ORGANISATIONAL MODULES 2024

MUCKAMORE ABBEY HOSPITAL INQUIRY
WITNESS STATEMENT

Statement of H92

Date: 09 April 2024

I, H92, make the following statement for the purpose of the Muckamore Abbey Hospital (MAH) Inquiry.

The statement is made on behalf of H92 in response to a request for evidence by the Inquiry Panel.

This is my first statement to the Inquiry.

There are no documents produced with my statement.

Qualifications and positions

1. I am a qualified social worker. I hold a B.A (Hons) Social Work degree from the University of Ulster (Jordanstown) dated 1987.

2. I have held the following positions: December 1987 to March 1988 temporary social worker Muckamore Abbey Hospital (MAH), South Belfast Community Unit of Management. From April 1988 to December 1988 Temporary social worker, Mental Health Team, North Down & Ards Community Unit of Management. From January 1989 to November 2016 social worker at MAH. Now known as Band 6 social worker moving to Band 7 Senior Practitioner Social Worker (Approved Social Worker) and Band 7 Senior Social Worker August 2009 to November 2016 before going on long term sick leave and being medically retired in January 2018.

Module

3. I have been asked to provide a statement for the purpose of M7: MAH Operational Management.

4. I have been asked to address a number of questions/ issues for the purpose of my statement. I will address those questions/issues in turn.

Q1. Please explain what your role was in the management of MAH and when you held that role? In doing so please explain:
i. the cohort of staff for which you had leadership and or management responsibility.

5. I was Senior Social Worker from August 2009 to November 2016. Immediately prior to this there were five social workers in MAH. With the retirement of the previous Senior Social Worker this reduced to four and in March 2010 with a further retirement reduced the team to three permanent social work staff. It was planned to reduce the team further to two social workers as MAH inpatient numbers declined. This did not happen due to increased workload. In December 2012 two additional Band 7 staff social workers were appointed whose caseloads were exclusively Adult Safeguarding referrals. These two members of staff and I were supervised by the Service Manager. One of those Band 7 staff moved to another post within a few months. The other remained in post until retirement in April 2016.

6. Additionally, due to work pressures, there was an agency based social worker who remained for a short period and two newly qualified social workers who had been working within Day Care Services at MAH and were offered their first social work posts by joining the MAH team. These two individuals came at different time periods. I cannot recall those dates. With the Band 7 social worker's retirement in April 2016, who had been working exclusively in Adult Safeguarding, I fulfilled the Designated Officer role until a replacement was appointed in July 2016 who had also social work responsibilities for a designated ward. From July 2016 to November 2016 there were four social workers in the MAH social work team.

ii. the day to day responsibilities of your role.

7. As Senior Social Worker I was responsible for supporting staff in the delivery of the social work service to patients in MAH. The main vehicle for this was through monthly supervision of the social workers. Given the nature of the small team and that our offices were adjacent, supervision took place individually on a monthly basis or additionally as and when required. The newly qualified social workers who had previously worked in day care had additional supervision requirements as they were in their Assessed Year in Employment so had weekly supervision with myself, and also tripartite meetings regularly with a Practice Teacher from the Social Work Training Team in BHSCT.

8. My supervisor on site was the (and the titles changed) the Assistant Director and then the Service Manager. This was, in reality, a manager from a nursing background. There was also professional supervision with an Operations Manager who was professionally qualified in social work and was based in Belfast.

9. My predecessor had attended the CORE management meetings in MAH at the request of the then Director. This from my recollection was to ensure, that although not a senior manager, the most senior social work staff member on site was aware of all developments within MAH. I cannot recall what year this commenced.

10. Therefore, I took over the attendance at the CORE Meeting from approximately August/September 2009 until I was informed by the Service Manager that the Co-Director of MAH had decided as the senior management team were discussing issues beyond MAH that it was not appropriate for me to attend. I cannot recall what month or year this happened.

11. Historically the Senior Social Worker on the MAH site was both a practicing social worker with a case load and responsible for the social workers in the team. Therefore, on a day to day basis I was the social worker attached to Sixmile Assessment and Treatment wards and to Donegore ward attending weekly multidisciplinary team discussions and fulfilling the role of social worker for the patients in those wards. There was also a considerable amount of contact with

patients, relatives and community staff. This may have been with individual meetings/ telephone calls or as part of wider multidisciplinary team meetings. Within all MAH wards there were signs displayed saying which social worker could be contacted either by patients or relatives. Within the core wards (Cranfield Women, Men, P.I.C.U., Sixmile Assessment and Treatment, Donegore and Killead), social workers set aside time each week to be available for patients on the ward to meet face to face.

12. In MAH the social workers had a role in coordinating information coming in following admission, being involved in comprehensive risk assessments and in the forensic wards completing multi agency sex offender risk assessment and management forms (MASRAM). Social workers within MAH had a considerable role in the preparation and presentation of social circumstances reports to the Mental Health Review Tribunal.

13. With regards to Adult Safeguarding, I was a Designated Officer and fulfilled this role prior to the dedicated member of staff being appointed in December 2012. I supported this member of staff by covering annual leave and any sick leave periods. I covered this role on a full-time basis for a number of months from May 2016 to July 2016 in addition to my own duties until a replacement social worker was appointed.

Q2. If you had a role in the admission and discharge of patients to MAH, please explain:

i. How patients were referred for admission.

14. Social workers on the MAH site were not directly involved in the decision on whether or not to admit an individual. From my recollection admissions were for a number of reasons. Through concerns that had been brought to the attention of the Consultant Psychiatrist by parents or community carers, General Practitioners or at multidisciplinary community clinics. Through Out of Hours referrals to a duty Consultant Psychiatrist regarding a client living at home or in the wider community. Many of these referrals were situations known already to community and possibly

MAH staff if the patient was for instance on a trial placement or there had been attempts to maintain the community living situation but that this was now breaking down. Planned admissions when it was known that a client would require admission for a specific piece of treatment, for example, management of their medication. There were referrals from the Courts via the Mental Health (NI) Order 1986 in relation to the forensic service.

ii. Who was involved in the referral process;

15. From my recollection the Consultant Psychiatrist/on call Consultant Psychiatrist discussed the referral with the referring agent (a General Practitioner/ another medical colleague/community social work/nursing colleagues/ parents/carers). This in turn would have resulted in discussions with MAH senior management in terms of placement and resources necessary to support that admission. Within the forensic environment referrals were managed by the Consultant Psychiatrist, Consultant Forensic Psychologist and a Forensic Nurse Practitioner who would have undertaken an assessment of the individual. These referrals would have been discussed with the multidisciplinary team.

iii. What factors impacted whether someone was able to stay at home or in the community or whether they were referred to MAH.

16. Carer and support options had been exhausted in the community. A serious risk of harm to self or others possibly as a result of a deterioration in an individual's mental health and/or possibly behaviour that was so challenging that their home or placement could not be expected to safely manage such a deterioration.

iv. Specifically, did lack of resources or delay in availability of support in the community impact on whether a patient was referred to MAH? If so, please explain.

17. From discussions with community social work colleagues over the years there appeared to be a decline in the services available which could be utilised for the complex needs of certain individuals.

v. Were other options to enable someone to remain at home or in the community always explored prior to the decision to admit them to MAH?

18. I would be of the opinion from my experience that other options were explored by community staff to enable someone to remain at home or in the community. The community multidisciplinary teams with whom our social work team would have been engaging, did appear to have attempted a variety of measures, such as, additional support staff or in other cases a change in environment plus additional supports to maintain someone in the community.

vi. How was it decided when a patient was ready for discharge from MAH?

19. The multidisciplinary team working within a particular ward environment would decide if the individual had completed their treatment. This ranged widely from those who had been admitted to control their medication and therefore optimise the benefit, managing challenging behaviour and those who had completed a programme of treatment such as the Adapted Sex Offender Treatment Programme. The multidisciplinary team would have been able to access comprehensive risk assessment information following admission and reviews of this. There would have been reviews from particular specialist staff, for instance, Behaviour Nurse therapists/ Psychologists. All of these would have helped the team determine whether the individual was ready for discharge. In essence patients in the core wards were being prepared for discharge since admission. It was very clear that for those individuals who required very specialist staff intensive environments that the availability of these bespoke housing and staffing environments took considerable periods of time to realise.

vii. Were there patients at MAH for whom discharge was never considered? If so, why?

20. Not in my experience. There were patients throughout the MAH site who were discharged to community facilities who, years before, it could not have been envisaged they would be able to live outside of the MAH environment. It was not

a question of discharge not being considered but what could be done to adapt community living so that their needs could be met.

Q3. How regularly did management meetings take place at MAH? Who set the agenda for any such meetings? Were minutes always kept of such meetings?

21. There were a variety of meetings such as senior nursing meetings, meetings between the Consultants and the CORE management meeting which I attended for a period of time. From my recollection the agenda had items which were repeated and other items which were added and withdrawn as and when completed. The CORE management meeting took place monthly, and the agenda was set by the Service Manager although others could contribute agenda items. The minutes were taken by the Service Manager's secretary and circulated.

Q4. Did managers receive regular reports on:
i. The use of seclusion.
ii. The use of PRN medication.
iii. The use of physical intervention including MAPA.
iv. Safeguarding.
v. Complaints.
If yes, please explain who prepared any such reports and how any concerns identified from the reports were escalated.

22. There was a nurse whose role was to compile this information from the MAH electronic records. These reports were submitted to the CORE management team. Only point iv. of the above from memory was not included. Safeguarding data was discussed at CORE management and the Adult Safeguarding Officer attended these meetings although his attendance was not monthly. When I was in attendance at CORE meetings, I would have had the opportunity to discuss safeguarding issues. A monthly return of safeguarding activity was sent from the Adult Safeguarding Officer to the BHSCT's safeguarding office.

Q5 What procedures or processes were in place to ensure co-production between MAH staff and relatives of patients at MAH?

23. All patients had a named nurse. Many patients and their relatives were in regular contact with the ward and/or community and MAH social work staff. Core wards had weekly meetings involving community staff and relatives following admission and throughout the MAH journey. A patient and his/her relatives had input into care management assessments of their preferred options on discharge. Relatives visited potential community placements either with the patient or sometimes separately.

24. Other wards had monthly meetings of the multidisciplinary team and I cannot recall whether relatives were invited to attend although they may well have been. I do recall that relatives were to be updated on the outcomes of the review by the named nurse. As wards became resettlement wards, meetings became much more frequent, and relatives were actively contacted by MAH and community staff.

Q6. What procedures or processes were in place to ensure co-production between MAH staff and community teams?

25. Following admission, the MAH social work department was involved in coordinating the gathering of information from the community social work staff and in the completion of the comprehensive risk assessment for individual patients. Following MAH multidisciplinary team meetings, MAH social workers would have been updating community social work colleagues on any recent developments. This was particularly evident in the admission and assessment wards when at times there was joint working with community colleagues directly with an individual patient. Within other wards there was much less community staff involvement given the lengthy periods of time that patients had been in MAH.

26. The care management process involved the completion of assessment information from a number of disciplines whether it was in admission/assessment wards or in a resettlement identified ward. Each Trust had identified care managers who would

come on site, engage with the patient, the carers and MAH staff in order to complete the care management assessment.

Q7 What were the arrangements for multidisciplinary team working with patients at MAH?

27. Each ward within MAH had a Consultant Psychiatrist, ward manager, named nurse, day care worker and social worker who attended the multidisciplinary team meetings. The named nurse and the named day care worker could vary at multidisciplinary team meetings depending on which nurse was responsible for a patient and what group a particular patient attended in day care.

28. In the longer stay wards there was a medical review usually completed by the ward doctor, a nursing review and a day care review. There may have been input from physiotherapy in certain wards as well. The social work team had a first assessment form for new referrals and reassessment form used at reviews of known patients. In these wards historically there were monthly reviews when a number of patients were discussed. This ensured that every patient on the ward had a yearly review.

29. In the core MAH wards the meetings were weekly and usually all or most of the patients were discussed. Other professionals attended those wards such as Psychologists, Behavioural Nurse Therapists and latterly Occupational Therapists. Patients had the opportunity to attend multidisciplinary team meetings if they wished to raise an issue. They could also ask to speak to individual members of the team when the team met weekly and in my experience did this regularly. Any updates from the multidisciplinary team meetings in relation to that patient would be shared with them by nursing staff generally.

30. In the core wards patients were very aware of their access to their named nurse or named social worker and exercised this. Within the forensic wards there were opportunities for multidisciplinary team members to work in various group work settings with patients.

Q8 What arrangements were in place at hospital level to monitor the implementation of and adherence to BHSCT policies by staff at MAH?

31. Each member of social work staff had a Personal Development Plan (PDP) which set out key goals in line with BHSCT principles. Social work staff went on regular training to meet their training needs and also had to attend mandatory training from the BHSCT. There was a yearly EQUATE audit which examined compliance with BHSCT policies within the department. A supervision record for a member of staff was picked randomly and examined by an external auditor. Safeguarding records were examined by the Operations Manager with professional responsibility for the social work team. In addition, for the application for Charter Mark status, social work staff had been interviewed by the assessor in relation to their understanding of BHSCT policies and procedures.

Q9. What were the arrangements for clinical supervision of the practice of staff across all disciplines (including health care assistants) at MAH?

32. If I could refer to my response to question 1i. This gives the supervision arrangements for members of the social work team in MAH. I am not in a position to answer in relation to any other staff group within MAH.

Q10. What were the performance management arrangements for all staff, including managers, at MAH?

33. As part of the supervision process there was discussion on objectives set by individual social workers from their previous PDP. These plans were reviewed annually including one for the Senior Social Worker involving the Service Manager and the professional line manager.

Q11. What opportunities were available for the professional development of staff at MAH?

34. Through the PDP and monthly supervision social workers could identify pieces of professional development. This could be directed to the social work training team

or if additional funding was required via the Senior Social Worker to the Service Manager. Each member of staff had to complete a prescribed number of hours of training within a certain period of time. I cannot recall the exact number of hours or time span. These hours could be completed in a variety of ways, for example through reading of articles, to attendance at mandatory updates of training. Staff did request and receive training in new areas of their interest but given the pressure of current work had limited opportunity to use it.

Q12. Did you have any role in workforce monitoring, planning and implementation of ensure the appropriate staffing levels and skill mix (and thereby to ensure safe care) at MAH? If so, please describe that role. Please also explain how any concerns about such matters were escalated.

35. I had no role in the wider workforce monitoring, planning and implementation but did discuss concerns over a period of years in relation to adequate social work staffing levels. The first was in relation to Adult Safeguarding and the tremendous amount of work and paperwork generated. This concern was expressed to my line and professional line managers and resulted in a specific post holder for Adult Safeguarding. The second was when the social work team was reduced in numbers but had increased its involvement to include Iveagh Centre as the Centre had no social work attachment to its multidisciplinary team. Two additional newly qualified social workers joined the team at separate times to assist the team to maintain the same social work service by allowing a permanent team member to attend Iveagh Centre for the weekly multidisciplinary team meeting and work on the Iveagh Centre site for part of the week.

Q13. Did MAH managers carry out regular data analysis and trend identification? If so please explain how this was done.

36. I had no role in the above.

Q14. What arrangements were in place at hospital level to monitor the use of seclusion at MAH?

37. For the period I attended the CORE management group meetings this data was reviewed and discussed.

Q15. Please provide details of any occasions on which you became aware of concerns over the abuse of patients by staff at MAH and describe your recollection of action taken at management level to address such concerns.

38. I am not sure of the exact date the reporting of all adult safeguarding incidents commenced but I am aware that MAH was the first psychiatric inpatient facility within BHSCT to do this. Prior to this any concerns over the abuse of patients by staff were managed by senior management at MAH.

39. My recollection is that where there were accusations of staff abusing patients, whether independently witnessed or not, the staff member was immediately suspended, and Joint Protocol procedures initiated. These investigations were undertaken by the police and the patient's owning Trust. After a file was prepared for the PPS, my recollection is that the Trust awaited the PPS decision which could take a number of months.

Q16. Do you wish to draw to the attention of the Panel any other matters not covered by the above questions that may assist in the Panel's consideration of the Terms of Reference?

40. No.

Declaration of Truth

The contents of this witness statement are true to the best of my knowledge and belief. I have produced all the documents which I have access to and which I believe are necessary to address the matters on which the Inquiry Panel has requested me to give evidence.

Signed: 

Date: 09 April 2024