider examination of conduct and practice within the Hospital at that time. 13:58

13:59

Turning then to Ms. Long's statements.

The first statement she made, dated 29th March 2024, is dedicated to the RQIA's response to the questions

concerning Ennis.

Her second statement is dated 26th April 2024, and that is, in fact, the primary statement for the purposes of Organisational Module 5, which addresses the mechanics and effectiveness of RQIA inspection. I am, therefore, going to deal with that statement first in my questioning of the witness this afternoon. 13:59

There is one final matter that I want to address briefly before the witness is called. 13:59

As a follow-up to the witness's first statement concerning the Ennis Ward, she also provided the Inquiry with a supplementary statement dated 7th May 2024, to exhibit a large number of documents relating to Ennis and within the possession of RQIA. 14:00

Those exhibits, Chair, run to over 700 pages. A significant number of those documents had, in fact, already been included within the Ennis Bundle that had been compiled by the Inquiry team. 14:00

In addition to those documents, there are also many documents that are not considered necessary for the purpose of the Inquiry's analysis of Ennis, having regard to the Inquiry's approach to this matter as I've already outlined. 14:00

I would emphasise that this implies absolutely no criticism of the witness, as she has quite properly sought to assist the Inquiry by providing this material and, in fairness to the witness, the Inquiry did not provide RQIA with the Ennis Bundle itself when Ms. Long was invited to make the statement. Perhaps that ought to have been done. 14:01

In any case, the Inquiry counsel team is now assessing this material, adopting the same approach to its initial compilation of the Ennis material, and it may be that from this material we will add a small number of documents to the Ennis Bundle, and we will, of course, keep Core Participants updated in that respect. 14:01

I should add, Chair, that the supplementary statement also exhibits a few documents that had not been located by RQIA at the time of the first statement, and I'm going to deal with those corrections briefly when the witness comes to give evidence. 14:01

Thankfully, Chair, there is nothing in the additional documentation to which I have referred that is going to require any pause before Ms. Long's evidence. The Inquiry counsel team is confident that we can proceed today with both parts of the witness's oral evidence relating to Organisational Module 5 and also to Ennis. It is hoped that the oral evidence in respect of RQIA will be completed today and tomorrow when we hear from 14:02

the two former Inspectors, and I should, however, emphasise that it will be open to the Inquiry, if necessary, to supplement the evidence as appropriate as we approach the final stages of the Inquiry.

14:02

It may be, for example, that the Inquiry will wish to follow up the oral evidence this week with further questions to be addressed on behalf of RQIA, and it may be appropriate to receive a further supplementary statement to address any such questions. It will be open to the Panel to require further oral evidence, if that appears to the Panel to be necessary or desirable.

14:02

And with those considerations in mind, perhaps the first witness, Ms. Long, can now be called.

14:03

CHAIRPERSON: But if -- the effect of all of that is that you hope to be able to question Ms. Long fully now, without with recourse to any additional documents. If, in fact, it turns out that additional documents are critical, we can always go back to the witness.

14:03

MS. BERGIN: Yes, Chair, that's correct.

CHAIRPERSON: All right. All right. Well, let's proceed and see how we do. Let's get Ms. Long in.

MS. LYNN LONG HAVING BEEN SWORN, WAS EXAMINED BY MS. BERGIN AS FOLLOWS:

14:03

CHAIRPERSON: Ms. Long, can I just welcome you to the Inquiry. Thank you very much for taking the time that

you did to make your statements and for giving us your time this afternoon.

A. Thank you.

CHAIRPERSON: Okay. Ms. Bergin.

113 Q. MS. BERGIN: Thank you, Chair. Good afternoon, Ms. Long. We met briefly. As you know, I am Rachel Bergin, I am one of the Inquiry counsel team, and I've explained to you how we will be moving through your evidence this afternoon. 14:04

Now, you should have some documents in front of you. Firstly, you should have a cipher list, and just to remind you, where you need to refer to the individuals who have a cipher in front of you, please refer to them by that cipher, and if you are in doubt about the name of any patient or staff member, please just check with the Secretary, okay? 14:04 14:05

You should also then have two statements in front of you, and I just want to ask you to confirm, there appear to be some notes written in those statements; are they notes that have been written by you or... 14:05

A. Yes, they are my own notes.

114 Q. Okay. Thank you. Now, your first statement is dated 29th March 2024, and you've signed that statement at the back, there's a Declaration of Truth. I understand that you have some corrections to make to that statement. So, subject to the Panel, if we can go through those now, please? 14:05

CHAIRPERSON: Yes, please.
MS. BERGIN: And perhaps that statement could also be brought up on the screen? Thank you. So if we begin with paragraph 28.
CHAIRPERSON: Page 7. 14:06
115 Q. MS. BERGIN: Yes, Chair. And I understand, Ms. Long, that three lines down into paragraph 28, the name "Maura Mannion" appears, and it should in fact read Aine Morrison. Is that correct?
A. That's correct 14:06
116 Q. If we could then go to paragraph 45, please? And in the second line of your statement, it should now read:

"RQIA does not have a copy of the meeting minutes from this date but has located a briefing note completed by 14:07 the Belfast Health and Social Care Trust dated 9th January 2013."

Is that correct?
A. That's correct. 14:07
117 Q. Yes. Thank you.
CHAIRPERSON: Yes. Hold on. Yes.
118 Q. MS. BERGIN: Paragraph 47, please. And the third line down, beginning with the sentence "RQIA", that sentence should now read as follows: 14:07

"This incident is referred to in the SCCG minutes from 5th April 2013, and a notification of untoward incident referral from the Belfast Health and Social Care Trust

makes reference to this incident."

A. That's correct.

119 Q. That's correct. A document has now been located?

A. Yes. 14:08

120 Q. Yes. Thank you.

CHAIRPERSON: Yes. Is there anything else?

121 Q. MS. BERGIN: Yes, thank you, Chair. Paragraph 51, and we're not making a correction here in terms of changing the language, but I think is it correct that in 14:09 relation to the second sentence, which states that the three suspended staff had returned to work, is it correct that you wanted to indicate that you have since been informed that that is based on a minute which is incorrect. 14:09

A. That's correct.

122 Q. And who were you informed by in relation to that?

A. It's my understanding the Belfast Trust made RQIA aware of that.

123 Q. And the Inquiry can follow up on that. Okay. And, 14:09 finally, if we could go to paragraph 57, please? And the final sentence in that paragraph, beginning with the word "In", should be replaced with the following:

"Dr. Milliken provided a response dated 26th February 14:09 2013, which addresses the concerns raised by RQIA and provides a background to the patient's medical history, medication prescribed, and reviews of the same."

CHAIRPERSON: I'm so sorry, can we have that again?
MS. BERGIN: Yes, of course, Chair.
CHAIRPERSON: So he did provide a response in fact?
MS. BERGIN: Yes, Chair.
CHAIRPERSON: 26th February same year? 14:10
MS. BERGIN: 2013.
CHAIRPERSON: Can you just read out what you've just said?
MS. BERGIN: Yes, of course.
14:10
"Dr. Milliken provided a response dated 26th February 2013, which addresses the concerns raised by RQIA and provides a background to the patient's medical history, the medication prescribed, and reviews of the same."
14:10
Is that correct, Ms. Long?
A. That's correct.
124 Q. Thank you.
CHAIRPERSON: Okay.
125 Q. MS. BERGIN: And I did say that was the final one, but 14:11
there is actually one more correction at paragraph 65, please, it's a minor one. And the date referred to, 8th March, should in fact read 20th March, is that correct Ms. Long?
A. That's correct. 14:11
126 Q. Thank you. So, subject to those corrections, are you content to adopt that statement as your evidence before the Inquiry?
A. Yes.

127 Q. Thank you. Moving then to your second statement, you should also have it before you, dated 26th April 2024, which you have signed also, and are you content to adopt that statement as your evidence?

A. Yes. 14:11

128 Q. Thank you. So, as I've already indicated, those statements are published on the Inquiry website, and the Core Participants and the Panel have all had an opportunity to consider those.

14:12

Before we begin, if I could just remind you, as I have to remind myself sometimes, to try to speak as slowly as you can, and speak into the microphone, just for the ease of the stenographer. We will take a break at an appropriate time, but if at any stage you require a 14:12 break, please let us know. All right?

So, I'm going to start with your second statement, all right? Have you got that in front of you?

A. Yes, I have. 14:12

129 Q. Yes. Now, this statement deals with the effectiveness of RQIA's inspection processes, and as I've indicated to you, we will then separately deal with the Ennis questions in a moment.

14:12

Your statement is provided on behalf of RQIA, and as you've heard, the Inquiry has already heard evidence from RQIA, and is it correct that you have a professional background as a nurse from 1992?

A. That's correct, yes.

130 Q. And you had some experience working with patients with learning disabilities?

A. Yes, that's correct.

131 Q. And you joined RQIA as an Inspector in 2009? 14:13

A. Yes.

132 Q. And you've held various positions within RQIA during your time there?

A. Yes.

133 Q. As an Inspector between 2011 and 2013 within the 14:13 Independent Healthcare Team; and then as Assistant Director; and then your current post then as Director?

A. Yes.

134 Q. I don't need to go to the paragraph, but within your statement at paragraph 72, you refer to having 14:13 personally made a decision about an announcement -- an announced inspection in 2020 in relation to Muckamore, and that concerned compliance around two improvement notices for patient finances and adult safeguarding. Were you involved in any inspections at Muckamore? 14:14

A. Yes.

135 Q. Yes. Can you give us a brief outline of the time period during which you were?

A. So my first inspection working in RQIA in Muckamore was in February 2019, when we undertook the first 14:14 inspection using a whole hospital approach to inspection, and I was part of the inspection team at that stage. And then in my role as Assistant Director, and more laterally as Director, my involvement in

inspections has potentially moved from being on-site inspection to meetings with senior leaders within the Belfast Trust as part of the review of governance arrangements within the Hospital. So I've had various opportunities since 2019, February, to be involved in in inspections in Muckamore.

136 Q. Thank you. So your evidence, whilst you provided a statement on behalf of RQIA as a body, you're also able to speak to your experience as an Inspector at Muckamore as well? 14:14 14:15

A. Yes.

137 Q. Now if we could begin by looking at paragraphs 7 to 9, and I am going to summarise really what you say here and then ask you about this, okay? So, here you say that: 14:15

"RQIA made a significant change in approach to the inspection of Muckamore in 2019 when it changed from ward-based inspection to the inspection of Muckamore as a whole..." 14:15

- as you've just referred to.

"The potential benefits of the whole site approach were reinforced to RQIA by the findings of the "A Way to Go" Report..." 14:15

- which we know was published in November 2018:

"...and since 2021, Inspectors have been aligned to a particular Health and Social Care Trust rather than wards across a number of services, which didn't promote broad oversight of the service beyond ward level."

14:16

Was the change to the whole site inspection model in 2019 just a change made in relation to Muckamore, or was this a change across all of the sites that Muckamore -- or that RQIA would inspect?

A. So the change in -- the first inspection using that methodology was 2019. RQIA had made the decision to change the methodology in 2018, and that coincided with the change in internal structures within RQIA, and the mental health and learning disability team moved into another directorate under a former director at that time, and the approach that was considered beneficial was really adopting that which had been applied across acute Health and Social Care Trusts. And in answer to your question, we were seeking to -- I mean Muckamore is unique in that the service provision of inpatients is contained within one site in the Belfast Trust, but the approach was adopted across service provision for mental health and learning disability across all Trusts, so we were seeking to inspect a whole service, and we viewed Muckamore, and the wards within it, as a whole service for patients with learning disability who were inpatients in hospital.

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CHAIRPERSON: Can I just ask, that change wasn't triggered in any way by the events at Muckamore?

A. It wasn't. It was more to align to the approach that the organisation had for our acute hospitals, and the benefits that had been realised by taking that approach. And as you've said, in terms of the information received in the "A Way to Go" Report as well, that reinforced that approach as beneficial.

138 Q. MS. BERGIN: Yes. Thank you. If we could look at paragraph 15, please? Now, here, you state that a significant disadvantage of individual ward based inspection is that it provides RQIA with a snapshot of just one ward and doesn't help identify trends across a whole site, and then later on in your statement, and we'll come to this, you refer to the alignment of inspectors to wards, so inspectors built knowledge of a service and recurring themes over time. 14:18

When inspecting individual wards, was there a risk that if Inspectors were dealing with the same ward every time they did an inspection, that they could become familiar with the wards, and that that would be detrimental to the inspection process? 14:19

A. I think there's a benefit as well as a risk. I think if you become familiar with the layout of a ward, the environment, the types of patient care and treatment that takes place in that ward, I think that's beneficial, and I think you bring a history. I mean, our Inspectors are all professionally qualified and certainly learn a lot about a service and how it is provided at ward level, having had knowledge and 14:19

expertise. I think RQIA have systems in place to take account of where there is that potential for people to become familiar and potentially then not challenge, but those systems relate back to peer review of the outcomes of inspection, discussions with peers, and also with senior staff within the organisation who would be reviewing the outcomes of inspection, and through supervision and discussions with staff, that there would be respectful challenge and opportunities to identify if matters hadn't been specifically addressed as part of an inspection. 14:19 14:20

139 Q. I want to ask you more about how, I suppose frequently, the same Inspectors might have been inspecting wards in terms of that? And if I could, just to illustrate this, have the statement of Alan Guthrie, please, and paragraph 6. Now, Mr. Guthrie hasn't yet given evidence to the Inquiry, so he can be asked about this, but at paragraph 6, Mr. Guthrie states in his statement that he was an Inspector between 2013 and 2020, and he states that: 14:20 14:20

"The Senior Inspector or Head of Programme reviewed and realigned inspector caseloads annually in March every year. Subsequently, with the exception of Six Mile Ward, I did not maintain a consistent caseload of wards in Muckamore." 14:21

So there appears, and correct me if this is wrong, but there appears to be some difference in terms of

Inspectors inspecting the same wards, or Inspectors, as Mr. Guthrie appears to be saying, not doing that. Can you tell us about the allocation of ward inspection?

A. So, at that point in time there was an allocation, and Mr. Guthrie is correct, those would have been revisited on a regular basis, and that is to try to address some of the challenges that there can be with the same people inspecting the same wards. I think where Muckamore is concerned, there was so much of a changing profile to the wards, and the patients, and the staff that worked in Muckamore, from our perspective, that, you know, had you have gone back, the potential would have been that there wouldn't have been the same people, the same staff, or the same profile of the ward at that point in time. But RQIA did have a policy, and do have a policy for, I think it's 20% of caseloads should be rotated on a regular basis, and that is to try to address issues of high profile services, and I'm talking particularly -- we don't just look after Muckamore, but all of our registered and regulated services, and there's opportunity then where people have particularly challenging services within their caseload, that they have an opportunity to have some relief, and potentially maybe someone could have a caseload where quite a number of their services would be known to the organisation to be risk challenging services, and, again, it's to try and mitigate some of those matters.

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140 Q. Thank you. If we could look at paragraph 30, please,

of Ms. Long's second statement? And at that paragraph, and in the proceeding paragraphs, you explain how RQIA's time and resources during inspections needs to be focused on key themes which are generally identified before inspections, based on intelligence about the Hospital, or a review of previous recommendations. And at paragraph 30, in particular, you state that:

"It is difficult for RQIA to reach a conclusion on the effectiveness of its systems for identifying themes, but it is apparent that the Inspector's methods were identifying areas for improvement and leading to recommendations being made."

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14:23

While it is true that RQIA was identifying areas for improvement at its inspections, given that both the Ennis allegations in 2012, and the CCTV events that unfolded in 2017, seem to have resulted in much more critical or higher volume RQIA inspections than immediately prior to those, what does that say about the effectiveness of RQIA inspections?

14:24

14:24

A. Sorry, could you repeat your question?

141 Q. Yes, of course. So, if we're looking at the topic of how effective RQIA's inspections were, and you've made the point at paragraph 30 of your statement that it's difficult for RQIA, I suppose, to quantify how effective they were, but certainly recommendations were being made, the question that I'm asking you in that context is; given that we know now, I think, that after

14:24

the 2012 Ennis allegations, and after the 2017 CCTV matters came to light, it seems that RQIA had a higher level of engagement with Muckamore, and a higher frequency of inspections compared to before. So can you comment on what you think that says about the effectiveness of RQIA investigations before those incidents? 14:25

A. I think if I could take the Ennis piece first, which occurred in 2012. From RQIA's perspective, the Mental Health Commission came across in 2009, and we started from a very static position in 2009, where we didn't have a former inspection methodology to immediately start with, and our inspections at that time, '10 and '11, were focused particularly on patient experience. Certainly, from our perspective following the Ennis allegations, we -- our role is to understand how safeguarding is being managed and, in doing so, we were keen to understand that the issues being identified in Ennis were not being evidenced through poor adult safeguarding processes in other wards, and I think that accounts for our inspections to the majority of other wards during 2013, I think there were ten other operational wards in Muckamore at that time, and eight of those wards were inspected in 2013, and the final two were inspected early in 2014, and I think that was in line with our regulatory responsibilities within adult safeguarding to check that patient care and treatment and adult safeguarding processes were being handled as they needed to be, and in line with the 14:25 14:26 14:26 14:26

regional procedures at that time.

142 Q. When you say that the focus, the prior focus was really on patient experience, do you think that there was, I suppose -- or do you think that was a detriment to being able -- for Inspectors going in to be able to look at wider issues that might not have perhaps then been spotted because they were so focused on a theme of the inspection? 14:27

A. That's not my view, having read -- obviously you'll appreciate that I have gathered a lot of evidence from other former colleagues, and I have read a lot of the information and the inspections at that time, but even then, where we were identifying issues that were not in line with best practice, and were highlighting that there were safeguarding concerns, or they were brought to our attention by patients at that time, it's my understanding that those matters were being raised and escalated within the Trust, even prior to some of the information that came to light as part of the Ennis Investigation. 14:27 14:28

143 Q. If we could look then at paragraph 32, please? And here you outline that:

"The current system limits the potential to track issues over a longer period than beyond the previous inspections, but Inspectors did also consider new themes, including those that had been reported on previously." 14:28

So it's not the case that once a recommendation was identified and compliance was reached, the matter would never resurface. So we're looking here at the ability of Inspectors, when they're going in to inspection, to look back, to go in with a view of the full context of the ward that they're going to.

Was there any system so that key issues in a specific ward were highlighted to Inspectors from previous inspections? 14:28 14:29

A. So the system that was employed at that time really was around the methodology for inspection, and I think my colleague, Chief Executive Briege, has provided some of that previous evidence to the Inquiry. So we would talk about themes, or key lines of inquiry, and those themes and key lines of inquiry are the same for all mental health and learning disability inspections that we would do. So we would start any inspection planning with those 10 or 12 key themes, and based on the intelligence that we have that has arisen since the previous inspection, as well as the previous areas for improvement, any intelligence, or concerns, or information that we have received will also lead us as part of our pre-inspection and intelligence to determine what themes need to be taken account of. If we were doing a whole hospital inspection, all of those themes would tend to be taken account of, but if we are addressing issues that relate specifically to a particular issue, we would focus in on maybe two or 14:29 14:29 14:29

three of those key themes as part of a more targeted inspection approach.

144 Q. Just staying on this topic, throughout your statement there's reference to, and the documents indeed also, to Inspectors looking at the prior inspection recommendations when looking forward to the next inspection. How far back, or was there any guidance to Inspectors as to how far back they might be expected to go to sort of try themselves even to track any issues with the wards that they were going to see? 14:30

A. So, from that perspective when we would undertake an inspection and the matter has not been addressed, so if we've made areas for improvement or recommendations in a report and those have not been addressed, or only partially addressed, at the next inspection they would be carried forward, and subsequently Inspectors would have been alerted to the fact that this issue had been ongoing for a period of time. So if we had stated it again, or indeed a third time, that would have been evident throughout the inspection reports. But I also think it's important to reflect on inspector knowledge and expertise of the services, and the fact that they worked reasonably close together, that there would have been opportunities to identify where services had come into and gone out of compliance, and that can happen, and be identified for consideration at the next inspection. What I would say is, we have limitations. We have a current IT system that is better than what we had previously, but RQIA recognise that there are

limitations to the intelligence and data that is provided to Inspectors to support them, and we're hopeful - we've had some positive funding from the Department of Health to look at our current IT system in a way that would be more enabling to identify and track themes and trends over time.

145 Q. I'm in fact going to come on to that now. So, at around paragraphs 34 and 35, you explain further in your statement the iConnect system?

A. Yes. 14:32

146 Q. And as you've also said in your evidence today, really the identification of themes or trends is very reliant at present, it seems, on individual inspector knowledge, would that be fair?

A. Yes. 14:32

147 Q. So, in terms of what the iConnect system currently looks like, we'll come to I suppose future matters, what exactly is held on that system? You've referred in your statement to Inspectors being able to ask for bespoke intelligence about certain matters before they do inspections? 14:32

A. So that system, and I suppose it's important to say that that system was created for some of the mental health and learning disability functions back in 2014, and that was when all of our inspections and concerns, etc., were recorded, and then again in 2019 when patient information was created on the iConnect system. So we've had a couple of iterations of iConnect in terms of information in relation to Muckamore. But 14:33

that information system retains all the notes of previous inspections. So it would give you the dates of all of the inspections, it will also advise where there has been an SAI in respect to a patient who is residing in some of our mental health and learning 14:33
disability wards. So you would have SAIs, detention information, you would have any concerns, complaints, information received from relatives or patients with respect, or staff, any whistleblowing. So there's quite a bit of intelligence, early alerts around the 14:34
system, retained in there, and that would all be considered by an Inspector in terms of making a decision to undertake an inspection and/or once the decision has been made, to seek information that would support the themes that are to be considered as part of 14:34
that inspection.

CHAIRPERSON: So, was all the information from previous inspections, prior to iConnect coming online, was all of that loaded into the system?

A. No, it wasn't. 14:34

CHAIRPERSON: Right. So what happened to all the old stuff?

A. So the older inspections were retained in manual records on an M-drive folder, so in some cases paper copies, and they've been stored offsite in Oasis back 14:34
in 2009 and 10, and in other cases what we would call an M-drive, and I apologise, I'm not very IT --

CHAIRPERSON: That's fine. So when did iConnect actually come online?

A. So for inspections of mental health and learning disability, in 2014.

CHAIRPERSON: Right.

A. And specific patient information around detentions and different parts of the Mental Health Order, in 2019. 14:35

CHAIRPERSON: Right. Okay.

148 Q. MS. BERGIN: So if I'm correct in what you're saying, that system itself can't -- it's not I suppose intelligent in terms of being able to analyse and track specific data about trends or patients, is that 14:35 correct?

A. That's correct. It would be reliant on an Inspector asking our information team to provide information within parameters that they would set. So, for example, how many concerns have there been about a 14:35 particular ward, or in that hospital, but that would be at the Inspector's request; it's not producing reports and data. And I suppose it's important to say if we think about the Quality Standards in 2006, the Department of Health Quality Standards, which are the 14:36 minimum standards against which we inspect, there are five quality standards. So most of our inspections and areas for improvement will fall into one of those five breaches of minimum standards.

14:36

The system, as it stands currently, will only be able to tell you which one of those five areas for improvement have been breached, and it requires the Inspector then to undertake quite a manual process to

identify if there are similar breaches contained within the information in the area for improvement that they've made. That said, the Inspectors are very good at that, but that's a very time-consuming, labour-intensive process at this time.

CHAIRPERSON: Could I just ask this: To what extent, if at all, do you liaise with the CQC in England to see what their systems are and to try to learn from each other?

A. So, we do -- there is -- our Chief Executive currently sits on a Five Nations Regulatory Group and meets with the other Chief Executives. But also, at my level, we would reach out to the other directors with respect to mental health and learning disability. Now, I am aware that CQC have just implemented a new system that is supporting them to identify themes and trends, and it's my understanding that as we develop our strategic outline case for the new information system, that we are reaching out to other regulators, HIQA and CQC, with a view to determining whether or not our new system, that's -- that will take some time to develop -- can learn from some of the things that they...

CHAIRPERSON: Well, that's what I was going to ask. When you purchased iConnect, did you look at how it could be adapted for the future to identify trends and do the same sort of thing that CQC is trying to do?

A. I'm not aware, Chair, if we did reach out at that point in time, I'm sorry. iConnect was developed in 2013 for our other regulatory system, so our registered services

of care homes and children's homes. So it was in its infancy back in 2009/2010, and came into effect in 2013, and then mental health and learning disability team adopted it, with the new module being built specifically for patients throughout 2018 and commencing in 2019. So I'm sorry, I don't -- 14:38

CHAIRPERSON: No, that's fine. Okay. Thank you.

A. I'm not sure.

149 Q. MS. BERGIN: Apart from individual Inspectors as you've said manually going to the team and asking for these searches to be done, do RQIA ever carry out, I suppose, periodic reviews of even the data that you do hold on iConnect? So, for example, would there be a periodic review of a particular site like Muckamore, so that RQIA, at the end of a year or a six-monthly period, could have a global picture about what's happening on that site? 14:38 14:39

A. So, in terms of that, it's back to what I have just described, that would be at the request. So it's not -- it's not an automatic thing, but where the Inspectors would find that that is beneficial to support their decision-making, then we could ask our information team to produce a report, and often they do ask for what we call a self-service report. So each service, a service like Muckamore, our information team can produce a self-service report, and when that's produced, that still requires our Inspectors to analyse the information within it and make determinations regarding patterns and trends. 14:39 14:39

We've a couple of other systems that we've introduced back in 2020/2021, around safety briefs. So the team themselves, the team of Inspectors meet on a weekly basis, and they will share and discuss where they have concerns, or where they identify that they have received information that would be useful to the rest of the team, and may indeed identify that there's a problem emerging in a particular service area, and those are replicated then at directorate level. So I hold a directorate safety brief on a weekly basis with my Assistant Directors as well, where matters can be escalated and discussed at my level in terms of decision-making around particular issues that are emerging. 14:39 14:40 14:40

150 Q. Thinking back, and I appreciate it may not have been you personally at this time, but thinking back based on your review of the documents also, prior to the iConnect system, and certainly around the time of Ennis, or pre-2014 when the iConnect system came in, was there any level of analysis or data provided to the directorate level even of RQIA, so someone at directorate level could I suppose have a global view of what the level of incidents or issues were at a particular site like Muckamore? 14:40 14:41

A. I'm not aware, and I haven't -- I don't think I've read anything of that in the evidence that I have looked at in preparing my statement. I do know that certainly matters such as the Ennis matter were being discussed

within RQIA, and what was known at that time as our Serious Concerns and Complaints Group. So matters that required to be escalated were being escalated, and matters that were requiring to be escalated over time, there was evidence within the minutes that those things were being discussed by the director to the relevant attendees of that group.

151 Q. Thank you. At paragraphs 36 and 37, you say here that the RQIA inspection system is paper-based. Looking to the iConnect system also, what part of it is currently paper-based? 14:41 14:42

A. Yeah. So it's described as paper-based. It may well be that -- so that refers to the record of inspection and where we talked about the key themes and trends. So at this point in time, the inspection team will manage that in a particular way. So they will have a blank copy of their record of inspection, and when they are out there they will take manual notes of things that they identify as part of the inspection. That record of inspection is then, when completed and signed by the Inspector, and used very much to prepare their inspection report and their findings, that will be scanned and uploaded on to the iConnect system. I think what we're aiming for is some form of mobile technology that would allow that record of inspection to be transferred on to an IT system that would allow for better capture of data in real time. 14:42 14:42 14:43

152 Q. And in fact at these paragraphs also, 36 and 37, you refer to RQIA's position in welcoming, and you've

talked about funding earlier, a new IT system that would enable there to be support intelligence enabled regulation, and you've indicated in your statement that there's new software that is likely to be three to five years away. So, first of all, earlier in your evidence, you referred to some good news about funding; is there anything that you can elaborate in respect of that? Is there progress since you've made that statement? 14:43

A. So the progress in terms of funding is that we have received funding that has allowed RQIA to employ a full-time project manager to develop the strategic outline case, which is the first stage in terms of submission to the Department, and we've been given the resource, the funding for the resource of that individual to do the scoping for IT systems that are available in other parts of the UK and other regulators, and that is the positive message that there has been so far in terms of funding for that. 14:43 14:44

153 Q. I appreciate that system isn't in place at the time, but in terms of the issues that we've discussed around RQIA having a, I suppose a global view about a particular site at one period in time so they can track changes at the minute, have there been any changes made in RQIA in terms of how you're currently tracking or analysing data at the minute, until this system comes into place? 14:44 14:44

A. So I think the key perspective of that is our weekly safety briefs. So inspections of Muckamore, as it

stands currently, we tend to be in Muckamore three times a year in recent times, doing a whole system inspection. Those inspections involve a number of people, and it is those people, the key people are our Inspectors, with the knowledge and expertise that they have, coming together on a regular basis to share information, and that is supported by what I've advised of the self-service report, and also where we are tracking matters such as SAIs, or early alerts, or particular concerns. So we've developed reports, regular reports to our Executive Team and authority, we call them Performance Activity Reports, so they will identify particular matters that will support us to understand if there are some patterns or trends emerging or matters that are outstanding that we've requested. So things like returned quality improvement plans, or late SAI reports that are required, those matters are being flagged to myself as the director, and to the teams, and to our Executive Team and Authority Board. They're still limited. 14:45 14:45 14:45 14:46

154 Q. Thank you. If we could look at paragraph 38, please? And here you state that, and we're dealing with the effectiveness of RQIA systems following up on recommendations, and here you state that: 14:46

"If a recommendation has been stated for a second (or third) time, the date by which compliance must be achieved is determined by RQIA."

So is the date for compliance not determined by RQIA if it's only the first time a recommendation is made?

A. So, the date for compliance with a recommendation that is made doesn't change. So if it is being made at the point of inspection, and we revisit it and it has not yet been made, that date doesn't change; it is a case that that was not complied with within the relevant timescale.

155 Q. Okay.

A. Now, we would seek to understand as to why that particular recommendation has not been met or complied with within that timeframe, but the timeframe wouldn't tend to change, or shouldn't tend to change; it's just that it has gone beyond that particular timescale for compliance. 14:47

156 Q. Thank you. And then staying at paragraph 38 onwards until paragraph 42 here, you outline that:

"Where a recommendation from a previous inspection has not been met..." 14:47

- as you've said:

"...the recommendation is stated again and the report highlights how many times this has been stated..." 14:47

- the recommendation. And you say that:

"Some recommendations are escalated to senior Trust

personnel as serious concerns and that process elevates a recommendation beyond the normal process for following up on recommendations."

And you've given examples that this might occur where there's an issue which is considered to be particularly serious, or a lack in progress in terms of implementing previous recommendations, and you've indicated that RQIA have convened serious concerns meetings with the Belfast Trust in relation to Muckamore. 14:48

Now, do serious concerns meetings tend to precede the occurrence of a safeguarding concern, or what would be the interplay, if at all, between safeguarding matters?

A. If adult safeguarding matters arise as part of an inspection and there are issues, I think there are a number of processes. So if an Inspector would identify an issue or a concern that would require a referral to adult safeguarding, they would be asking for that to be made as part of that inspection, and checking that it has been made. 14:48 14:49

In terms of adult safeguarding recommendations, where we've made a recommendation because a particular -- and that tends not to be where a particular adult safeguarding referral hasn't been made, because we wouldn't wait for that to write a report and make a recommendation, the Inspector would be seeking for those matters, in terms of risk and patient safety, to 14:49

be addressed immediately through the adult safeguarding process. Where we make recommendations that highlight that there are weaknesses or gaps in the adult safeguarding processes, those can be followed up as part of a recommendation, and reviewed through the returned quality improvement plan submitted to us by the Trust, and also at the next inspection. The two wouldn't be mutually exclusive of each other, and so adult safeguarding matters that arise, and RQIA's involvement when an adult safeguarding issue does arise and is being handled through those procedures, would be twofold. We'd want to be ensuring that the patients on site, or in that ward, are also protected, and that there aren't other widespread safeguarding matters that need to be addressed, but also from our independent perspective within the Joint Protocol and being part of the adult safeguarding strategy meetings and protection planning at those points in time. 14:49 14:50 14:50

157 Q. Thank you. And in terms of how frequent or not those meetings are, is it only the most serious types of issues that are escalated, or how frequently would RQIA be involved in those types of serious concerns meetings? 14:50

A. So from the information that I've looked at, I think there were approximately 15 serious concerns meetings with personnel in Belfast Trust as a result of matters that were identified as part of an inspection, and those were handled in line with our escalation, and also our enforcement procedures. And. Again, RQIA 14:50

would take action, even when something has only been identified for the first time, if the risks are such that it wouldn't be sufficient to wait for a report to be produced and a recommendation to be made. So they have been -- there has been quite a number of escalations over a period of time.

PROFESSOR MURPHY: Could I ask how long that period of time is when you're saying there were 15 such serious concern meetings? 14:51

A. From the information that I have, 15 times between 2011 and 2021. But I would also add that we also served improvement notices in line with our enforcement procedures in 2019, and in line with our enforcement procedures, serious concerns where a Trust would be the first level of escalation following an inspection, or an incident, or a matter that has been brought to our attention, and then when we would move that escalation further, the next stage would be intention meetings to serve an improvement notice, and in some cases we have served those improvement notices and in other cases we haven't. So the term "serious concerns" relates to a particular type of meeting, but there have been other types of meetings that have been called an intention to serve an improvement notice meeting, and meetings associated with those processes. 14:51 14:52 14:52 14:52

PROFESSOR MURPHY: Okay. Thank you. But could you give us some examples of what serious concerns might be, so that we can get a feel for the level that you're talking about?

A. So, I mean, I don't have all the examples of each of those, but certainly from my perspective in 2019, we moved to serve improvement notices as a result of critical staffing matters, adult safeguarding processes that were not being followed and were placing patients at risk as a result, and inappropriate management of patients' finances onsite. So where we believed that there were breaches in minimum standards and patients were at risk as a result, they would be escalated.

PROFESSOR MURPHY: So those were the improvement notices. And am I understanding you right that they all followed the raising of serious concerns in these serious concern meetings?

A. Not necessarily. So, they could -- so a serious concerns meeting could be one level of escalation, and where you would find that you would not have -- the issues would be such that you did not wish to move to serious concerns, and you believed that the risks were such that you needed to move beyond serious concerns to an intention to serve meeting. The normal course of action would be that serious concerns would be an opportunity for the Trust to improve, as would the issue of a recommendation within a report, but it doesn't say that we couldn't, given the risks associated with some of the matters, we find that we wouldn't move straight to an intention to serve.

PROF. MURPHY: Right. Thank you.

158 Q. MS. BERGIN: At -- just finishing off on the issue of serious concerns. Is there any notification to

patients or relatives that a serious concerns meeting has occurred, or the outcome of that?

A. No, those matters are not published on RQIA's website. We do publish our enforcement action at the point where we would be -- when we have moved to serve an improvement notice, or in the case of regulated services, a failure to comply notice. Those matters are published on our public-facing website. 14:54

159 Q. If a relative, for example, of a patient at Muckamore happened to raise a concern, or even if they didn't and they are just aware that their patient is at Muckamore, they're not in any way informed then that the ward that their relative is on is subject to, I suppose, a serious concerns meeting? That's not something that they're ever made aware of? 14:55 14:55

A. Not by RQIA. It may be that the Trust themselves have taken the opportunity to highlight that to the relatives. We do, when we publish our public-facing reports, if we have moved to undertake escalation or enforcement action, that will be recorded, but appreciating that the inspection report comes some time later. 14:55

CHAIRPERSON: So if a relative raises an issue with you, and you take it forward with the Hospital, does that relative ever know that you've taken it forward with the Hospital and what the result of that is? 14:56

A. So where relatives do raise concerns with RQIA, that information forms part of our decision-making, and if that information led us to take action, then we would

be contacting directly that relative with the decision-making and outcome from the matter that they've raised with us. The Inspectors would seek to advise, usually after we've taken our action, obviously inspections are unannounced, and we don't always wish for people to know that that is the decision that we've made in terms of our regulatory response, but often after we have been out to the Hospital, undertaken an inspection, a relative will be informed. 14:56

CHAIRPERSON: Well, are they always informed? 14:56

A. I'm not sure I could -- I have evidence to say that every time someone is contacted, but we would strive to do that where people have brought those matters to our attention.

CHAIRPERSON: And if you decide to take no action, for whatever reason, because you think the level of complaint perhaps is too low, are they informed of that? 14:57

A. Again, if we would be following up with the relatives, we would be advising that their information has been retained for intelligence purposes, that it's being managed through adult safeguarding processes, or perhaps a complaints process, and that at that point in time, that RQIA have logged their information as intelligence and will consider it as part of a further inspection. 14:57 14:57

CHAIRPERSON: Thank you.

160 Q. MS. BERGIN: Thank you. At paragraphs 43 to 46 now, please. Here, you deal with the effectiveness of

RQIA's inspections in responding to individual patient concerns, and you say that:

"Patient feedback is gathered by questionnaires and speaking with patients during inspections." 14:58

And you also say at paragraph 46, in fact, that:

"Concerns do not need to be actively stated by a patient for an inspector to respond." 14:58

But for those patients who might have concerns, some of those patients may be able to communicate with RQIA through questionnaires, but other patients, as we know at Muckamore, may have more complex communication 14:58 difficulties, or in fact be non-verbal. How did RQIA engage with then the range of patients that are at Muckamore, in terms of catering to those different communication needs?

A. So, from my understanding at those points in time, we 14:58 worked with other organisation groups to develop easy read questionnaires, and indeed some of our Inspectors have worked with patients with learning disabilities and would have had the ability to correspond through the staff at the service, maybe with other forms of 14:59 communication, and, again, seeking to maybe speak to the advocates for those patients, and indeed their relatives as well as the patients themselves.

161 Q. Thank you. If we could look at paragraph 49, please?

And here, you say that:

"By 2013, it is evident that in some cases recommendations can carry over from one inspection to the next without resolution, and while the RQIA outlined improvements needed, this did not always prompt a positive outcome."

So is that based on your review then of RQIA documents?

A. Yes. 14:59

162 Q. Yes. This seems to indicate, and correct me if I'm wrong, that RQIA's powers are, in reality, quite limited, short of recommending that a Trust be put into special measures. Would that be fair?

A. Yeah, I think there are limitations to RQIA's powers. 15:00 We don't have the same powers as our colleagues in CQC, and I think my colleague, the Chief Executive, did describe those powers and some of the limitations to them previously. That said, I do think when you're inviting a Trust to a serious concerns meeting and/or 15:00 an intention to serve an improvement notice meeting, that is, if served, going to make its way into the public domain, that those things are serious, and in some cases were responded to positively by the Trust. On reflection, and at the point where we were doing 15:00 single ward inspections, from the evidence that I've reviewed it's my view that some of the matters that RQIA were raising were beyond the remit of the individual ward managers and the staff within those

wards, and actually related to some of the systemic and governance issues with respect to the Trust. So although they were made about the individual ward, it was limiting that the individual ward manager had the ability to make those changes. 15:01

163 Q. And was there anything else that RQIA could do in those types of circumstances to progress those types of issues?

A. Certainly, I think when we moved to the multidisciplinary site inspection, where we were able 15:01 to have very robust evidence that these matters were evident across a range of wards and that they needed to be addressed through the Leadership and Governance arrangements within the Trust, it was at those points in time that we had an ability and an evidence base to 15:01 bring the Trust to those intention to serve meetings, and indeed to serve those improvement notices, and request recommends from the Department to place the Trust in special measures.

164 Q. If we look at paragraph 50 to 52 then? Thank you. And 15:02 at paragraph 50 you refer to RQIA being able to formally escalate issues to the HSCB. What types of issues would be referred or escalated?

A. So it's my understanding from the evidence that I have read, a couple of examples of that would be 15:02 correspondence with the PHA, who, I think when we describe the HSCB at that time also incorporated the PHA, who held some professional nursing roles, so particularly around some of the matters relating to

registrants in the Ennis Investigation, the former director at that time was having discussions and meetings with colleagues in PHA, and also there is evidence where the former director was raising issues with HSCB around the resettlement of patients from Muckamore. 15:03

165 Q. What's -- I suppose we've talked about RQIA escalating matters and acting on recommendations or making recommendations. What's the purpose of a referral from RQIA to the HSCB? 15:03

A. So I'm not sure that it's a referral but more to highlight -- so within our powers, it's RQIA's responsibility to bring matters of concern to the attention of the Department and/or the commissioners, and at that point in time the HSCB were commissioners, and it was through that mode that RQIA were bringing those matters to their attention, as they believed that the issue in respect to resettlement of patients was wider at times. I mean, Muckamore served more than one Trust, and some of the matters around the delayed discharges related to matters outside the Belfast Trust's control. So it's my understanding that that was the rationale for raising those matters at that time. 15:03 15:03

166 Q. And in relation to the matter you've just touched on about -- and if we look at paragraph 52, in fact, you refer to a Quality Improvement Plan following 2016 inspections in which patients had voiced frustration about delayed discharge, and then placement breakdown 15:04

and re-admission, and you say that:

"The Quality Improvement Plan noted a lack of involvement of psychiatrists and nursing staff in the commissioning, planning and delivery of community placements, and a lack of meetings between consultants and senior matters."

And that RQIA then did, in fact, write to the HSCB to highlight this as one such issue we've just discussed. Do you know in respect of this specific example, and I appreciate you may not, what effect, if any, RQIA's writing to HSCB about this had? Were there any changes or improvements?

15:04

15:04

A. I don't know the answer to that question.

15:05

167 Q. It may well be something that the Inquiry can follow up on, if required. If we could look at then paragraph 53, please? And here, staying on the same topic, you state that:

15:05

"In 2017, all patient concerns..."

- as far as you were aware:

"...appeared to be related to delayed discharge."

15:05

And RQIA highlighted the impact of delayed discharge to the HSCB on a number of occasions.

So in this instance, or indeed generally, would RQIA follow up with HSCB if they're having to, I suppose, relate the same issues over and over again? Do you know if, if RQIA had any response from HSCB in terms of this issue being dealt with? 15:06

A. I'm not aware of whether or not we received any formal communication from HSCB. I haven't seen anything to that effect in the papers that I've reviewed in preparing for today. I certainly did evidence through review of inspection reports that it was being 15:06 frequently mentioned that the issues around resettlement were being raised with the Health and Social Care Board, the commissioners, but I don't have any further information and wasn't part of those meetings. 15:06

168 Q. Do you know, though, when -- and this is one such example -- but do you know when this type of matter is referred or highlighted to the HSCB, would RQIA's involvement then essentially stop at notifying them? Would there not be any sort of further engagement to 15:06 follow up generally?

A. RQIA, at that point in time, did have some powers with respect to -- similar powers to what we would have had against Health and Social Care Trusts, we would have had the same powers at that time as the Health and 15:07 Social Care Board, but I'm not aware of any formal escalation that RQIA took at those points in time.

169 Q. Okay. Thank you. If we could look at paragraphs 59 and 60 of your statement, please? And here you say

that:

"In respect of whether sufficient time was available for RQIA Inspectors to complete inspections..."

15:07

- you say that every inspection is time limited and there are boundaries, having regard to proportionality of resources available, but it's not the case that an inspection must end on the second day. If an Inspector requires additional time, they could ask for an extension, and this has, in fact, occurred. 15:07

Now, I don't intend to take us to Ms. Cullen's statement, and I've already indeed summarised her statement in the evidence, and I've already highlighted what I'm about to say, which is that at paragraph 48 of Margaret Cullen's statement which is before the Inquiry, she states that: 15:08

"The last couple of hours of any inspection was usually spent preparing the report and summary and it felt as though we were always rushing. There was never really enough time." 15:08

So, what I want to ask you about that is, was the ability to extend inspections something that was actively made known to Inspectors, or do you think Inspectors were under pressure to comply with these timeframes? 15:08

A. Well, I think I'll answer that question having been a former Inspector and in my current role: I've never certainly felt that I've had any direction that I couldn't extend an inspection, bearing in mind the impact that an inspection has on any service, and when Inspectors are in services, particularly like Muckamore, it can be quite disturbing and distressing for patients to have strange people in their service, but I'm not aware of having any set time limits, having worked as an Inspector, that couldn't be extended, or further information couldn't be sought as part of an inspection. 15:08 15:09

CHAIRPERSON: Can I ask, how many inspections is an Inspector meant to conduct per week? Does it work like that or not? 15:09

A. It doesn't work like that, because in some cases, like a multi-site -- multidisciplinary inspection, it would be a team of Inspectors maybe over the course of a week, and indeed beyond, beyond the part of the visit that is onsite. If it was a care home of a small size, or a children's home, of which I'm responsible for, they may be able to do one or two in a week, but it may be that the mental health and learning disability team only do one inspection in a three or four-week period, or beyond, given the nature and size of the inspection. But there was no requirement -- the team would have had had a caseload and we would have been, at that time, hoping that all inspections on that caseload were covered, but there were opportunities, if you were 15:09 15:09

delayed in a particular inspection, where the team would have come together and someone who maybe had managed to cover their inspections at an earlier stage, would have supported other members of the team with their caseload.

CHAIRPERSON: Okay.

MS. BERGIN: Chair, I still have some way to go, not too much further in relation to this second statement, but I'm just conscious of the time.

CHAIRPERSON: Yeah, I was looking at that too. Presumably the Ennis side of life is going to be a bit shorter?

MS. BERGIN: Yes.

CHAIRPERSON: All right. Let's take a ten-minute break now. Thank you very much. We'll see you back in about ten minutes.

THE INQUIRY ADJOURNED BRIEFLY AND RESUMED AS FOLLOWS:

CHAIRPERSON: Thank you. Apologies for the slight delay. Are we now ready?

MS. BERGIN: Yes, thank you.

CHAIRPERSON: Okay.

170 Q. MS. BERGIN: Yes. Good afternoon, again, Ms. Long. If we just pick up again with Ms. Long's second statement, please? And I want to ask you very briefly, at paragraph 76, you indicate here that it has not been possible to compare the culture of different wards over a period of time based on your review of inspection

reports. Aside from inspection reports, in terms of other tools that RQIA might use, did they use anything, for example, the group home culture scale or any other types of models to try and assess culture?

A. I'm not aware of any specific tools used to assess culture as part of the inspections, from my perspective, and I think RQIA's perspective, culture is a very broad concept, and I believe that the matters that we've targeted as part of our inspection, such as adult safeguarding concerns, complaints, management restrictive practices, incident management, you know, autonomy, privacy, dignity for patients, have all formed part of our inspection methodology right from the inception of RQIA. We have, and do, look out to other pieces of other evidence-based practice and have used matters such as the Hull Indicators of Concern, or indeed CQC's reflections on the Whorlton Hall issues to review and enhance our inspection methodology over time. 15:32 15:32 15:33 15:33

171 Q. Thank you. And moving to paragraph 79, please. And keeping on the same topic in relation to, I suppose culture or observations of Inspectors on wards, and you say here that one of the observations when you were speaking to former or current RQIA Inspectors, was that, for example, patients in older wards awaiting inspection -- or awaiting resettlement, rather, rather than active treatment, had less MDT input. Now, that doesn't appear to be an issue that was raised during RQIA inspections. Is the lack of MDT or a lesser input 15:33

of MDT in those types of wards not something that would be of concern to RQIA?

A. It is something that would be of concern to RQIA, and I don't have the examples here, but I do believe where we talk about MDTs, such as positive behaviour support and the input of consultants, psychiatry, and psychology, has formed part of RQIA's decision-making with respect to our inspections. If it hasn't featured in reports, I don't have the answer as to why that is the case, and I'm certainly happy to look back over and provide to the Inquiry where there may be examples of those matters, and you'll appreciate I've taken a lot of my information from previous colleagues and current colleagues. 15:34 15:34

172 Q. Yes, certainly. And in fairness, Ms. Long, you do make that clear in your statement. 15:34

If we could look then now at paragraphs 84 and 85, please, and from these paragraphs onwards, really, you outline various methods by which RQIA tried to engage with families during inspections, and you list these, I won't go through them all, but they include sending questionnaires to be returned to ward staff, ward staff contacting families and offering them the opportunity to talk to an RQIA Inspector, and leaflets which ward staff were to distribute to visiting family members, and you say also that the number of responses from relatives was generally low, although that wasn't unique to the Muckamore site. 15:35 15:35

Now, one of the methods to try to improve family engagement was for Inspectors to remain on wards into the evening to try and speak to relatives when they might have been visiting. When did that happen? 15:35

A. So that would have happened as part of a normal inspection. So where an Inspector -- I don't have an example that I can talk to, but happy to have a consideration of have. So in some cases, inspections would have started early in the morning, and indeed 15:36 went on into the evenings, and then those opportunities would have been available should relatives visit at those times, but happy to provide examples of where those are the -- those have happened.

173 Q. Yes. Thank you. And do you know, and I appreciate in 15:36 light of what you've just said you might not, but do you know if there was any change in terms of engagement then with RQIA following that coming into place?

A. I'm not aware of the difference that that made in terms of relative engagement or the comparators, but I do 15:36 recognise that as an organisation, we have, over many years, utilised different methodologies to try and gather the views, recognising the importance of gathering the views of patients and their family members and, again, there's been a recent change around 15:37 us making direct contact with relatives as part of our inspection process, in an attempt to strengthen getting engagement from relatives.

174 Q. Yes. And I'm going to come to that now, in fact.

Could I just ask you to clarify, in terms of the, I suppose, the measure of RQIA staying later, is that something that was always the case, or was that something that was introduced more recently?

A. I think -- well, certainly from my perspective, I'm not sure about Muckamore, I don't have the evidence, the detail of the Muckamore inspections, but I do know that that's something that would have happened even back when I was an Inspector, that we would have sought to undertake a proportion of our inspections out of hours, weekends, out of hours, evenings, early mornings, in an attempt to speak to as many people as we possibly could and/or to target maybe matters that had been brought to our attention around issues that were happening over the weekends or late evenings. In terms of the relative engagement and the benefits that staying later in the evening brought to the inspection processes, I don't have that level of detail at this time. 15:37 15:37 15:37

175 Q. That's fine. Thank you. And to summarise then the various methods we've just discussed, it seems that what you've described in your statement are largely methods which require families to have contact with or go through ward staff to get to RQIA, in terms of making contact with the families in the first instance, and you've indicated that there was a change in approach in 2023, so RQIA now request relative contact details, you say in your statement, so that they can contact them directly. Would you agree that asking wards to invite families to speak to you could result 15:38 15:38

in, I suppose a bias, in terms of really only hearing from the families who are maybe having a positive experience?

A. So, I think there is a potential that that's the case, but I think in some cases RQIA would select patients as well as ask ward staff to select patients, and certainly the current position would be that RQIA would select the patients that perhaps we would wish to have contact with their relatives. So I think that negates that opportunity for ward staff to be selective, but I appreciate that RQIA don't have the contact details of the relatives, and they may not wish for RQIA to have those contact details. So that is a problem that needs to be continuously thought through to a resolution, and something that is positive that's not -- there isn't undue bias then in terms of selection. But I think questionnaires being left, and cards being left openly in wards, provides an opportunity to avoid some of that happening. 15:39 15:39 15:39

176 Q. Did RQIA have any engagement with any of the family or relative groups at Muckamore that we've heard about during the Inquiry? 15:39

A. So during my time as director, I know that certainly we have met on one occasion with the Friends of Muckamore group, following an inspection, where they were keen to understand the reason for the inspection and the outcomes from the inspection, and during that engagement we did offer that at any time we would be happy and welcome to come along to the group meetings 15:40

and to describe any matters that related to our regulatory role in Muckamore.

177 Q. And in terms of the change that we've just discussed, whereby RQIA can contact families directly, albeit through getting information being passed through the wards, I appreciate that's a relatively recent change, but can you say anything about whether there's been any sort of a noticeable change in terms of engagement with RQIA following that? 15:40

A. Outside of the inspection process, I'm not sure that there's been additional engagement with relatives coming to speak to RQIA, but certainly as part of the inspection process. So, for example, I think in 2022 we did an inspection that was targeted around 12 specific patients, and it's my understanding that at that time, that quite a substantial amount of those relatives did engage with RQIA as part of that inspection process. So from our perspective, we certainly - where we're selecting patients and their relatives - we are having engagement. 15:40 15:41 15:41

CHAIRPERSON: But can I just ask, when you're talking about having engagement with relatives, are you talking about on the ward, or are you talking about phoning people at home, offering them a Zoom meeting so they can speak in privacy to you? Does any of that happen? 15:41

A. That's correct. The new methodology is after the on-site visit, or perhaps during the on-site visit one of the Inspectors will remain at RQIA, and their role as part of that inspection is to make that direct

contact with relatives at home and/or over Teams or Zoom.

CHAIRPERSON: Right. And that does happen?

A. And that's happening now.

CHAIRPERSON: Right. Thank you. 15:41

A. Thank you.

178 Q. MS. BERGIN: Thank you. If we could look at paragraph 91, then, please, and here you indicate that:

"RQIA has to be mindful about what information it puts 15:42
into the public in terms of its inspection reports, so it may not be appropriate at times to record particular concerns that are sensitive or might identify patients in reports."

15:42

Would you agree that this approach could have left family members with the impression that maybe nothing was being done about their specific complaint because they weren't seeing that reflected in the reports?

A. I do, I do appreciate how families might have felt that 15:42
that had not been followed up. I think the evidence that I've obtained as part of this was that there was evidence that the vast majority of concerns that were brought to RQIA's attention were followed up. I think sometimes there is a misunderstanding that all concerns 15:42
result in an inspection, and at times they don't. We talked about it earlier, they may be held as intelligence and used at the next inspection, and indeed they may well have been dealt with and resolved

outside of an inspection process, at which point it is not appropriate then for that to be described as part of an inspection, because it wasn't part of that inspection, it would have been the intelligence used in terms of the themes of that inspection, but not necessarily followed up during the inspection, as it had previously been resolved. 15:43

179 Q. In your evidence earlier we were dealing with the serious concerns and whether families would be made aware of those. In terms of the outcome of inspections, apart from an inspection report being published, for example on the RQIA website, is there any or was there any specific process for RQIA to inform and update relatives, either before the publication or after the publication of the report? 15:43

A. So from my perspective at this point in time, if an inspection had had a specific issue about a particular patient that had been brought to our attention by that patient's relative, my expectation would be that the team would be making contact with that relative to advise them that their matter had been followed up as part of an inspection and/or another regulatory process, and that they would be provided with the outcome. I can't speak to how those matters were addressed in the past, in terms of making direct contact with the relatives. 15:44

180 Q. And when you say "your expectation", not to be pedantic, but does that actually happen? Is that what's occurring? 15:44

A. I believe it does happen.

181 Q. Yes. Thank you. If we could look then at paragraph 105, please? Here, in answering a question from the Inquiry about how the difference between what was seen by Inspectors at Muckamore and what appeared on CCTV in 2017 could be explained, you have said that: 15:44

"It is possible that the presence of an inspector on a ward acts as a deterrent and that RQIA tries to mitigate the limitations of the inspection process by triangulating various sources of evidence, including patient records and engaging with patients." 15:45

So, what I want to ask you about that is: does the fact that Muckamore was a hospital treating and looking after patients with learning disabilities, make a significant difference to the likelihood that RQIA would fail to identify concerns? And what I mean is that unlike other hospitals, some patients at Muckamore would not be able to communicate complaints like patients at other hospitals might be able to? 15:45 15:45

A. That wouldn't be my experience. I think there are many patients across our mental health and learning disability services that, due to their conditions or vulnerability, would not, would be similar to those patients in Muckamore, and the same methodology is applied to those inspections and to how RQIA conduct their business and triangulate the evidence and information-gathering as part of the inspection or 15:46

regulatory process.

182 Q. And staying then on the topic of the CCTV, do you know, and you've said in your evidence, and indeed it's reflected in your statement, that I suppose some of the limitations of the inspection model are met by looking at a broader range of evidence, including patient records and notes, and various other ward notes; do you know if, after the 2017 CCTV issues came to light, or abuse on CCTV came to light, do you know if CCTV then formed a part of RQIA inspections in terms of the information that you were getting from wards? 15:46 15:46

A. So CCTV did feature as part of RQIA inspections, but not the viewing of CCTV. That has not formed part of our inspections since 2017. But what RQIA have sought to do is ensure that the Trust's policies and procedures with respect to CCTV were -- they had been in draft for a period of time, and as part of our inspections we've been seeking that they would be ratified and become extant policies and procedures, that staff would be aware of the purpose of CCTV, and we also encouraged the Trust to utilise CCTV for learning as well as to identify any areas of concern or abuse, but also areas of good practice, that staff would be aware there was a number of different purposes for the CCTV at the times when we were inspecting in Muckamore, and we would have asked the Trust to ensure that staff would be fully aware of the benefits realisation of the CCTV, as it was as part of our inspection, staff were very concerned about the use of 15:47 15:47 15:47

CCTV and that continuous observation of their practice. So we were seeking opportunities that the Trust could use to evidence good practice as well through the use of CCTV and the protections.

183 Q. Where if RQIA were going on to wards and observing patients and staff, why were they not viewing the CCTV? What's the reason for that? 15:48

A. Because it was, or it is our view that there are processes in place to view CCTV as part of the Trust's policies and procedures, and it's not something that up until now we have considered as part of our inspection. I'm not saying it's something that we may never consider in the future in terms of the use of CCTV in these settings, but it hasn't formed part of our inspection methodology at this time. I think there would be data protection issues and matters to be considered, as with paper records and observations of patients, that we would seek to work through if we were going to adopt that as part of our inspection methodology. 15:48 15:49

184 Q. Do you know --

DR. MAXWELL: Can I just ask you, you said -- I think you said that you had recommended to the Trust that they use CCTV as a learning exercise, but the only copy of the CCTV policy that we've seen is the 2017 policy, which is very clear, as you say for data protection reasons, it's a very tight criteria about how it can be used, and education and learning isn't one of those. So if the RQIA has suggested that the Trust should 15:49

consider this, have you followed through whether they have changed the policy to allow this to happen?

A. It's my understanding that we did follow through on that policy, and I believe that education and learning did form part of the process -- because it does currently -- what I do know is that in practice the CCTV is being used for education and learning purposes, and is being viewed on a regular basis by staff that are not responsible for viewing it where a concern or an adult safeguarding matter comes to light, but that where there have been -- incidents have occurred and there has been positive practice identified, it's my understanding through our inspection processes that the Trust are using it for education and learning. 15:49 15:50

DR. MAXWELL: So you think they've updated the policy? 15:50

A. That was my understanding.

DR. MAXWELL: Okay. So we can ask the Trust for their updated policy.

185 Q. MS. BERGIN: Thank you. The final question that I have for you now in relation to this statement, is in relation to the Leadership and Governance Report. Now that can be brought up, the relevant section. That's contained within David Bingham's statement, STM-115-171, and I take it you're familiar with the Leadership and Governance Report written in 2020? 15:50 15:51

A. Yes.

186 Q. And if you could just is scroll down, please? Yes. Thank you. So the third bullet point along there states:

"RQIA had no joined up approach to inspecting wards at MAH, but neither had the Trust a joined up approach to identifying trends from such reports or in learning from the Iveagh Report where it had relevance to the adult hospital sector." 15:51

What do you say about that criticism?

A. Prior to 2019, February 2019, in terms of the inspection, RQIA would recognise that that was a limitation to its inspection methodology of single wards by different Inspectors, and I think in taking account of that in 2018 and moving to the methodology of a multi-site inspection, we recognised the limitations that we did have as part of single ward inspections with different inspectors going into the Hospital. 15:51 15:52

187 Q. Okay. Thank you. If we could now move to your first statement, please? The reference is STM-219. And this statement, just while it's being brought up on screen, this statement is made in relation to some questions about Ennis, and at paragraph 21 and 24, please -- 21, thank you. Here -- and I'm going to briefly summarise -- here you state that: 15:52

"RQIA first became aware of allegations of physical assault and degrading practices and concerns about staffing levels in Ennis Ward on 8th November 2012. RQIA were made aware of these allegations during a 15:52

telephone call from the operations manager for the Priory Group."

And you then set out RQIA's role after it was made aware of these allegations, and throughout your statement you describe a chronology of RQIA actions after the Ennis allegations. 15:53

Engagement between RQIA and others, including the Belfast Trust, the Belfast Trust Chief Executive, attendance at various meetings, including Serious Concerns and Complaints Group Meetings, and the first of those meetings actually being a Vulnerable Adult Strategy Meeting on 9th November 2012, the day after the report, there were then RQIA unannounced inspections on 13th November and 20th December 2012, and also 29th January 2013. 15:53

Now, I'm not going to take you through all of this today; I just want to ask you a few matters in your statement. 15:53

So, at paragraphs 26 and 27, please? After the allegations came to light in relation to Ennis on 8th November 2012, you state here that: 15:54

"A Vulnerable Adult Strategy Meeting took place the following day on 9th November, attended by RQIA."

And you set out then the actions that I've already discussed.

Apart from inspection and issuing reports, does RQIA have any power independently to suspend an individual from practice, or to give advice to the Trust or at Muckamore about whether to do so in that type of scenario? 15:54

A. Yes, I think in line with the Regional Policies and Procedures at that time, I think the Regional Policies were 2006, and the Joint Protocol, in which this matter was being handled, RQIA do -- well, they certainly were an independent person as well as the Trust and the PSNI, but our role in that perspective is, it's twofold: In terms of our role under the 2003 Order, it's my view that we need to be taking account of whether there are risks for any other patients, and across the site, when a matter such as this comes to light. But certainly in terms of adult protection, RQIA would be making recommendations as part of that strategy meeting to ensure that any actions that were being taken were suitably protective at those points in time. 15:54 15:55 15:55

CHAIRPERSON: So you obviously don't have any direct power, but you can recommend to the Trust in relation to an individual patient -- 15:55

A. Yeah, we don't have any employment powers around the suspension of staff, but we would have -- and I have to say we would be listened to, and our views would be

taken on board in terms of protection planning, and where we would be concerned that a protection plan wasn't going to provide the relevant protections for that patient or any other patients, we would very strongly -- at that table our voice would be heard around actions that needed to be taken. 15:56

188 Q. MS. BERGIN: Yes. And we in fact know that one of the immediate steps that was taken was the suspension of three members of staff. And then shortly afterwards, and staying here at paragraph 27 then, on the 13th November, the inspection, the unannounced inspection, you state: 15:56

"...involved a review of the Quality Improvement Plan and the seven recommendations from the previous inspection in November 2010." 15:56

Now, we can bring up the previous inspection plan in a moment, but I think it's correct that the November 2010 inspection was in fact the last RQIA inspection before the Ennis allegations, is that correct? 15:56

A. That's my understanding.

189 Q. That is a two-year gap, where there were recommendations made in 2010. The first question is, is that sort of type of a time gap of two years between inspections, particularly when so many recommendations have been made in 2010, common? 15:57

A. So, in terms of an inspection in a hospital and in a ward, RQIA don't have any statutory frequency of

inspection to hospital wards. I'm not aware of the decision-making at that time not to undertake an inspection between 2010 and 2012. However, it would be my view that decisions would have been made for potentially resource reasons and/or risks that have emerged in other services where resources needed to be redirected, but I don't know why there was that gap at that point in time.

190 Q. Thank you. And if we could please just have the Ennis Bundle up on screen, and it's page 114 of the bundle? 15:57
Thank you. And, actually, if we could go to page 136, please? So if you scroll up a page, please? What we have here then are the Quality Improvement Plan Unannounced Inspection Notes from the November 2012 inspection, and if you could scroll down, please, to 15:58
page 140? Thank you. So, I'll come to this in a moment, but what we can see here is that seven of the recommendations, and as you've outlined in your statement, that were made in November 2012, had previously been made at the inspection two years prior 15:58
in November 2010, and without going through all of them, for example, the second row down deals with staffing levels and governance, and elsewhere below there's also recommendations in respect of reporting safeguarding issues, and governance arrangements around 15:59
safeguarding.

So in 2012, when RQIA inspected, there were staffing, and safeguarding and governance issues raised, and

recommendations were made. In terms of then ensuring compliance with those recommendations between 2010 until 2012, do you know what, if any, steps were taken by RQIA to ensure that those recommendation -- well, steps, at least, were taken to meet those recommendations? 15:59

A. So whenever RQIA undertake an inspection and make recommendations, one of the matters that needs to be undertaken is that we receive a returned Quality Improvement Plan with the actions that the relevant Trust have taken to address the recommendations that we have made. So back in 2010, at the conclusion of that inspection, there would have been a requirement for a Quality Improvement Plan to be returned to RQIA by the Trust, outlining the actions that they had taken. 16:00 Those Quality Improvement Plans, on their return, would be reviewed and assessed by the aligned inspector, usually the inspector who has undertaken the inspection, and a determination would be made on the basis of that information that there was or was not further follow-up required. At that point in time decisions would have been taken with regard to whether or not there needed to be a further follow-up inspection undertaken. 16:00

191 Q. And as far as I think we're aware, there wasn't then a further inspection until 2012? 16:00

A. I don't have any evidence of that.

192 Q. And we know then that in addition to these recommendations in 2010, in which staffing matters were

a feature, that the issue of staffing was also added to the Trust's Risk Register in April 2012 in relation to Ennis. Now, later on in your statement, you say that the RQIA was heavily involved in Ennis Ward following the allegations in November 2012. Reflecting now, do you think that the recommendations, that the level, and the type; safeguarding, staffing, and governance, ought to have triggered a higher level of RQIA engagement at that stage back in 2010? 16:01

A. On the basis of the evidence that I have seen, there was a -- the Quality Improvement Plan that was returned by the Trust at that time, would have been assessed by the inspector as a reasonable response to the issues that were being identified. So I'm not in a position to say why a decision wasn't taken to further escalate at that time. But if that happened today, my view would be that an assessment had been made, that the issues identified as part of the areas for improvement have been sufficiently provided with assurance by the Trust at that time. 16:01 16:02

193 Q. This is a net point: The Inquiry has been told by other witnesses that Ennis Ward was very old-fashioned, so in terms of its environment, and it was institutional in appearance, but that doesn't appear to be how it's described in the 2010 report. Can you say anything about that? 16:02

A. No, I don't know why that is.

194 Q. Thank you. If we could look at paragraph 28, then, of Ms. Long's first statement, please? And here -- I'm

going to just continue while we wait for the document to come up -- but here what you say is that during a Vulnerable Adult Strategy Meeting -- thank you -- on 15th November 2012:

16:03

"...RQIA raised concerns about staffing, that the actual number of staff on Ennis Ward and their areas of responsibility remained unclear, and one concern was that using relief staff to reach the agreed staffing complement may be detrimental to patient care and 16:03 safety in other wards."

Do you know what the problems were with using relief staff, as RQIA saw it?

A. Yes. It's my understanding from the information that 16:03 I've read that there were gaps in substantive staffing in Ennis Ward, and that requires those shifts to be covered by staff, and it's my understanding that at that time, the approach by the Trust in Muckamore was that staff would have moved around the wards to support 16:04 wards when they were short-staffed. However, when you have gaps in your substantive staffing over a long period of time, that's going to be required for every shift, and on a regular basis, and that has issues with respect to continuity of care for the patients in that 16:04 area, where there are relief staff, or bank staff, or agency staff coming to support those patients.

195 Q. And do you know, and I appreciate you may not be able to answer this, but do you know in terms of those

concerns whether there was any further engagement with the Trust and whether they took any action in respect of the concerns around relief staff?

A. I'm not sure specifically around relief staff, but I do know that RQIA did escalate our concerns with respect to staffing throughout the duration of the Ennis period, both around the use of relief staff and bank staff, the issues with substantive staffing, and also the issues with being clear around the levels of staff that were required for the Ennis Ward at that period of time, and I've read quite a bit of that information. 16:04 16:05

196 Q. Thank you. And at paragraph 30 then, just briefly, you say here that RQIA mentioned the Ennis situation in its bi-monthly meeting with the DHSSPS. And you've also talked about other methods of escalation. Did RQIA have any way of directly alerting the Trust Board to issues? 16:05

A. Not that I'm aware of.

197 Q. And remaining at paragraphs 30 and 31 then, you state that: 16:05

"On 16th November 2012, Aine Morrison from the Belfast Trust sent the RQIA written guidance for supervising staff in Ennis Ward, and also guidance for ward managers in Ennis Ward, and supervising staff were to prepare a daily report about staff on wards." 16:06

And that is contained, for reference, at page 84 and 85 of the Ennis bundle, but we don't necessarily need to

go to that.

What I want to ask you about that is, in terms of the monitors on wards, did RQIA either have or hear about any concerns about the presence of the ward monitors? 16:06

A. So from the information that I've read, there were concerns around the levels of -- grades of staff who were undertaking the role of monitoring, there were issues around the impact on patients of the role of monitoring, and I think there were discussions between 16:06 professional grades of staff in the Trust with respect to the levels and continuation of monitoring.

198 Q. Thank you. We're looking at paragraphs 29 and 35 of your statement, and you outline that there was correspondence between Esther Rafferty and RQIA, and if 16:07 we could please go to Ennis Bundle, page 201. Thank you. And you outline here in your statement, referring to the documents we're just about to see, and if you could just go to the top of the document for me, please? Yes. Thank you. So we can see here 16:07 correspondence from RQIA to Esther Rafferty on 15th November 2012, and if you continue to scroll down there, please, then we can see that Esther Rafferty wrote back to RQIA on 23rd November, and she explained that the new monitoring staff unsettled patients and 16:07 caused them to be more challenging. And as I've already indicated, her response also includes the action plan for Ennis Ward, and appropriate staffing with experience and skill mix.

That correspondence from Ms. Rafferty, in the body of it, which we can scroll through, outlines efforts by Ms. Rafferty, and indeed those at Muckamore, to increase staffing levels, and one of the measures is 30 whole time equivalent healthcare workers had been appointed awaiting access and eye checks, and 18 whole time equivalent staff nurse posts had been advertised. Did RQIA seek any assurance about the proportion of those staff who would be learning disability trained when they were receiving assurances from Muckamore about staffing? 16:08 16:08

A. I'm not sure about that particular incident, but certainly as part of our inspections we would seek, as part of staff training, to understand that staff have the relevant knowledge and skills required to look after patients with the conditions of the patients in Muckamore at that time. I can't answer about that specific issue, but I can answer in the generality of staff training and competence and expertise and professional backgrounds. 16:09 16:09

199 Q. Yes, thank you. And in respect of the comment by Ms. Rafferty in that correspondence that the new monitoring staff were essentially causing the patients to be unsettled, the Inquiry I think has been told that there was usually one monitor per shift; are you able to comment on that in terms of whether one monitor per shift is something that would have unsettled patients in terms of RQIA having a concern about even the 16:09

presence of one monitor on a ward?

A. It's my understanding that the needs of the patients in the Hospital, and their conditions, that where there are changes and things that are different for them, that that can be unsettling, but I do think that, and appreciate, that they were balancing the role of the monitor in providing the necessary assurances with the distress, potential distress being caused to patients. So I think through our strategy meetings and the attendance of RQIA at those, we were seeking to have consistency in the monitors to ensure that any levels of distress would be minimised as much as possible. 16:10 16:10

200 Q. And what was the RQIA view in relation to the monitors generally being present on the wards, or the ward, rather? 16:10

A. I can't speak for colleagues that were there, but it would be my view that it was a positive outcome to provide the necessary assurances. And from memory, back then monitors, 24-hour monitors and other types of monitors, were a general adult safeguarding response in terms of protecting patients. 16:11

DR. MAXWELL: Are you saying that was common? Because when we've asked other people, social workers, and including Aine Morrison, they said they'd never seen that being used before? 16:11

A. So my background isn't just in hospital and isn't just in Muckamore, I would have had, when I started in RQIA, worked in the nursing homes regulation, and monitors were used on a regular basis. So from my perspective

back then, when a protection plan was put in place, a monitor or someone observing practice in that type of role would have been in place.

DR. MAXWELL: 24/7?

A. Not always 24/7, depending on what the issues or the allegations were, it may have been through the day, or it may have particularly been targeted in the evenings or the weekends, depending on what the matters of concern were that were brought to the attention. But I was certainly -- I also managed a nursing home in the past, and certainly it was something that I was very aware of. It may have been the first time in Muckamore that a monitor was used, but I have experience of monitors being in services. 16:11 16:12

201 Q. MS. BERGIN: Thank you. Referring then to paragraph 37 of your statement, but actually if we could stay on Ennis, please, and scroll down to page 204? Yes. Thank you. Now, I appreciate you do have a copy in fact of your statement in front of you, so for your purposes I suppose at paragraph 37, you refer to correspondence between RQIA and Esther Rafferty in December 2012, and that: 16:12 16:12

"...an assurance was given that meetings had been held prior to Bohill staff working on wards, including person-centred assessments and agreeing shifts." 16:13

So staying on the topic of disruption to patients, were RQIA provided with any assurance that any impact of

Bohill staff being present on wards had been considered and in advance of Bohill staff coming on to the ward?

A. I'm not aware of that.

202 Q. Thank you. The correspondence from Esther Rafferty also provides assurance that appropriate staffing levels were being maintained. Do you know if RQIA checked if that was correct? 16:13

A. So it's my understanding from the information that I've read that we weren't assured that the staffing levels -- I think some of the issues that have been raised through our inspections were that it was difficult to ascertain what the actual staffing levels were for Ennis throughout that period, and I know that the Trust were using various tools and information to determine safe staffing in Ennis at that time, but certainly our review of staff rotas, discussion with staff, and information that we were gathering, continued to give us cause for concern with respect to the staffing of Ennis. 16:13 16:14

203 Q. Yes. And staying with that then. At page 32 of Ennis, please, on the same date then, on 12th December, there was a Vulnerable Adult Strategy Meeting in which some of those concerns you've just referred to were raised. Yes. Thank you. And those are the minutes of that meeting that I've just referred to. And if we scroll down in the minutes, please? Keep going, please. Thank you. It may be that it's difficult to find it just at present, but within those notes, some of the concerns raised by RQIA at that meeting included 16:14 16:14

staffing levels, and the staff allocated to Level 3 observations -- sorry, included concerns that the staff who were allocated to Level 3 observations were considered to be part of the routine staff, rather than observers, and RQIA's position I think at that stage was that that was contradictory to Muckamore policy, and the notes then indicate that RQIA was informed that there was no specific staffing requirements for Ennis. Do you know what policy is being referred to there in terms of staffing? 16:15

A. No.

204 Q. And in terms of any understanding that you might have about there being specific staffing requirements for Ennis, what would you -- there not being specific staffing requirements for Ennis -- what would you say about that? 16:15

A. So, there are -- it's my understanding that there aren't specific tools and there's regional work going on around what is an acceptable staffing model to manage the needs of patients that were in Muckamore and/or any other mental health or learning disability wards. So there are some tools out there that can be used. But it's our understanding that the tools that were used needed to also take account of the individual patient needs, which included levels of observations, and best practice would suggest that if you -- your role is to undertake a particular level of observation, that you can't also then be counted as part of the staffing numbers. So those would have been the matters 16:16 16:16

that RQIA would have been raising with the Trust, where they were coming back and advising that the staffing complement was satisfactory.

205 Q. Thank you. Now following this, on 20th December 2012, there was a second unannounced RQIA inspection, and the purpose of that was to see what progress had been made following the November inspection. And following that December inspection, three of the Quality Improvement Plan recommendations were staffing recommendations, which were being raised for the second time in relation to defining and monitoring staff, defining staff requirements for special observations, and informing RQIA, in fact, of deficits in staffing. Now, that's dealt with at paragraph 41 of your statement, and the Ennis reference is page 145. I want, though, to ask you -- that's the context -- a more general question about that, which is: What influence, if any, can RQIA bring to bear on an organisation like the Belfast Trust in relation to taking action; for example, in relation to staffing, where, in this scenario, we're on our second unannounced inspection and staffing issues are being raised for the second time? 16:16 16:17 16:17 16:17

A. So where staffing issues are being raised, or there's a breach, or RQIA identify as part of an inspection that there are issues with respect to staffing, there's a few things that we can do in terms of escalation to a serious concerns meeting and seek further assurances from the Trust through those processes, and also through the process of alerting the Department. We 16:18

talked earlier about special measures, but also in between those, those areas, and they're not parallel -- they can run in parallel to each other, but also to take enforcement action against a Trust, and we have taken enforcement action against the Belfast Trust with respect to staffing and the model of staffing in the Hospital in 2019.

206 Q. In terms of understanding I suppose how significant it is that any type of recommendation would be repeated, is that something that RQIA see routinely, where they're making a recommendation and they're on a second and third restatement of that recommendation following inspections, or is that something that's less common?

A. Currently, I would say where RQIA would be making, or needing to make a recommendation for the third time, we ourselves would be holding internal meetings to decide on what type of escalation or enforcement action that needs to be taken. It wouldn't be routine that we would be stating matters for the third time. With all of these matters sometimes there are mitigations, sometimes there are reflections on whether or not the ward, as I spoke previously, the ward manager had the opportunity to fix some of the matters that were being raised as part of the RQIA inspection, but it wouldn't be routine at this time that we would be stating things more than twice.

207 Q. Thank you

CHAIRPERSON: Can you just tell me what your levels of escalation are?

A. So in area for improvement, so a recommendation within a report from RQIA's perspective would be the first stage.

CHAIRPERSON: Yes.

A. And then where a Trust is concerned, it would be a serious concerns meeting, and then it would be consideration of an improvement notice, and then special measures. But what I would say is that those things could run in parallel. So you could still make an area for improvement within a report, but also escalate something to a serious concerns. Or you may well serve an improvement notice, but also request special measures. So they can run in tandem. 16:20 16:20

CHAIRPERSON: I can't remember where it is, but somewhere in here I've seen that you wrote to the Chief Executive, the RQIA, rather, wrote to the Chief Executive of the Trust. Where would that lie in the level of escalation? 16:20

A. I would say that would lie at the serious concerns level. 16:20

CHAIRPERSON: Right. Thank you.

208 Q. MS. BERGIN:. Thank you. At paragraph 45 of your statement, but if we could go to page 52 of Ennis, please, the Ennis Bundle, please? So while that's coming up on screen, at paragraph 45 of your statement you say that a Vulnerable Adult Strategy Meeting took place on 9th January 2013, and we in fact now see the minutes from that fact meeting, and if I could ask you, please, to scroll to page 57? And under the bullet 16:21

point 5 "Monitoring Reports", the second line, this is a report provided to the meeting by Moira Mannion, it states:

"Moira Mannion outlined her review of the 108 monitoring forms she received. She confirmed they all give examples of positive care. She stated that her review of the monitoring forms and her own time on the ward showed that there was no evidence of a culture of abuse within the ward." 16:21

And she continues to give examples of clear evidence of nursing care planning being in use, and then concludes:

"On this basis, she proposed to cease monitoring in its current form." 16:22

What reassurance, if any, did RQIA take from Ms. Mannion's comments that there was no evidence of a culture tolerant of abuse? 16:22

A. From the information that I've read throughout the Ennis actions of RQIA, I think that we would be -- it would be difficult to confirm or deny that there was evidence of a culture of abuse. I think Ms. Mannion's report evidences quite a robust process of monitoring and action taken by the Trust to address whether or not there was a potential culture, but taking account of the investigation undertaken, led by Aine Morrison, it was RQIA's view towards the conclusion of that that it 16:22

was -- it was -- we were unable to say that there was no evidence of a wider culture of abuse.

209 Q. Staying on this topic, but if I --

DR. MAXWELL: Can I just clarify that? Because what it says here is not that Aine Morrison didn't accept that at the time, but she felt that that wasn't evidence that there wasn't a culture before the monitoring started. So was RQIA still concerned about the contemporaneous culture, or was it saying this doesn't prove that there wasn't a culture on the ward prior to all the actions the Trust had put in place? Because in terms of what you do, if you're saying historically there was an issue but the Trust has addressed it, your actions would be different from if you said 'We're not sure that the actions the Trust have put in place have addressed this', and I'm not clear which of those you're saying was the RQIA position? 16:23 16:23 16:23

A. My reading of the information was that at the conclusion of the report that was produced, the staff from RQIA, who were present at that meeting, were agreeing with Ms. Morrison that there was no -- they were unable to substantially say that there hadn't been an evidence of culture in the Hospital. Now, my reading of that was that that was not just prior to the Ennis incident, that that was a general view. 16:24 16:24

DR. MAXWELL: Based on what? Because you've got some statements from some Bohill staff, not all of them, and only relating to Ennis Ward, the Bohill staff positively said they didn't have concerns about other

wards. The only evidence about the current culture seems to have come from the monitoring. So on what basis did the RQIA have continuing concerns?

A. Sorry, I don't -- I don't think I'm saying that we had continuing concerns. I think what I'm saying is that the evidence gathered, both through the monitoring - which was very specific to Ennis Ward - and also Ms. Morrison's investigation, that it wasn't conclusive to say that there was or was not a culture within that ward and/or a wider culture, because the investigation hadn't taken account, and that's my reading of all of the information that I've had, account of all of the other wards, and there wasn't monitoring on all of the other wards, it was very targeted to Ennis. 16:25 16:25

DR. MAXWELL: And I appreciate you weren't there and you've only read the records, but was it your belief from what you've read that the RQIA had continuing concerns about a culture of abuse after the conclusion of the Safeguarding Investigation? 16:25

A. No. 16:26

DR. MAXWELL: No. Okay. Thank you.

210 Q. MS. BERGIN: Thank you. If we could look at page 62 and 63 of Ennis, please? Now, I'm referring to paragraph 67 of your statement, Ms. Long, and some of this will hopefully have been answered in your responses to the Panel questions, but a safeguarding meeting was held on 29th March 2013. RQIA was not in attendance, but has a copy of the minutes. And if we go to page 63, please, and the second paragraph towards 16:26

the end -- no, apologies, the second paragraph on the page. Thank you. In any event, I'll read out the part that I'm trying to find, it states that:

"Mr. Veitch told the meeting that there was no evidence of institutional abuse within the Ennis Ward." 16:27

Okay. Now, what I want to ask you about that is, if RQIA weren't at that meeting, how is it that they came to have a copy of those minutes? Would they routinely have been shared with RQIA? 16:27

A. Yes, RQIA are unfortunately not able to be in attendance at all adult safeguarding meetings, and I assume on this occasion that was the case, and potentially sent apologies, but as a member of the group and as part of the regional policies, we would have received those minutes. 16:27

211 Q. And in terms of whether you can say anything about RQIA's response to Mr. Veitch's expressed view that there was no evidence of institutional abuse in Ennis, is that something that the RQIA would have accepted at that time, or is that something that the RQIA would have made their own findings about? 16:28

A. I think the RQIA attendees at the meeting then and now would, where necessary, challenge evidence if it was not clear, and would ask for further information to support some of the matters that were being described as part of a Safeguarding Investigation. 16:28

212 Q. Thank you. And at paragraph 68 of your statement, and

this is the first long statement, please, you say that around this time, so this is 5th April 2013, it was confirmed that Ennis would remain on the agenda for RQIA until Quality Improvement Plan recommendation had been -- apologies, until the Quality Improvement Plan had been returned by the Belfast Trust. So at that stage is it correct there were still outstanding Trust actions to be taken in response to the previous RQIA recommendations? 16:29

A. I'm not clear if there were -- I'm not clear if there were outstanding recommendations, but certainly there would have been recommendations made in that January 2013 inspection that required to -- RQIA to receive a response from the Trust in relation to. 16:29

213 Q. Thank you. If we could then, and I appreciate we're jumping around somewhat, but if we could then go to Ennis, please, to page 217? 16:29

CHAIRPERSON: Could I just ask, Ms. Bergin, how long do you think you're going to be?

MS. BERGIN: I mean we will be finished before five, certainly. Perhaps another ten minutes. 16:30

CHAIRPERSON: Okay.

214 Q. MS. BERGIN: Thank you. So at -- we're -- thank you. We're looking, Ms. Long, at paragraph 70 of your statement, and we're referring to this document. 16:30

"On 9th May 2013, RQIA wrote to Mr. Veitch asking for assurances in relation to the care, treatment and culture within Ennis and other wards at Muckamore."

And then for reference at page 219, on 6th June 2013, Mr. Veitch then replied to RQIA, and without going through all of the detail, essentially what Mr. Veitch's letter does is provide various assurances to RQIA, for example, that the Trust had immediately initiated a thorough investigation through Joint Protocols about Ennis, and that the Belfast Trust had addressed immediate protection needs of patients on the ward, and that the PSNI investigation was complete, and no adult safeguarding issues remained outstanding.

Can you say from your review of the papers whether RQIA was reassured by this later assurance from the Trust?

A. I'm not sure that I've seen clear evidence that RQIA were assured, but what I do know is that a further inspection of Ennis was conducted by RQIA at the end of May 2013, which would have sought to determine whether or not those assurances that were provided during that period of time had been addressed as part of the Ennis Investigation.

215 Q. Yes. Thank you. And at paragraph -- if we just remain there with Ennis, but at paragraph 80 of your statement, you state that:

"A bi-monthly meeting was held on 8th October 2013 between RQIA and DHSSPS, and that the RQIA representative, Mrs. Nixon, confirmed that recommendations for improvements on Ennis Ward had not

been implemented and that the Southern Trust was taking action, which was understood to have been as a result of patients under their care remaining on the ward."

So Mr. Veitch was providing RQIA with assurance that there were essentially no ongoing problems, but at the same time the RQIA recommendations had not been fully implemented. Is that correct? 16:32

A. That's my reading of it, yes.

216 Q. Yes. And in this context, where there had been allegations, this obviously sits after the Ennis allegations came to light. In that scenario where allegations of abuse have been made at a hospital setting, would you then, RQIA, expect then I suppose strict adherence to these recommendations in order to have some reassurance as to safety on the wards? 16:32 16:33

A. Yes. Yes.

217 Q. And if we look at page 71 of Ennis, please? And I just want to ask you briefly again about this point about institutional abuse, okay? So in your statement you refer to this meeting, and there was a Vulnerable Adult Strategy Meeting on 28th October 2013, at which the Ennis Report was discussed, and the minutes of that meeting state that Ms. Kelly from RQIA concurred with Ms. Morrison's views -- Aine Morrison's views -- that it had not been possible to reach a conclusion on whether or not there had been institutional abuse, and she stated that RQIA felt there was enough evidence to justify at least some concern about wider practice on 16:33 16:33

the ward.

Can you say anything about the concern about wider practice?

A. From the information that I have reviewed, I think the enormity and seriousness of the allegations that were witnessed by external staff coming on to a ward, and the practices that they observed, I think that's where Ms. Kelly's position was coming from, that if staff openly believed that that was acceptable practice in front of staff coming from another area, that that would give cause for concern that there was issues with wider practice. 16:34 16:34

218 Q. Thank you. Now, at paragraph 83 of your statement, and I won't need to refer to Ennis, again, thank you. At paragraph 83 of your first statement, here you state that on 11th November there was then a meeting between RQIA, the Public Health Agency, and the Health and Social Care Board. Thank you. 16:34

16:35

"RQIA updated that two members of staff had been referred to PPS and the Belfast Trust did not accept that there was evidence of culture leading to the abuse allegations. RQIA's view on the matter was that this may not have been an isolated case and that this was supported by Aine Morrison." 16:35

Now, the minutes from that meeting are in fact included in the additional bundle that I've referred to the

Inquiry being in receipt of. But my question about that is: does all of that mean that the Belfast Trust didn't accept that there was a culture of abuse on Ennis, but the RQIA wasn't quite satisfied of that?

A. Having not been at that meeting, I can't comment, but what I -- I would take you back to Ms. Kelly's, you know, I think that meeting, the meeting with PHN, the Health and Social Care Board, would have drawn upon the final meeting, where Ms. Morrison would have been discussing her report and where Ms. Kelly would have given her views. So it's my view that the meeting with the Health and Social Care Board, and the Public Health Agency, was reiterating what Ms. Kelly had said at the final meeting. 16:35 16:36

219 Q. Thank you. You then go on to outline at paragraph 91 onwards, that following the publication of the Ennis Report then in October 2013, RQIA conducted inspections on eight other Muckamore wards. So we've dealt with this briefly I think already, but were those inspections prompted by the Ennis Report? 16:36

A. Prompted by the Ennis allegations, because I don't think they were -- they weren't necessarily after the publication of the Ennis Report, the inspections in 2012 to the other wards were over a period of time during 2012 and early 2013, but they would have taken account of arrangements for adult safeguarding and the concerns that were highlighted as part of the Ennis Investigation. 16:37

220 Q. And do you know if any consideration was given to

inspecting -- you've now talked about moving towards this model of inspecting the whole site -- do you know if any consideration was given to doing that following the Ennis allegations, as opposed to specific wards?

A. Not in any of the evidence that I've seen. 16:37

221 Q. In hindsight do you think that, given that RQIA still seemed to have some concerns despite the Trust assurances, that that should have prompted any further steps by RQIA at that stage?

A. From the information I've read I think from my perspective RQIA took the allegations around Ennis particularly seriously, and were heavily involved both through the strategy meetings, through internal and external escalation, both with the Trust and to the Health and Social Care Board, and PHA, and also 16:37 16:38 undertaking a range of inspections across the other wards. So from the evidence that I've gathered as part of preparing for today, at that point in time I think there was reasonable efforts by RQIA to address the risks associated with the allegations in Ennis. 16:38

222 Q. And do you know if the allegations on Ennis, and the steps that RQIA then took after those, prompted any sort of a review by RQIA in terms of its own policies and inspection procedures at all?

A. The methodology for inspection has been under review, 16:38 and continues to be under review on a regular basis, and in particular aligned to our corporate strategy, '12 to '15 there was a review of the inspection methodology, we moved to looking at seeing effective

and compassionate care in line with Quality 2020, that was the regional strategy at that time, and RQIA undertook a pilot of 12 different inspections that were then subsequently reviewed through the lens of Professor McConkey from the University of Ulster, and some changes were made to the methodology. I've no doubt, having read the Ennis stuff, that some of that was prompted by some of the actions and information that came to light as part of the Ennis Investigation.

223 Q. You've referred to a review there. Were you, or the RQIA indeed, aware that the Department of Health had commissioned a report on safeguarding in 2020? 16:39

A. Yes. 2020?

DR. MAXWELL: It was a review of the safeguarding files, and the Department of Health commissioned Dr. Lorna Montgomery from QUB, and three others, to review files during the year of 2020. 16:39

A. Yes, I am aware of that.

DR. MAXWELL: So given that you had issued an improvement notice on safeguarding in 2019, did you seek to have a copy of this report of the safeguarding files and the processes? 16:40

A. I'm not aware of any formal request. My understanding of that was led by the office of social services at the Department, with respect to some concerns that they had identified in their discussions directly with the Belfast Trust around how adult safeguarding was being managed. I do know that some of that fieldwork was being undertaken at the same time as an RQIA inspection 16:40

of Muckamore, and I know that the Inspectors involved in that inspection sought to speak with the team that were undertaking that piece of work at that time. I'm unsure of the commissioning arrangements with respect to that piece of work, or the outcome report, although RQIA do refer to it in our inspection at that time and did consider that where any recommendations or issues were identified, that we would follow those up as part of our ongoing inspections in Muckamore, but we never received a final copy. 16:41

DR. MAXWELL: So we have heard evidence, we have seen that report and heard evidence this morning about that, and there were a number of concerns about the files and the decision-making in safeguarding being inconsistent and not transparent. So in the light of that, the fact that you then lifted the improvement notice without seeing that report, does that speak to the joined-up-ness of intelligence in Northern Ireland on these issues? 16:41

A. Having not been cited on the report, not knowing what the issues are, that's a really difficult piece. 16:42

DR. MAXWELL: But you would have --

A. But certainly RQIA would have been interested and wanted to know if there were continued issues with safeguarding processes at Muckamore, at the point in time when we were determining to assess that the Trust were compliant with the actions that we had made as part of our inspection processes, appreciating that I'm unaware of the Terms of Reference of the piece of work 16:42

that was undertaken at that time, and indeed the focus and exactly what was reviewed to come to those conclusions.

DR. MAXWELL: I appreciate that. But you didn't receive it in any way? 16:42

A. We didn't.

DR. MAXWELL: And you still haven't seen it?

A. No, I do recall it being discussed at MDAG meetings between Aine and colleagues in Belfast Trust that there was follow-up with the Belfast Trust in terms of the 16:43 actions that were required falling out of that work, and that was as a member or an observer of MDAG, as RQIA are. So I've definitely heard it being talked about at MDAG.

CHAIRPERSON: And if that report was provided to the 16:43 Department of Health, is there any way that that could get to the RQIA? Would you have expected it to get to the RQIA if it was sitting in the Department of Health files?

A. I would hope that if a report such as that was made, 16:43 there's a couple of things in terms of it -- its publication, its sharing with relevant stakeholders to enable all of us to take any necessary actions, but I think particularly with respect to RQIA having some powers to take action where there are issues, maybe in 16:44 comparison to some other organisations. So we've two key things that we do have some powers, albeit we've described their limitations, but also that we also make our reports public.

CHAIRPERSON: So is the answer "yes"?

A. Yes.

CHAIRPERSON: Thank you.

224 Q. MS. BERGIN: Thank you. Ms. Long, you'll be glad to know that I only have two further questions for you before we finish. I know it's been a long afternoon. If we could look at paragraph 44, and I'm referring also to paragraph -- apologies, paragraph 84 and also paragraph 88 of your statement, and here you indicate that the Ennis Ward was amalgamated with Erne and Mallow Wards in December 2013 to become Erne Ward, and an unannounced inspection of that amalgamated Erne Ward then took place on 29th January 2014, and the RQIA Inspector noted that all of the recommendations made in the unannounced inspection of Ennis on 29th May 2013 had been met. So by January 2014, is it correct then that all recommendations relating to Ennis throughout that time period had been met? 16:44 16:44 16:45 16:45

A. The recommendations that were outstanding from the 29th May '13, yes, that's correct.

225 Q. And do you know if there was anything further from any previous inspections?

A. Any recommendations made in previous inspections would have been carried forward.

226 Q. Yes. 16:45

A. -- to that January or May 2013 inspection, subsequently reviewed as part of the January '14 inspection. So even though those wards, that they were amalgamated, it's my understanding in evidence that I've gathered

that the Inspectors took all the previous Quality Improvement Plans and brought them to the inspection of January '14 of the amalgamated ward.

227 Q. Thank you. So that brings us to 2014 then, and we know from other evidence before the Inquiry from one of your colleagues in RQIA, that then RQIA inspections continued at Muckamore then from 2014 onwards, at least to 2021. RQIA are the regulator in terms of Health and Social Care services in Northern Ireland. Looking at 2010 onwards, RQIA were inspecting Muckamore before the Ennis allegations, and then as we've just talked about, from 2014 throughout the years before the 2017 CCTV matters came to light. Reflecting now, what do you or RQIA say about how these practices and abuses that have come to light were able to occur essentially undetected by RQIA? 16:46 16:46 16:46

A. It's my view that the information that came to light as part of the Ennis Investigation, and subsequently the CCTV investigation, that that would have been difficult to identify as part of an inspection. I don't believe that any member of staff has ever been observed, in my time, of abusing a patient whilst an inspection was ongoing, and I think it is fair to say that they are points in time and there are limitations to what an inspection can identify. I think staff training, and understanding of adult safeguarding, and actions taken by organisations to ensure that patients are safe in their care, are the points that RQIA would be looking at as part of an inspection, and making areas for 16:47 16:47

improvement where we identify that there are gaps in those processes, or where improvements could be made.

MS. BERGIN: Thank you. I have no further questions, Ms. Long, but the Panel may.

CHAIRPERSON: Can I thank you very much. We've asked the questions as we've gone along, obviously, so can I thank you very much indeed for giving up your time and coming to assist the Inquiry, and we've sat slightly late, so apologies to you for that, but thank you very much, you can now go with the Secretary to the Inquiry. 16:48

We're going to sit tomorrow at 10:00 o'clock. It is possible that we'll finish both witnesses in the morning, because they're relatively short, and we've covered a lot of ground today, but no promises. And thank you to the stenographer for staying a bit late. Thank you. 16:48

MS. BERGIN: Thank you.

THE INQUIRY WAS THEN ADJOURNED TO THURSDAY, 20TH JUNE 2024 AT 10:00 A.M. 16:49