MUCKAMORE ABBEY HOSPITAL INQUIRY

SITTING AT CORN EXCHANGE, CATHEDRAL QUARTER, BELFAST

HEARD BEFORE THE INQUIRY PANEL

ON MONDAY 21ST OCTOBER 2024 - DAY 118

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THE INQUIRY RESUMED ON MONDAY, 21 OCTOBER 2024 AS FOLLOWS:

MS. BERGIN: Good morning, Chair and Panel, this morning's witness is Sean Holland and he is ready to be called. I understand that counsel for Core Participants is on her feet and wants to address the Panel.

CHAIRPERSON: Yes, of course.

09:37

MS. ANYADIKE-DANES: Chair, it's a very simple matter, the Inquiry wrote on the 14th of October, this is in relation to the McBride evidence, and that letter said, and I am going to read it because it's relevant to the instructions that I received.

09:37

"The Panel remains of the view that this witness is very unlikely to be able to contribute more than what is already contained in his written evidence, however, in the interests of working together with Core Participants, the Panel has decided to invite Professor Sir Michael McBride to attend the Inquiry in order to provide oral evidence in answer to Core Participants questions."

09:37

And you confirmed that one hour would be set aside. That of course, Sir, was before you had seen what questions the Core Participants might want to ask. We then got a letter on the 16th of October, so two days later, which was a sort of general point about evidence

and it says:

"The Inquiry, as it has to date, will ensure appropriate time is given for each Module 9 and Module 10 witness to allow any relevant matters to be put to them. You will note that on occasion the Inquiry has sat for longer than normal to ensure that all relevant matters are addressed in oral evidence." 09:38

The following day, Sir, you said, or it was said, in the chamber and I am reading from the transcript of the 17th of October it appears at 101 and 102, and it starts with a comment from senior counsel to the Inquiry, Sean Doran, line 23: 09:38

"Looking at the schedule on the website for next week, one will also see that Professor Sir Michael McBride is listed to attend at 3.00pm on Tuesday the 22nd. Having considered his statement and the other evidence for the purpose of this module the Panel does not need..." 09:39

So it's repeated.

"...to raise any further questions with him in oral evidence and the purpose of its consideration of the Terms of Reference, he was not therefore asked to attend the Inquiry. You, Chair, did however accede to requests on behalf of relatives of patients that he should attend to provide oral evidence." 09:39

once again that is before any questions have been seen, it. Then goes on, this is the bit I particularly want to take you to because this is what my instructions relate to. 09:39

"The questions that have been received will be considered by the Inquiry team in consultation with the Panel to assess what matters require to be raised with the witness in oral questions." 09:40

And these are the two issues that concern my clients. One is they would like you, Sir, to provide some reassurance that you are, since you are going to be participating and deciding on the questions that you 09:40 are not approaching that with a closed mind, that notwithstanding the fact that you've already stated and it has been stated on your behalf on a number of occasions that effectively you don't see there is any value can come out of this, nonetheless you will 09:40 approach those questions and assess them on the basis of the value of those questions, as opposed to your provisional or original view. And secondly, if it turns out that more than one hour is required to deal with Professor Michael McBride's evidence, that that 09:40 time will be afforded, as has been already made clear before.

You'll understand the importance of that to my clients

and I would be very grateful just if on the record you could give that reassurance. Thank you.

CHAIRPERSON: No, I've heard that. First of all can I say, I don't say this flippantly at all, I generally don't approach anything with a closed mind thus we are calling Professor Sir Michael McBride. We'll start him at 3 o'clock, we will ensure that he is asked all the questions that it is appropriate to ask him. It does seem right to mention now that there have been a large number of questions that have come in, understandably, for Professor Sir Michael McBride and what I have directed to happen is that counsel should go through those and should formulate a list of issues for him to deal with. Now those have now been provided to him, not the questions themselves but the issues because one of the problems this Inquiry has faced is witnesses coming along and saying well, I can't deal with it now, I'll deal with it in writing afterwards it and seemed because there was a late change of plan in relation Michael McBride, it was only fair for him to at least know the issues that he will be asked about, that happened on Friday. Those issues will be circulated to CPs so that you see what those are.

09:41

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09:42

MS. ANYADIKE-DANES: Can we have them before he gives his evidence?

09:42

CHAIRPERSON: Yes, of course, they will be circulated today. Of course he is not giving evidence today, he is giving evidence tomorrow.

MS. ANYADIKE-DANES: Of course but we do have to have

time to consider it and see how those are affected by other evidence. There is one final matter which might assist, actually, which is whether we could have a meeting that is sort of devoted to issues -- I don't just mean acting for myself, but Core Participants' legal teams might have with the Panel. As your Lordship -- sorry, I keep trying to elevate you. 09:42

CHAIRPERSON: I don't mind.

MS. ANYADIKE-DANES: It may yet happen. As you're aware, the way in which senior counsel for the Inquiry, Sean Doran, put it was that essentially all oral evidence would be concluded this week and then there would be a sort of I suppose you would call it a housekeeping session thereafter. The slight difficulty with that is that there are some issues that for my clients and maybe some others, that do relate to the evidence and it will probably be better to have a meeting with the Panel before you finally close all of that. I'm quite happy to have a discussion with your senior counsel as to what some of those issues are, but I think we've reached a very important stage of this. 09:43 09:43 09:43

CHAIRPERSON: Yes, we have.

MS. ANYADIKE-DANES: Where you are about to close it and I think it would be unfortunate if that happened and there were people there that thought that matters had not been addressed. One of the reasons I say it now so it's clear, is that we did get -- we have over time corresponded significantly with the Inquiry about evidence that we think could be explored further or 09:43

matters that weren't covered at all. Some of that actually has been picked up as the Inquiry has gone on and we have been grateful for that, others have not. And we then received a letter from the Inquiry, I think it's dated 17th October, saying we are in receipt of all your correspondence, because a chaser was sent as to what was outstanding, and you will get a substantive reply on all of that after the evidence concludes, which rather begs the question, because quite a bit of that relates to evidence. So it struck me it would be better to deal with that before, Sir, you actually conclude all the evidence so we all know where we are. 09:44 09:44

CHAIRPERSON: Yes, I understand that. I am also aware of the correspondence and the outstanding issues. The difficulty has been there is a huge amount of effort focused on these witnesses at the moment and that's why you haven't had a substantive reply. I can indicate you will be getting -- I think there are at least three outstanding issues. 09:44

MS. ANYADIKE-DANES: There may be more but we can write and draw that to everybody's attention. 09:45

CHAIRPERSON: So I expect senior counsel is listening to this exchange as we speak downstairs and I think the first step will be for you to have a meeting with him but probably that may not be able to take place until Wednesday. Can I just give you some assurance that those issues are still alive in the Panel's mind. They haven't been forgotten about. 09:45

MS. ANYADIKE-DANES: I am grateful for that and I hate

to repeat it but it is just that if, Sir, you are going to say we're not hearing any more evidence, we've dealt with as much of your suggestions as we think are necessary, then it's probably as well to have that view before you conclude the oral hearings because that may lead to other matters. 09:45

CHAIRPERSON: Remember also that things can be followed up in writing and can be followed up with witnesses in writing and we've said that before, that if a further statement really is required then the Inquiry can take that course. 09:46

MS. ANYADIKE-DANES: Of course.

CHAIRPERSON: Can I just say I am keen to get on now.

MS. ANYADIKE-DANES: I understand but I just wanted to get that on the record and I'm grateful to you. 09:46

CHAIRPERSON: Thank you. Right.

MS. BERGIN: Yes, thank you Chair, the witness can be called.

MR. SEAN HOLLAND, HAVING BEEN SWORN WAS EXAMINED BY MS. BERGIN AS FOLLOWS: 09:46

CHAIRPERSON: Mr. Holland, welcome to the Inquiry. Sorry, we asked you to attend early and kept you waiting for a bit. We will now -- you have probably seen how this works. If you want a break at any stage please let me know. We'll probably take a break in about an hour, a short break, and then another one a bit later on in the morning because we have got a 09:47

slightly longer morning than normal, all right.

A. Thank you.

1 Q. MS. BERGIN: Good morning, Mr. Holland. As you know my name is Rachel Bergin. We met earlier and I am one of the counsel Inquiry Team. You should have a copy of your statement in front of you dated 28th June 2024 and you have attached a large number of exhibits to your statement which you also have. You have signed a declaration of truth at the end of your statement and I understand that you have two minor amendments to make to your statement? 09:47 09:47

A. Yes, page 27, para 81, correction required is --

CHAIRPERSON: Hold on, let's just find it. Yes.

A. Where it says "they was" should read "they were" and page 35. 09:48

CHAIRPERSON: I spotted that, yes.

A. Para 123, "exhibit 16" is added in error and that sentence shouldn't be there.

CHAIRPERSON: You mean those words?

A. Yes. 09:48

CHAIRPERSON: Is that it?

A. That's it.

2 Q. MS. BERGIN: And subject to those corrections then are you content to adopt your statement as your evidence before the Inquiry? 09:48

A. Yes, I am.

3 Q. Now, turning to your statement then, and you will be able to follow along on the screen in front of you, at paragraphs 1 and 2 you outline your professional

background. Now we won't go through all of that but in summary you qualified as a social worker in 1986 and you were then seconded to the Department of Health in 2001. You became the Assistant Chief Social Services Officer in 2008, is that correct?

A. Yes.

4 Q. And then in July 2010 you were appointed as the Chief Social Services Officer or the Chief Social Work Officer and those titles are used interchangeably and you held that role for 12 years until 2022 so you are no longer with the Department of Health?

A. That's correct.

5 Q. In terms of understanding the role of the Chief Social Work Officer, that sits within the office of Social Services and the OSS and you outline then in your statement that the OSS is located within the Department Social Services Policy Group and it provides professional social work advice to the Minister, Deputy Secretary and Chief Social Worker and others. And you say that in addition to your role as Chief Social Worker From 2012 onwards you also became the Deputy Secretary of the Social Services Policy Group and that meant that you were also responsible for Mental Health and Disability and other parts of the Directorate. Thinking back to that time, do you consider it was beneficial to have those dual responsibilities or not?

A. A point of clarification is that from 2010 when I was appointed Chief Social Worker that post did encompass policy responsibility for children's Social Services

but not those other areas, they were added in 2012 and other areas were Mental Health, Social Care For Older People and Learning Disability and Physical Disability. I think the motivation in putting all of those into one post was to try and make sure that there was professional insight in the policy leadership of those areas and that was the ambition, as far as I understand it from Dr. Andrew McCormick, who you've heard from. As to whether it was beneficial or not, it's a very broad portfolio and I would note that in England, by comparator, it isn't organised that way. There are two chief social workers, one in the Department of Education who handles matters relating to children, one in the Department of Health who handles matters relating to adults and those are professional posts only, they don't have policy responsibility beyond policy as it relates to the education and regulation of the profession. 09:50 09:51 09:51

In my post, all of that was in the one post and certainly, at the point when I left that post, as part of my departure the Permanent Secretary, Peter May, sought my views on the post and I suggested to him that there are many different ways, obviously, that you can divide and organise work and it is rarely a Manichean situation where there is the right answer or the wrong answer. But I did reflect it was a broad portfolio and suggested he might consider splitting some of those responsibilities and subsequently those changes have 09:51 09:52

been made so there is a Deputy Secretary with policy responsibility for those areas and there is a Chief Social Worker who solely has the professional remit. I think that's all I would offer.

6 Q. Those changes have been brought in since you left post in 2022? 09:52

A. Yes, when my post became vacant it was recruited on that basis so there was a Deputy Secretary recruited and there was a Chief Social Worker recruited.

7 Q. And another element of your role at that time was, as you will come on to see as you detail in your statement, was that following the allegations of abuse at Muckamore in 2017, MDAG, the Muckamore Departmental Assurance Group was established in 2019 and you were the co-Chair of MDAG along with the Chief Nursing Officer? 09:52 09:53

A. Mhm-mhm.

8 Q. Before we then continue with your statement, can you tell the Inquiry, in your roles either as Deputy or as Chief Social Work Officer did you ever cause to actually visit the Muckamore site? 09:53

A. Post '17 I visited Muckamore on a few different occasions. I visited with the Permanent Secretary. I visited it with the Minister and I met relatives there and I think I attended a meeting there. Prior to that, many many years ago I visited the Muckamore site but that was before my employment in the Department. I previously worked in the Mental Health and Disability Directorate which included Learning Disability in the 09:53

then Lisburn Trust, which was one of the precursor Trusts to what is now the South Eastern Trust. I recall attending a meeting about psychology services on that site. Then before that I do remember visiting Muckamore many, many years ago as a student social worker just as a service visit that was arranged for students to get a feeling for different services.

9 Q. You were asked a number of questions in your statement and those are split into. There is an initial set of questions and then questions for departmental witnesses. And if we look to the first question on page 3, you were asked about the professional reporting lines from Muckamore to the Chief Social Work Officer. At paragraph 7 you outline that there's no direct professional reporting line between social work staff at Muckamore and the Chief Social Work Officer but there are reporting arrangements on delegated statutory functions. New arrangements were introduced when the Health and Social Care Board functions transferred to the SPPG and you received annual reports on delegated statutory functions from the HSCB, or now the SPPG, which identified any issues which needed to be escalated or acted upon.

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Pausing there, in terms of the delegated statutory functions, those reports were broken down by Trust, were they, when they came to you in terms of --

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A. Each Trust submitted a report to the Health and Social Care Board, which was the authority, it was from the

Board that the authority was being delegated to the Trusts and those reports would have gone to the Board and then an overview report was compiled on the basis of those which came to the Department, and I would have seen that. 09:55

10 Q. And so would you and your colleagues in the Department through those DSF reports have received or been able to access information by Trust which gave you a picture of what was happening in each Trust at various times?

A. There would have been times when that would have been highlighted within that overall report and we could always seek additional information about any aspect of those reports. The reports when they were received would have been considered by relevant professional officers within the office of Social Services. So, for example, there would be two professional officers who would have dealt with matters relating to child protection, who looked after children and family support services. There would have been somebody who was specifically designated to look at issues to do with Mental Health and Learning Disability. They would have considered those, raised issues with me that they felt should have been pursued in our discussion with the Board. We would have met with the Board about the reports. 09:56 09:56 09:56 09:56

DR. MAXWELL: So just to confirm, you saw an overview report prepared by HSCB?

A. Yes.

DR. MAXWELL: You wouldn't routinely see the

submissions to the HSCB from the Trusts?

A. Not directly. I think it's also important to clarify, because I have watched some of the previous witnesses and I don't think it's been quite clear, adult safeguarding is not a delegated statutory function. 09:57

DR. MAXWELL: So we've heard a little bit about the arrangements with the local adult safeguarding partnerships. Would you have as Chief Social Worker, have received reports about adult safeguarding through that report, that route? 09:57

A. There would have been a report that would have came through -- well there would have been reference to adult safeguarding in the delegated statutory function report in the context of their statutory functions, but adult safeguard is not currently a statutory function. 09:57

DR. MAXWELL: No, I understand what you're saying.

A. There was also statistical information that was provided on adult safeguarding activity in a separate report. Both of those came through the same route, the Board. 09:57

DR. MAXWELL: So your report on adult safeguarding, which isn't a delegated statutory function, your report on that also came from HSCB?

A. Yes.

DR. MAXWELL: Thank you. 09:57

11 Q. MS. BERGIN: The Inquiry heard evidence from a witness called Cecil Worthington, who was a Trust Board member, in respect of the Directors of Social Work raising concerns about the delegated statutory function

structures from as early as 2013, '14. Is that something, all I want to ask you about that is is that something you were aware of, of concerns being raised about the delegated statutory function structure or reporting mechanisms?

A. Yes, we would have discussed it. I would have held regular meetings with the Directors of Social Work and we frequently discussed issues in relation to the delegated statutory function reporting process.

12 Q. And can you tell us a little bit more about that, what time frame was that and what was the outcome of that and what were the issues? 09:58

A. The reports had grown over the years and I think I certainly felt when I came into post and looked at the report that it was becoming unwieldy. An awful lot of it was very repetitive in the narrative section. And also, while a lot of activity was being reported on, in itself that didn't give any indication as to positive or otherwise outcomes that were associated with the activity. So we talked frequently about how that could be improved and in the course of my time I think the circulars were revised. Certainly they were revised and two new circulars were issued around 2015 and then again in 2018 I asked for a further review to be done of the statutory function circular and the reporting. That, unfortunately, was delayed with Covid but my understanding is that new circulars have yet again been issued on the basis of that review resulting in a much more streamlined and focused report. My understanding

is there was actually a workshop held last Monday, this day last week, with relevant staff to look at the operations and new circular. In addition to that, there were times within the confines of the existing circulars some changes were made. So we asked the 10:00
Trust to include more outcome orientated information at a point in time. And I think that was in -- there was a review we asked for between 2012 and '14, then the circular was reissued in '15 and then again I think in '15 or -- I think it was 2015, maybe '16, there was an 10:00
issue where we'd asked for a more outcome focus to be included in the reports. There was a deadline set for that and the Trusts asked for an extension to that deadline. I wrote to them saying that I was prepared to accept a short extension but I didn't want it to be 10:01
so long that the next reporting period would not include the new information, or it wasn't new information but it was trying to focus more on outcomes. I mean, for example, and it's not relevant to this but just to give you a flavour, we would have 10:01
had an awful lot of information about children in the social care system, including looked after children, and an outcome that was relevant I felt was, you know, sort of the educational attainment of those children. So we started to look at things like number of children 10:01
with five GCSEs and above to get that greater kind of outcome focus.

Other changes, the late Finnoula McAndrew that was at

one stage a director in the Board, she was actually the first Director of Social Services in the new Board, I recall she secured additional statistical support to improve the statistical analysis that was presented in the report to the point in time.

There was also a discussion quite early on where when people were talking about the statutory functions and the difficulties with them. I asked well, you know, should we abandon this scheme and should we just incorporate or mainstream these reports into the other reporting lines because the Department would seek a lot of information saying why are we treating differently. I mean I knew the reason why, but just to test the point was it a good idea to continue. Unanimously the directors said they wanted to retain the statutory function report, because they felt it was an opportunity to give a profile to activity that they said they sometimes struggled with getting a profile within integrated health and social care trusts and I was sympathetic to that position.

PROFESSOR MURPHY: Was that because acute services tended to dominate the agenda?

A. I would say healthcare services generally, including acute services, but within that description there are certain areas of activity which are always of a very high level of concern, both to the public, to political representatives and the media and to Trusts. And it's unusual to have these activities counted or considered

within the same organisational bucket. I mean, in most of Europe, social services aren't dealt with in that way, they are dealt with normally by municipalities i.e. local authorities and that's the case in other parts of the UK. It's I think a challenge to make sure 10:03
when you are being faced with something like cancer waiting times and the number of children who require to be looked after, to achieve a balance between those things, it's not comparing like with like and I think that remains a difficulty. I know that a previous 10:04
witness had raised the issue about things might have been better if we had a dedicated mental health and learning disability trust and I think there is merit to that argument, I am not saying it would work or wouldn't work, but it's definitely an argument to which 10:04
there is merit.

And also, having all of these functions within single organisations has resulted in very large spans of control for those organisations. So although Northern 10:04
Ireland is a small place with a small population and indeed often I've heard commentators say we should have one Trust for Northern Ireland, for all of it, the reality is that in an equivalent population size say in England these functions would be discharged probably by 10:04
a range of organisations. You would you have acute health care trusts, you might have primary health care trusts, you would have possibly a mental health and learning disability trust and you would have a local

authority. Now, again separately to this, because of challenges that have arisen in recent years in child protection services, I commissioned an external expert or I requested, sorry, that's not correct -- I recommended to the Minister that he commission an external review of those services and he did so, Professor Ray Jones, the eminent expert in the field of child protection came and did a piece of work for us. He explicitly commented on the Belfast Trust and its size and span of functions. He actually recommended, and this is a recommendation which is with the Department, that children's social care should be removed from the integrated health and social care and there should be a separate ALB established to focus on that. 10:05 10:05 10:05

Now, this is a complex area and I don't think the same argument necessarily applies for learning disability and mental health. Is it okay to continue to explain on this or am I drifting too far off? 10:06

DR. MAXWELL: No, go on.

A. Children's social care, there is an interaction between children social care and health obviously, health visitors play a crucial role within child protection and family support, and there are health consequences to aspects of child neglect and abuse obviously. But, they are either acute health consequences from an immediate injury or, more significantly, cumulative consequences which show themselves in adult life. It 10:06

is not the same relationship that there is, for example, between adult social care and health systems where, when an older person needs -- when an older person's social care need emerges it is almost always associated with emerging healthcare needs. That's not the case for children. I mean, there is poor health amongst children who have been known to social services, absolutely, but it is not the same kind of relationship. Likewise with learning disability and mental health, but particularly learning disability, it is well established that people with a learning disability experience both poorer health outcomes than the general population, but their experience of health services is also often found to be less than it should be. And so, it is intuitive and it is argued that there is a benefit to those things being held within the same organisation structure. 10:06 10:07 10:07

Now, as I said, you can argue all of these things different ways and you also have to balance the cost and disruption of making a major structural change to the system. I mean again there is research about major structural changes to healthcare systems which show they almost invariably cost more than people anticipate, take longer than people anticipate, deliver less than people anticipate and often you will experience a deterioration in performance and outcomes during a period of change in those structures so all of those things have to be balanced in these arguments. 10:07 10:08

13 Q. MS. BERGIN: Terms of the size of the Belfast Trust, the Inquiry has heard about that issue from witnesses. One of the themes that has emerged from some witnesses is that the Trust is very large and that that can mean that acute services can take precedence over Learning Disability Or Mental Health and Social Care Services. On the same vein then are you able to express a view about that? 10:08

A. I think it certainly presents a challenge and I think it's incumbent upon both the Board and leadership generally of those organisations to try and make sure they mitigate, take mitigating steps to address that challenge. 10:08

I also think that there is an issue about the focus that can be given by any Board, depending on how broad it is. If I can again draw in another example, I sit as an non-executive Board member of an organisation called Tusla which is the state agency in the Republic of Ireland for child protection services. It is a national state agency that overseas and delivers all family support and child protection services, other than those that it commissions from third sector providers. I have been struck very much when sitting on that Board that when that Board sits and considers anything from how to spend its allocated budget for investment in IT services through to how it undertakes workforce planning, that it is only doing so for that one sector. Whereas both in our department, the Board 10:09 10:09 10:09

and the Trusts, those functions are being addressed across a range of really divergent kinds of services. I mean I think it is true that sometimes certain services suffer in that. A recent example, there has been a major investment programme in IT services and a system called Encompass has been introduced. Now Encompass is one of those, I think it would be fair to describe it as a proprietary system, it is sold by a private provider and it is then adapted to individual clients, but it is a healthcare system and certainly it has not been able to be adapted to meet some of the reporting requirements of some social services and so there are some outdated old systems like SOS Care that have to continue to be used to gather information because Encompass does not address those. But that's where the bulk -- that's where the money went to for the major IT investment, certainly in my time. 10:10 10:10 10:10

So I'm not saying it can't be done but I am saying there are definitely challenges by having such a wide span of responsibility and focus. People can only deal with a certain amount of -- there are only so many things can be your top priority. 10:11

CHAIRPERSON: But, it is easier presumably in, not a smaller organisation, but an organisation with a smaller focus such as the one you described, is it Tusla? 10:11

A. Tusla, T-U-S-L-A.

CHAIRPERSON: To focus on those issues which most

matter to that sector?

A. Absolutely. I Chair a service and quality subcommittee of that Board and it's one of three subcommittees, there are the usual other subcommittees, audit, risk and what have you, but that committee only focuses on children's social care issues. Whereas say the Assurance Group in Belfast Trust or any other Trust is covering a huge range of activity. 10:11

14 Q. MS. BERGIN: At question 2 then on page 4 you were asked how often Muckamore was discussed within the office of Social Services and what types of regular information was received by the office. At paragraph 9 you say~ 10:12

"Before 2017 the OSS did not receive regular information about Muckamore nor was Muckamore regularly discussed." 10:12

Issues raised with your office were at a strategic rather than operational level and occasionally the HSCB annual report would mention Muckamore in respect of resettlement. 10:12

Can you tell us a bit more about why Muckamore wasn't an item that was on the agenda or a subject of focus for the OSS prior to 2017? 10:12

A. The strategic position of Muckamore was considered in the context of resettlement and it would have been something that would have been occasionally mentioned

in the overall drive towards resettlement. Operationally, I mean it wouldn't be routine for single facilities to be discussed in the office of Social Services, unless they had been escalated to us as being issues of concern. That did happen. I mean I can think of a secure unit for adolescents which had operational difficulties that were of sufficient significance for concerns to be escalated and discussed in the Office of Social Services and that was through a combination of concerns by the Trust who were operating that facility, who they themselves said we are not comfortable with some of the risks we are managing here. That would also have been verified by the RQIA who were inspecting that facility. 10:13 10:13

DR. MAXWELL: But did you discuss the fact that resettlement wasn't progressing? So we've heard there were various dates for resettlement, everybody was supposed to be resettled by 2015 was one of the targets. We have also heard witnesses say that the needs of the patients to be resettled changed because those with more complex needs remained in the hospital and that the slow down in resettlement was because the patients remaining had very complex needs and current community services couldn't meet them. That would be a strategic issue rather than an operational issue to be discussed surely? 10:14 10:14

A. The first point you were making before the complex needs --

DR. MAXWELL: There were various targets for the long

stay resettlement. I think there was an early one but there was certainly a target that nobody would call a hospital a home by 2015 and clearly that's before 2017. So, I'm wondering, I take your point about not discussing all the operational issues, but there were surely some strategic issues about resettlement of people in long stay facilities who had learning disabilities and just wondering what discussion there was before 2017 about them?

10:15

A. They would have been raised in accountability meetings with the Health and Social Care Board and with Trusts. I think it's important to recognise that very significant progress was made in resettlement. We have gone from a facility that looked after several hundred people, in my time it was probably around 300, 400, down to I think the current numbers are 16, so there was significant progress. Targets were missed regularly, although not always, there were two years when the targets were actually met. And probably also worth noting, and I have to admit I wasn't aware of this analysis until it was provided through something we may come on to later which was the report we commissioned from Ian Sutherland and Bria Mongan that within the overall resettlement issue Belfast was an outlier. That was dragging down not only the overall figures, but it also had an impact on the figures for other Trusts because there were some schemes being brought forward by the Belfast Trust which were being brought forward on the basis that other Trusts would

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have patients placed in those schemes and, unfortunately, the review that Sutherland and Mongan did identified that the targets that were being -- or the information about progress against those targets was unrealistic.

DR. MAXWELL: They have given evidence to the Inquiry, we have heard that, this point about did it slow down because the needs of these patients were different and could not be met by Belfast Trust and therefore government or the Assembly would have to do something, was that ever discussed?

A. I think from the 1990s there were people resettled out of Muckamore who had the highest levels of complexity of need and they were resettled successfully. I recall from my time, I mention I worked in the Disability Directorate of the Down Lisburn Trust, there were people being resettled from Muckamore then and there was a range of people being resettled from those who were able to live independently to the point they had their own key to their front door and some of them went into employment, through to people who were at the highest dependency with dual diagnosis, particularly of either mental health difficulties or autism and learning disability. So it may well be that the concentration grew, but that wasn't the only reason why the cohort who are there are the cohort who are there. Some people were reluctant to be resettled. Some relatives were reluctant to have their relatives resettled, and those were also factors. So it wouldn't

be a straightforward question that it was an issue of complexity. And people of the highest level of complexity have been successfully resettled, over decades.

DR. MAXWELL: So there wasn't a discussion about whether there was a capacity in the community to manage these patients? 10:18

A. Oh, no there was a discussion and the discussion would have been held in accountability meetings, but it wasn't a case that this is an impossible task. It was this is going to take longer, we are running into issues with finding a provider to proceed with a scheme or what have you, but it was never suggested to me that they weren't capable of doing it. And indeed, as I say, the evidence would not stand that up because people at the highest level have been resettled. And that would mirror the experience in other jurisdictions as well. 10:18 10:19

MS. BERGIN: If we then go to paragraph 10 and here you say that operational responsibility for Muckamore rested with the Belfast Trust and that you wouldn't have expected direct involvement by your office unless professional social work issues had arisen which were of sufficient gravity to require escalation. What types of issues would fall into that grave category to be escalated? 10:19 10:19

A. I suppose I would draw parallels with other services again and there were occasions when facilities were escalated to me and services were escalated to me. I

mean unallocated cases in child care was an issue that was escalated by Trusts to the Board and through the Board to me. There was a growth in the number of cases were referrals had been received, they were initially screened but they were not allocated a social worker to respond. Now, that was a grave issue because you run the risk of children who were very vulnerable and in need sitting without a service appropriately being provided to them so that would have been escalated to me. It would have been then discussed. We would have done analysis into that issue. I think at one point an additional £5 million was allocated specifically to address that issue on the back of the concerns of the Trusts around that. So those kind of things would have been escalated to me. 10:20

We also always would have had a situation where a child death would have been escalated to me. I would always have been phoned whenever a child was known to services, in advance of receiving an Early Alert the Director would have rung me and said look, we have had a situation, a child has died, and I would have directly informed the Minister about that. 10:21

15 Q. In the context of learning disability what are the types of things that you would expect to be brought to your attention in the Department? 10:21

A. Certainly if there had been an incident of significant abuse in a learning disability facility, but that would have to be beyond simply the fact of abuse having

happened or being suspected because there are ongoing referrals and investigations in delivered services into safeguarding every day of the week so it would have to have been of a level. Or if the sense of those who were responsible for operating the service was that they couldn't safely operate a service. As I say, Trusts have escalated those concerns to the Department and to me when they've said look, we do not feel we are currently operating a safe service. 10:21

PROFESSOR MURPHY: Wouldn't institutional abuse or beliefs about institutional abuse going on have reached that gravity criterion to have been escalated to you? And if so, you know, why didn't the Ennis Report get escalated to you? 10:22

A. Firstly I'll deal with the point about institutional abuse. As I've said, adult safeguarding is not on a statutory function currently so we hope that that will change and a bill is currently programmed for this legislate programme. But it is not on a statutory footing. One of the deficits as a result of something like this not being on a statutory footing is you don't have the same accompanying regulation and guidance associated with discharging that statutory function. So there is currently no definition in statute of institutional abuse in adult safeguarding and I think there may well be one in the current guidance, but certainly the 2015 guidance, although it identified institutional abuse as a type of abuse there was no definition of institutional abuse. So that's a 10:22 10:22 10:23

challenge. That said, in facilities, again I'm sorry to keep going back to children's services but it is a comparator, were we to have identified or been flagged up that there was complex abuse, and that is defined in a lot of guidance in children, there is various aspects about whether it involves a number of people, whether it involves a degree of organisation, whether it involves a number of different services, that would be escalated. So I would have had calls from directors on a number of occasions where there were joint operations with the police where they suspected they were dealing with organised abuse and that would have been escalated to me, not necessarily to do anything, because the operational responsibility, but certainly I would have been told about those. Had we had a situation, to be specific, about Ennis, if I had a children's home where a number of staff had been arrested that would have been, I would have been advised of that. 10:23 10:24 10:24

CHAIRPERSON: Right, I suspect that a whole area on Ennis, was there an area on the Ennis Report that you were going to deal with or not? 10:24

MS. BERGIN: Yes, but certainly if the witness is dealing with it now, if there is anything that hasn't been dealt with I can come back to it.

DR. MAXWELL: So you're saying the social worker who undertook the safeguarding review at Ennis didn't escalate it to you? 10:24

A. It wouldn't have been for the social worker to escalate something like that to the Chief Social Worker. When

those things were escalated to me it would have been by the relevant director of service. A designated officer, a DAPO, would be much closer to the ground, they would have done their investigation, the findings of that investigation would then go up the line within the Trust. 10:25

DR. MAXWELL: So if the designated officer had done a safeguarding investigation, as indeed was done in the Ennis Ward, and there had been, had remained concerned that the overall consensus was this was contained, if that social worker had ongoing concerns, that you would have expected them to raise it with the Executive Director of Social Work in the Trust? 10:25

A. I would have expected them to raise it with their line manager. I mean, I struggle to understand, regardless of the outcome of the safeguarding investigation -- 10:25

DR. MAXWELL: Yeah.

A. Why, if you had several members of staff who had been arrested in a managed delivered service, as I say in parallel services the Trust just would have phoned me. I mean you would have had obviously subsequent mechanisms, there would have been an Early Alert and what have you, but it would have been something that I would have expected a director just to call me about. 10:26

DR. MAXWELL: So I think there was an Early Alert. 10:26

A. There was an Early Alert.

DR. MAXWELL: And that didn't come to you?

A. I have no recollection of seeing it but the early alerts are really, I mean they are not a major part of

the governance structure, they are what they say. They are about just letting you know this is going on. The governance structures would then follow either through a safeguarding investigation or an SAI and indeed my understanding is that we were advised that an SAI was being undertaken. Certainly I've recently looked at the Early Alert and there are -- I mean it makes a reference to this matter as being referred to the independent safeguarding authority, there is no such organisation. 10:26 10:27

CHAIRPERSON: I mean an Early Alert, as I understand it, is a warning to the Department that something may come up or the press may contact them.

A. Mhm-mhm.

CHAIRPERSON: And it is sort of a warning so they don't get surprised, but it doesn't actually trigger necessarily any reaction; is that right? 10:27

A. No, no.

16 Q. MS. BERGIN: At paragraph 11 then you say that you don't recall any issues about Muckamore being raised at regular meetings with the Directors of Social Work from the Trusts and that you had no information to suggest that there were systematic issues at Muckamore. You then describe being made aware of follow up work by the HSCB on allegations of peer on peer abuse at Muckamore which first emerged in 2005. Then you go on to describe your correspondence in relation to that issue. If we just pause there, in terms of there not being an awareness or any evidence to suggest systematic issues 10:27 10:27

at that time, this is against the backdrop of the 2005 peer on peer and we'll come to the historic allegations, Operation Damson in a moment, and then the 2011 Ennis, Early Alert and also then the investigations that followed. Is there anything else, with the benefit of hindsight looking back, that you would say the Department had on its radar in relation to Muckamore or learning disability issues at that time that ought to have made it consider that there were wider issues at Muckamore? 10:28

A. I think there is a general point about the risks associated with running facilities of this type. Those risks are very well known and it's not to say they always materialise, it is not to say that you can't run this kind of facilities safely and I think Professor Barr might have made that point. But they are well known that institutional care of vulnerable people carries with it inherent risks that --

CHAIRPERSON: Could we stop the interchanges in the room? I'm finding it really distracting. Please carry on.

A. That providers should be aware. I actually was reminded when we started this process when we were talking to the Minister about this Inquiry being established, I think it was the first major public inquiry into health and social care of modern times was Ely House in Wales '67 maybe, late 60s anyway, and it was about abuse of vulnerable people in institutional care. And since then there have been many, Winterborne

View is explicitly referenced in the questions. We have also had the Historical Institutional Abuse Inquiry here in Northern Ireland looking into institutional abuse in mother and baby homes, children's homes. It is a known risk that when you care for vulnerable people in large group living settings that you need to be aware of, and I think that just should be part of the ongoing business. 10:30

But specifically in relation to Muckamore, I mean when I do recall being aware of the Ennis Investigations in the context of receiving an assurance that these had been thoroughly investigated and the RQIA had considered those investigations, they had made recommendations and those issues had been dealt with so it wasn't at a point when flags were being waved. 10:30 10:31

DR. MAXWELL: You made the important point that we know that vulnerable groups of people, children but also people with learning disabilities in institutional care, using a non-pejorative term, are at higher risk of abuse than perhaps other client groups. Does that not then suggest there should be some positive measure of assurance that people are alert to that and are looking for it? 10:31

A. I think we did seek positive assurance that the Permanent Secretary explicitly on the back of the historical abuse wrote to all Trusts and said I require assurance that the risks that are inherent in these facilities, based on looking at the historical issue, are now being managed currently and he received those 10:31

assurances. I think also it is incumbent upon any organisation that runs such a service to be aware of those risks. I mean they shouldn't need to be told. If you are an organisation of 20,000 people with executive members, with particular professional expertise, with assurance groups and what have you, that you shouldn't need someone to tell you there are risks inherent in running those facilities.

DR. MAXWELL: I am not suggesting you should have to tell them, I suppose it all hinges on what you mean by receiving assurance. So receiving assurance could be oh, I can tell you it's fine but I am not producing any data to support that, you just have to believe me. You could say we don't have any incidents of harm so no news is good news. Or you can actually say we have got proxy indicators that this is actively being managed and that there is a positive environment and those are very different things and I am wondering what you mean by got assurances. Was that just we haven't got any incidents of abuse and we have got a policy and that people were saying that that was assurance?

A. I think that that is in part an assurance. I mean if people are accountable officers and they give you an assurance it is based on the premise that they are acting in good faith, that is part of their contract of employment and in many cases it is part of their professional responsibility if they are registered with a regulatory body. But at departmental level then your additional assurance, and there is no absolute

assurance that be achieved in this space.

DR. MAXWELL: No.

A. But the additional check is the fact the service would be inspected. And again, that doesn't guarantee. But if you have an accountable officer giving you the assurance and then you triangulate that with the information that you are getting from your regulator, that gives you a level of assurance, clearly not 100%, obviously not. I suppose we can't get away from the fact that abuse is notoriously difficult to detect and identify. Now, that's why you should take steps to prevent it before. I mean, as I said earlier, all of the investigational reporting of abuse that's happened is too late. So you have a regulator, you have people who have a statutory duty of quality. You have levels of expertise and seniority within an organisation. And I mean, I have no doubt that there are better ways of doing that and maybe that will feature in the recommendations from the Inquiry, but that's what we were using. 10:33 10:34 10:34 10:34

DR. MAXWELL: Okay, thank you.

17 Q. MS. BERGIN: Staying with paragraph 11 and I've already referred to your reference to the allegations of peer on peer abuse at Muckamore which first emerged in 2005 and you refer to follow up work in relation to that. Can you recall what triggered that follow up work? 10:35

A. I mean I have to say that this was a process that started long before my involvement and I came in at the tail end. My involvement, I think, was at the point

where we were trying to make sure that we were satisfied that that work was concluded and that people were aware of it and so that's why the Permanent Secretary would have written to people, but it's also why we would have looked to, I think it was the Strategic Management Group had been set up who had undertaken this work which was a combination of HSCB staff and the police service. It was about receiving a declaration from them, their work had been completed, they felt they pursued it as far as they could and the Permanent Secretary then making sure that everyone was reminded of their duties in respect to this. I think there was a bit, I have a memory but it's not a particularly reliable memory and I refer to it, where I was asked, and this was not when I had policy responsibility for this area, but probably when I was Deputy Chief Social Worker and I was asked by a member of my team with members of other professional teams, I think it was with Dr. Ian McMaster and I can't remember who the nurse would have been at the time, where they said look, we are not satisfied that a sufficient -- because there was point where all Trusts were asked to check about this and the returns that came back were inconsistent. I was asked well, did I think that was okay or not and I concurred with them saying no, you need to go back again because if you are not satisfied that this has been done in a robust and consistent way you need to go back again, and that happened.

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18 Q. We will come on to the historic allegations later, you

address those I think in more detail at question 8 of your statement. If we look then at paragraph 12 and you say that up until 2014 you attended Belfast Trust mid and end year assurance and accountability meetings with departmental colleagues, but after that there were new arrangements for these meetings. What was the change, did you continue to attend and what was the reason for the change?

A. I wasn't responsible for the change and I didn't make the changes in that approach, but I believe you will be talking to another witness who can give you more information about that. I can say from my own personal experience one of the difficulties, and I suppose it relates to the point we were discussing earlier, was that these had become incredibly long meetings with so many important things being discussed, it was hard to deal with them in that large meeting. It would be speculative but I'm assuming the change was an attempt to address that because they were replaced with a much more strategic but less granular process.

19 Q. Did you continue to attend those meetings?

A. I would have been involved in what were called ground clearing meetings. I don't think I would have attended then the subsequent accountability meetings for the Belfast Trust, I don't think so.

DR. MAXWELL: And I think this also applied to the other professional officers as well, they stopped attending?

A. Yes.

DR. MAXWELL: The question then is how did the professional oversight of Trusts and their accountability take place? Because I take your point the meetings were very busy but I imagine without the professional officers they focused on finance and activity?

A. Even when the professional officers were there it was very hard to get beyond that.

DR. MAXWELL: But the reason for having the professional officers was to have a more rounded discussion about the Trust's accountability. If the professional officers weren't there, what was your role in holding the Trusts to account or did you not have one?

A. If there were issues that you wished the Permanent Secretary to raise you could do so and that would be something that did happen. But there were also the other mechanisms with delegated statutory functions for example. There was an accountability between the Board and the Trusts and then subsequently the Board would have met with me. Separately to that I would have met with the Directors of Social Work on a fairly regular basis where issues were raised, that also included challenge on occasions where information had reached the Department that was an issue of concern. Again I can give you an illustrative example. I became aware of an issue with unaccompanied asylum seeking children who were being dealt with without the procedures and protections afforded under the Children's Order. I

would have raised that both with the directors collectively and with an individual director where the airport existed and we became aware that children who really should have been received into care was being placed in accommodation, it was dealt with there.

20 Q. MS. BERGIN: At paragraph 13 you say that after you became aware of the allegations of abuse by staff at Muckamore in August 2017 and the existence of CCTV evidence which raised systematic concerns about safeguarding at Muckamore you and the Department took a number of steps to ensure that information about Muckamore was then provided to the Department on a regular a basis for assurance purposes. We'll come to those matters in more detail in a moment, I want to ask you now in terms of the types of grave issues that we discussed before that would make their way to the Department, would issues in respect of the CCTV and system of CCTV and issues about that, are those the types of issues that you would expect to come to the Department?

A. Well I have to say I wasn't aware that there was CCTV in operation, even after we first became aware of the abuse in 2017. It was only subsequent to that that the Trust advised us that CCTV existed. I can't say the Department wasn't aware of CCTV because in response to a question by an MLA which had been raised by a former patient in Muckamore, we'd gone to the Trust for information to contribute to a response to the MLA and I now know that that reply included, or information

received from the Belfast Trust made reference to CCTV being -- well they didn't say CCTV was in place actually in that. It was I think -- sorry, I have been reading this and I am trying to recall the dates but I'm not certain but I think maybe it was 2015 but I can't be certain. There was information provided, I think, from a press officer in the Belfast Trust which made reference, just as overall context, background information, the Trust is I think exploring the possibility of introducing CCTV later this year and that was in February of the particular year. I can check the date but I think that was in February. But then I now subsequently know that the contractor confirmed that the CCTV had actually been installed the following month and was recording. 10:42 10:43 10:43

21 Q. If we move on then before we take a break to paragraph 15. And here in relation to you had referred to funding I think a moment ago and here half way through the paragraph you say that:

10:44

"I was aware however that RQIA raised concerns about staffing at Muckamore after 2017."

I am not going to read the full paragraph out but in summary you say that: 10:44

"Where inspections fine staffing levels in any service are consistently inadequate responsibility for addressing these rests with the provider organisation

in the first instance."

And then you outline the steps they can take, including raising the issue with a service Commissioner, by a bid for additional funding and also where there are workforce supply issues, then these could be raised with the service commissioner and if appropriate through the relevant departmental chief professional officer to consider any action that is required regionally. 10:44 10:45

Now prior to 2017 were workforce supply issues or bids for funds raised with either of those offices as far as you are aware?

A. I never received a request for additional funding for the service at Muckamore on the basis that they weren't able to staff it. Although I now am aware that staffing had been raised in inspection meetings with the Trust, that was the first time those had been escalated to the Department through the Article 4s. 10:45 10:45

DR. MAXWELL: So if they had been raised with the Chief Nursing Officer, because a lot of the issues that were raised were about nurse staffing, I recognise there were shortages in social work as well but a lot of the issues that were raised were nurse staffing, would you as Chief Social Worker expect to have a conversation with the Chief Nursing Officer? 10:45

A. Not necessarily as Chief Social Worker but as Deputy Secretary I would have, yes. And indeed the period we

are discussing in 2017, myself and the Chief Nursing Officer were discussing this almost daily.

DR. MAXWELL: Okay. Would you have expected the HSCB to raise issues with you, because we've certainly heard about from John Veitch who was the Co-Director, they had a meeting with the HSCB in 2015 that covered a number of issues, including staffing, would you have expected the HSCB to inform you about that? 10:46

A. It would depend on what information they had received from the service about the level. I mean, I think on any day of the week in many, many facilities, I mean many wards, you'll have a daily situation where we don't have enough staff. 10:46

DR. MAXWELL: Of course but I think --

A. Sometimes those are a bit more persistent but can be managed by different initiatives that can be taken at the provider level organisation. If it was a consistent or a persistent and irresolvable problem then it would be for the Board to raise it with us, but it would have to be escalated to them in those terms. 10:46 10:47

DR. MAXWELL: So I think this meeting, there was a suggestion they might close to admissions because they didn't have enough staff. Would you have expected that level of anxiety to be raised with you?

A. I think it would depend on how that meeting resolved itself. I mean if someone simply says, you know, we are having real trouble sort of staffing X ward and, you know, if we don't get it sorted we will have to close to admissions, that wouldn't be escalated to me. 10:47

If it were a case of we have a persistent problem here, we can't staff this facility to the point it is not safe and we may have to close, yes, that would be. That wouldn't be something you just discuss in a meeting, that would be an exchange of correspondence between the Trust and the Board. You would expect the Trust to be putting a formal notification to the Board.

CHAIRPERSON: I was going to ask, it wouldn't be necessarily something for you to deal with personally, it would be something for the Board to deal with.

A. It would be in the first instance. Here in 2017 you can see a situation where we do very quickly get drawn into dealing directly with things but that was a very unusual situation, the escalation. When I say "the escalation" I don't mean of the issue, I mean the way the issue escalated as it went on. I was trying to think of a way of describing it and this isn't meant to be flippant, but it was like a run on the banks sort of what happened between 2017 and 2020, it just became self-fulfilling, it was like...

CHAIRPERSON: We are going to take a short break, this is not the morning coffee break, this is a 10 minute break for us all, for the stenographer and the witness. So we really will keep it to 10 minutes, there will be another break later on in the morning, okay, thank you.

THE INQUIRY RESUMED AFTER A SHORT BREAK AS FOLLOWS:

CHAIRPERSON: Thank you.

22 Q. MS. BERGIN: Mr. Holland, if we just remain on question four and we were talking about the issue of staffing. The Inquiry has heard evidence from Brenda Creaney from the Trust in relation to a period in 2018 when the PICU Ward was closed due to staff shortages. Is that something that you recall being made aware of?

A. Yes but I don't remember the specific -- I can't remember the occasions or whatever but I was absolutely aware that PICU was closed. I think there was an issue about whether the order of that was correct, as in we were told it was closed as opposed to asking us we think we need to close it, but yes I was aware it was closed.

23 Q. Again on the issue of staffing if we could go to STM-299-196, that's the statement of Richard Pengelly and Exhibit 12 of his statement and I know you've had the opportunity to consider this, isn't that correct, Mr. Holland?

A. You shared it with me this morning but I had actually read it recently.

24 Q. Yes. We can see the submission from you to Richard Pengelly dated 10th May 2019. If we scroll down to paragraph 5, thank you, it states:

"Separately the Department has sought assurances from Trust colleagues, in particular on the staffing point. Although they acknowledge that issues remain at Muckamore they do not share RQIA's assessment as to the position on staffing numbers. They have advised that

staff levels are safe and are regularly reviewed. This suggests some discontinuity between RQIA and the Trust."

Can you recall if this discontinuity that you were flagging to Richard Pengelly was addressed by the Department? 11:00

A. I recall having a meeting with the RQIA where we discussed it and I think the Trust was present at that meeting. And I can't say it was resolved, other than to say the Trust argued to say look, you're now saying that our staffing levels are inadequate, we have more staff and less patients than when we were inspected the previous year or whenever it was and you didn't say it was inadequate then, and the RQIA saying this is a dynamic situation and on the basis of our assessment today, the staff you have with the patients you have is not sufficient. I don't recall it being resolved beyond those being the two positions. 11:00 11:00

DR. MAXWELL: I think the Chief Nursing Officer took quite a lot of action as a result of this and she's talked about that in her statement. 11:01

A. Yeah, no, I'm sure she did.

Q. MS. BERGIN: If we move then on to question 5 at page 7 and here you were asked whether you were in a position to express a view on whether the immediate suspension of staff identified following the review of CCTV at Muckamore made patients at Muckamore safer. From paragraph 17 onwards you describe how the Belfast 11:01

Trust's decision to suspend staff identified on CCTV was reflective of normal practice across care settings and ensured that vulnerable people weren't continuing to be cared for by someone that they might, for example, be afraid of. You say at paragraph 18: 11:02

"However in Muckamore the sheer number of staff suspended was unprecedented and also due to media reporting the Trust also had difficulty recruiting staff to fill the gaps created by those suspensions." 11:02

You go on in paragraph 19 to say that:

"In order to address these challenges the Department made additional funds available to the Belfast Trust to 11:02 allow it to avail of high cost agency staffing."

And if we can then go to page 89 and Exhibit 6 to your statement please. Here we see a funding allocation letter from the Department of Health dated 16th July 11:02 2021. If we could scroll down, please, it says the Revenue allocation for the HSC Board has increased and it provides the figures. If we could go to page 90 then please. Thank you, stop there. At paragraph 3 then, I am not going to read these out in detail, the 11:03 first paragraph refers to £150,000 of non-recurrent, assumed recurrent allocation for integrated therapeutic care associate psychologist posts for a period of nine months. Does that translate into the recruitment of

psychologists across the Trusts or what does that refer to?

A. I can only say that obviously psychology has been identified as being one of the pressure areas and we, well, I say we, it would have been at that stage the SPPG but it would have been the Board saying what's the problem and they've arrived at a figure as to what's needed. Whether that's purchasing sessional time or recruiting people, I'm not sure. But I suppose what it illustrates is the point about, if we had an issue escalated or when we've had an issue escalated among the responses might be to make additional resources available, although in the first instance that would be from the Board, but this is an instance they had reached a position and we were responding with assistance. 11:03 11:03 11:04

26 Q. If we look then down to paragraphs 9 and 10, please, thank you and here you refer to or the letter refers to 1.34 million of non-recurrent allocation to the Belfast Trust in relation to Muckamore Abbey. It states: "Acute in-patient unit for adults with learning disabilities" and that it should be classed as commissioning of HSC services. Then at paragraph 10 there is also what is described as additional in year funding for the Belfast Trust for '21 and '22 to meet these additional costs and that is a figure of £3 million non-recurrent allocation to the Belfast Trust also in relation to Muckamore Abbey Hospital. 11:04 11:04

Can you explain why the funding allocation to Muckamore was split in two in that way and what's that meant to be spent on?

A. I can't say for certainty which figure relates to which, but I remember there being two significant components to the financial support that we were offering as we progressed through this. One was additional money to engage agency staff, which is expensive, sub-optimal but it's a response when you have staffing difficulties. The other was a premium to try and attract and retain staff, I think it was a 15% premium on their salary. So I don't know, I'm presuming those are split between the two. When I say agency, it wouldn't just have been agency, there was also a drive to see if we could get staff, relevant staff from other Trusts to go to work in Muckamore on a temporary basis. Now if they were covering people who were suspended, the Trust would have had a double cost there so they would have needed money to cover those posts, as they would to cover the agency posts. 11:05 11:05 11:06 11:06

27 Q. If we look then at paragraph 21 and that's on page 8 of your statement and here you say:

"Inevitably the difficulties experienced by Muckamore in covering rotas coupled with the high use of temporary staff was disruptive for patient-staff relationships and had the potential to undermine the quality of care. However, these detriments had to be balanced against the potential risk of harm being done 11:06

by a member of staff about whom concerns had been identified through the viewing of CCTV."

Then you refer to the decision to suspend being an operational one. What were you told in the Department about how Muckamore and the Belfast Trust were balancing these risks, is that something that was explored with the Department or probed by the Department? 11:07

A. We were told that where it was felt possible to keep someone in post they were doing so. And indeed there were people, I believe, who were identified as having deficits in their conduct through CCTV who were not suspended, but there were other measures taken to try and mitigate any risk that they would pose. Then we were also told there were people who, in the view of the Trust from what they had seen they had to suspend them. I have great sympathy with the Trust trying to manage that situation, it is a really, really difficult situation because the use of agency staff is nearly always sub-optimal anyway in any care setting. I think that when you're working with people with certain conditions predictability and routine can be important to providing a stable care environment and so bringing in a lot of people who don't work there regularly is going to have a detrimental impact on the quality of the service. However, if you continue to have people working with vulnerable people, particularly non-verbal vulnerable people who you suspect may have done them 11:07 11:07 11:07 11:08

harm, that is another risk. And it's not just a case of the risk that they might present if they did something bad again, their very presence could be traumatizing for people and that not be something that they could express. I mean this is -- again I don't think there is an equation or a formula that you could use that would simply give you an answer to how to balance those risks. I think it is a judgment and the judgment would have to take into account the vulnerability of the people you're caring for, their ability to protect themselves, i.e. by alerting people to the fact that they were being harmed, against what information you have about a particular risk from a particular person, i.e. what you've seen on CCTV or what's been reported to you by others. And then against that, the disruptive effect of removing that member of staff and replacing them with a sub-optimal solution. 11:09 11:09 11:09

I think the only thing I could say is if you had made the judgment call about someone and you were along the lines of we are under an awful lot of pressure here, let's keep them on the floor, and that person subsequently committed a criminal offence, harming that person, certainly that would be a liability to the Trust. I think it would probably constitute a breach of the individual person's human rights and it also is I think something that I can't, you know, and I say me, I don't think any of us can properly put ourselves in 11:09 11:10

the place of someone who is non-verbal and vulnerable and has very limited capacity and control over their situation. The traumatizing impact of both being abused but also being cared for by someone who you are scared of and who presents a threat to you, these are incredibly difficult situations.

28 Q. If we then move on to question six and that's at page 8 of your statement and here you were asked about the consequences of staff suspensions both intended and unintended and whether that issue that we've just touched upon was discussed at MDAG. From paragraphs 22 onwards you say that two of MDAG's four objectives related to ensuring safe staffing levels were maintained at the hospital and reports on hospital staffing levels and stability of the service were discussed from the first MDAG meeting on 31st August 2019 onwards. And in fact from the third meeting of MDAG, staffing became a standing item on the agenda. The first MDAG meeting was held on 31st August 2019, isn't that correct? 11:10 11:11 11:11 11:11

A. So I believe, yes.

29 Q. And given the scale of difficulties that were emerging from Muckamore in 2017 and 2018, with the benefit of hindsight do you think the Department ought to have stepped in earlier with a tool such as MDAG? 11:12

A. That's quite possibly the case. I mean we were in very frequent contact and we were having, I think, monthly meeting with the Trust and the Board were engaged. And it certainly was not a casual situation that got worse.

I mean, I think from very early on in this process we felt the need to be proactively engaged. I mean, before these challenges from the point when we first were notified about the first instance of abuse, we were probably more involved than we normally would have been in a situation for various reasons. But in the run up to MDAG we had been meeting frequently, but by the point of MDAG we had had the RQIA Article 4 notices. RQIA were recommending at that point that some kind of special measure be taken and so that was our response. Whether it should have happened earlier, it's quite possibly the case that it should have done. I can't say it wasn't occupying an awful lot of our horizon, it was, but whether an earlier establishment of MDAG would have been more appropriate, that may well be the case. Although, I'd have to say that there were times when the establishment of MDAG, which was unprecedented in my experience, did not always seem to produce the result of the Belfast Trust getting a grip of the situation. And indeed we took additional measures beyond MDAG at a point in time in relation to resettlement and established a new group, although within the MDAG arrangements we had a sub group that was looking at resettlement, that wasn't working either. 11:12 11:13 11:13 11:13 11:14

CHAIRPERSON: What was the fault line, as it were, between MDAG and things not actually resulting from MDAG?

A. I think it was a combination of things. I mean on the

one hand undoubtedly the Belfast Trust were facing really significant challenges, this was a difficult situation. I talked about a run on the banks, they were experiencing that in real-time, that was a really difficult situation for them and I have great sympathy for them and, you know, if a situation is not resolvable simply more and more scrutiny in itself doesn't change the fact that that's a very challenging situation. But I mean there were other issues. Information flows both pre and through MDAG were frustrating at times. We would ask for accounts and explanations as to what was going on and sometimes we would get an account and the question being answered wasn't the one being asked, or information changed sometimes. This is not confined to MDAG, this was a difficulty from the 2017 referral, we had difficulty repeatedly. There are some exchanges of letters between the Department and the Trust which again were unprecedented in my experience but where we were really trying to say focus here, give us this information. 11:14 11:14 11:15 11:15

CHAIRPERSON: We've seen some of those?

A. The Trust seemed to be struggling with being able to get a grip on a number of issues. There were issues around safeguarding to the point that in the course of MDAG we commissioned an independent look at the safeguarding referrals because we weren't satisfied with the information we were getting from the Trust through MDAG. So there were several fault lines.

PROFESSOR MURPHY: The membership of MDAG was very

wide, wasn't it. Do you think it was really too wide and that was one of the reasons you couldn't get the focus you wanted?

A. I think that certainly probably is borne out by the fact that although we were very persistent about trying to get information on the progress on resettlement, information kept on changing and deadlines and dates kept on slipping which is why then we commissioned the Mongan and Sutherland review and then subsequent to that replaced the structure we had put there with a much more high powered structure to drive forward the focus on resettlement. I can't definitively say whether that worked and the previous structure didn't work because inevitably some of the resettlements that happened after that new structure was in place had been in train and maybe they would have happened at the same pace anyway, I don't know. There were other areas, I mean, and this isn't specific to the Belfast Trust, this was more an all Trust and Board issue. We went through repeated requests for a contingency plan because if you have a precarious situation like this, it struck me as being sensible, and we had been through the midst of Covid where you had to think about a lot of contingencies for services falling over, so we asked for a contingency plan to be developed if Muckamore became absolutely non-sustainable. Looking through the minutes I see us requesting and requesting and requesting until finally we got a contingency plan that basically said this contingency plan is so bad, don't

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use it. I don't mean the quality, I mean the consequences of it. Whether that was because our focus was too broad, maybe. Maybe other people might have been more effective in that position, I don't know. But certainly, if our expectation was by creating MDAG suddenly there would be a grip on this issue and we would start seeing a road through it in an immediate to medium term, that didn't happen.

PROFESSOR MURPHY: Nevertheless it sounds like RQIA to some extent thought it did happen in that they, the Improvement Notices that they had served, it sounded like they were accepting that the Trust was doing better? 11:18

A. And at times I think they were, but I think this was a very dynamic situation. You know, because remember, I mean, I can't remember the document but I was looking at something recently where I was communicating with someone and I said the situation is very serious, there have been 20 suspensions. Well we reached a far higher number of suspensions as time went on. So it was dynamic and I'm sure there were times when the RQIA inspected and they felt a bit of progress was being made and then other things happened, the situation changed, whatever, they would say things now are really concerning us. 11:18 11:19

30 Q. MS. BERGIN: If we look at question 7 then on page 9. Here you were asked a series of questions about data which demonstrates a rise in incident reports about inappropriate or aggressive behaviour by patients

towards staff between 2011 and 2018. If we could go to paragraph 29 on page 10 and here you say that:

"The Trust assurance reports to MDAG include information on rates of adult safeguarding referrals at Muckamore." 11:19

So the Department was receiving information about referrals for adult safeguarding essentially after an incident had occurred. Again, with the benefit of hindsight, would it not have been a more helpful piece of information for the Department to have been made aware of, I suppose, large or notable changes at Muckamore before incidents occurred rather than receiving reports after an incident had occurred? 11:20 11:20

A. I'm sorry, I'm slightly lost in that when an incident occurs that triggers a report. I mean you can't report on things that haven't happened.

DR. MAXWELL: I think the point I made earlier about it's reporting harms or absence of safety, but actually there's a lot of work being done globally about we should be reporting the presence of safety, not its absence. And if you only report absence, i.e. when a safeguarding incident happens or when a physical harm happens, then you are too late. You said that in your own statement. 11:20 11:21

A. Absolutely.

DR. MAXWELL: We know, for example, that there was a trend of increasing reported assaults of patients on

staff. We know there was a lot of peer to peer assaults, not referring to 2005, I'm talking about around this time before and after 2017. Would it not have been better to have some indicators of the rising temperature of the ward and take action before a safeguarding incident happened?

A. Yes, absolutely. And I would say that that is encompassed in the duty of quality on the provider. But I'd also say there were queries raised by the Department with the Board about the volume of incidents that were happening in Muckamore at that point. I think there was actually a media story at one point which described Antrim Police Station as being a crime hot spot and when we looked into it, it was being driven by the volume of referrals to the police of incidents in Muckamore. Now, we questioned that with the Board and the feedback we got was that there were a number of incidents that were being inappropriately referred to the police at that time. But I fully take your point about a range of measures that would, as you say --

DR. MAXWELL: I think the point I am trying to make is both before 2017 and certainly after it, there was already data telling people about that but people weren't looking at it, it seems. MDAG in normal times the Department of Health wouldn't be looking at operational detail like that, as you've said this wasn't normal times.

A. No, not at this stage.

DR. MAXWELL: MDAG was looking operationally, the question was were you looking at indicators of the climate of the ward or just the number of times a patient was harmed?

A. I think through the period of MDAG we were probably receiving lots of information, I mean including reports just about the atmosphere, the climate of the ward, we were certainly getting the safeguarding information, we were getting information on staffing levels. We were getting information about being able to access additional staff and where they were coming from. 11:23 11:23

DR. MAXWELL: So were you then using that information to target interventions? So we know that the rates were different on different wards, and was that information being used to target support to individual patients for individual wards rather than noting it in a global way? 11:23

A. I don't think MDAG ever got to the point where we were individually trying to manage wards but we certainly were asking what are you doing and the Chief Nurse in particular. I mean one of the steps that she took for the period it was operational was a really really positive step. 11:24

DR. MAXWELL: You mean the Chief Nursing Officer?

A. Yes, was when she sourced a very senior nurse to go and work. 11:24

DR. MAXWELL: **H785** .

A. On the site, ears and eyes and stabilise the situation. It was probably one of the few periods where I felt an

a sense of improved confidence in the situation in Muckamore. So there were steps like that being taken.

31 Q. MS. BERGIN: At question 3 on page 13 you were asked if the Department relied on incident reporting in respect of Muckamore. And from paragraph 40 onwards you say that the Department doesn't rely solely on incident reporting to become aware of emerging issues and you've already said something about that in your evidence this morning. You then refer to a range of reporting mechanisms including specific reporting arrangements for all HSC services, reports on discharge of delegated statutory functions, adverse incident reporting and the Early Alert system. At paragraph 43 you say: 11:24 11:25

"After the allegations of abuse emerged in 2017 the Trust provided regular update reports..." 11:25

Which you have already referred to.

"...from January 2018 to the Department on actions taken by the Trust to address the allegations. The Department was provided with information about the adult safeguarding and police investigations and RQIA inspection findings and enhanced assurance arrangements." 11:25

At Exhibit 9, we don't necessarily have to go to it for now because I have a very net question to ask you about it, but for the record at Exhibit 9 on page 120 you

provide the first of the Trust reports to the Department in January 2018. And in that document there is a reference to implementation of and reviewing of CCTV. Under that heading there is basically a reference to work being under way to install CCTV in the remaining Muckamore wards and the swimming pool, there already having been CCTV at other places in Muckamore. My question about that is do you know if and around this time the Department made any recommendations that CCTV should be expanded beyond Muckamore to other learning disability services? 11:26 11:26

A. No, we didn't make a formal recommendation in that regard, although it was something that featured very heavily in the policy development work I mentioned earlier that I was leading on for the new adult safeguarding legislation and we talked about whether or not it should become a statutory requirement to install CCTV. I have to say my personal view had changed about CCTV significantly, but there were other concerns raised. There were privacy concerns that were raised about it. There were human rights considerations. I have to be honest, I think that times have changed and our concept of privacy and surveillance has changed. We are all surveilled massively compared to 20 years ago and I think that I couldn't get away from the fact that the initial incident that was raised in 2017, had it not been for CCTV, could very easily have just been a case of just one person's word against the other, so I became very convinced about the value of CCTV. 11:26 11:27 11:27

We did have a policy which I think was from the RQIA which clarified if you're going to install CCTV these are the considerations you need to take into account for doing so. I think that you would find CCTV now in a number of the facilities, but it never became a formal direction from the Department. As I say, I think that the positives significantly for me outweigh the negatives in this context, but that's an individual view, people take different views on this. 11:28

CHAIRPERSON: Isn't that something that the Department could intervene in and direct, if you think the positive significantly outweigh the negatives?

A. It could but I think it would have to go through quite a significant process in each instance. But I think Trusts did do that, I am not -- I think there was CCTV in Dorsey, I'm not certain, I don't know about Lake View which are the two other relevant facilities for learning disability. 11:29

32 Q. MS. BERGIN: If we could look at question 5 then on page 17. You were asked whether the Department received regular data or other reports in respect --

A. Excuse me, just to go back, I think at one stage we included the issue and I need to check but I think we included consultation on the use of CCTV in care settings in part of the policy development process for the new legislation and it was a mixed response to it, ranging from people who wanted CCTV in every inch through to people who said they didn't want it anywhere 11:29

and it was a violation of privacy. That doesn't answer the question but it may be germane.

CHAIRPERSON: Okay, thank you.

33 Q. MS. BERGIN: At question 5 you were asked whether the Department received any regular data or other reports in respect of Muckamore and in your evidence already this morning, Mr. Holland, you've said something already about the different types of information the Department was receiving. Now, at paragraph 52 under the heading "performance management", you say that: 11:30

"Between 2006 and 2009 BSO provided weekly reports on hospital activity to track progress on the departmental targets, including resettlement from long stay hospitals such as Muckamore. From 2009 that function was absorbed into the HSCB information function. As part of the commissioning plan monitoring processes the Department received performance reports on progress against targets within the plan including those relevant to Muckamore, learning disability and mental health discharges. The HSCB received updates from Trusts and then provided reports to the Department for performance monitoring purposes."

So, resettlement targets were set as part of the annual commissioning plan for Trusts to deliver, is that correct?

A. Mhm-mhm.

34 Q. Yes and the Department then received progress reports

on those. Can you tell us a bit about how those targets were set by the Department?

A. I wasn't directly involved in the setting of those targets, the targets, the policy direction had been set by Equal Lives, the Bamford Review which became the policy direction for these services and so resettlement was set as a policy direction. Then the Commissioner would have determined what a reasonable target they felt was and that would have been in the context of what finance was being provided as well. I do know that the, I can't recall the exact numbers, but in I think the 08 CSR period a specific amount was identified for resettlement and subsequently that was cut by an amount and the targets would have been set in the context of -- now, I think they were always intended to be stretching targets, sort of, there is no point setting a target that you are already meeting so they were meant to be challenging and the reality is, as I said, I think there were only two years when those targets were met. Although, as I think I said earlier as well, it's important to note the context. This was a target which even if you missed the target the issue you were addressing was still being dealt with in a positive way in that the numbers of people waiting to be resettled was always reducing whereas you can miss other waiting lists targets like waiting list times for certain treatments and you are missing the target and the number of people is going up and that is a significant problem, we have the worst waiting lists

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targets in the UK. But this target is slightly different from that sense.

35 Q. The Inquiry has heard, as I'm sure you are aware, of large numbers of delayed discharge patients in Muckamore over many years. Do you think the resettlement targets were too ambitious? 11:33

A. Resettlement and delayed discharge aren't actually exactly the same thing.

36 Q. Yes?

A. The resettlement targets were initially established to address those people who had been living in the hospital for I think over 10 years. I think the terminology that was used to describe them from Bamford days was the primary target list. Those were people who were living there and the intention was people shouldn't live in hospital, so they were to be resettled. There was a separate issue about people who had been admitted for assessment and treatment who were fit for discharge but no longer receiving any active treatment and had been assessed and were awaiting discharge. Now, there was a point in time I think these groups became one, you know, as you got to fewer and fewer people that distinction was less relevant but that was a distinction initially. So was your first point that these targets were too difficult. 11:34 11:34 11:34

37 Q. Were they too ambitious in light of the numbers of delayed --

A. I don't know, to be frank. I don't know what the right level of target would be. But I do know they were

achieved sometimes when they weren't achieved at other times. There were factors that were reasonable or at least they seemed reasonable as to why they were being missed.

DR. MAXWELL: Surely the targets, whether the target was reasonable or not, depended on whether you had capacity outside the hospital. These were people that did not need to be in hospital so it was a reasonable target. The achievability depended on what alternatives were available for them. And certainly from Equal Lives on, which is nearly 20 years, everybody has said there should be alternative capacity in the community and yet we frequently hear there isn't, and I raise the point earlier about is that because there are some patients who are more complex and you said you didn't think it was. 11:35 11:35

A. I said it wasn't solely that.

DR. MAXWELL: It wasn't solely that. But it remains that the reason the Trust can't discharge people is because there isn't capacity, whether it's the estate, the physical homes or whether it's the staff to care for people in these homes. And so the achievability depends on how much resources is put into having capacity in the community surely? 11:36

A. People were being resettled. 11:36

DR. MAXWELL: Some people were.

A. Well the majority of people were being resettled. We went from nearly 400 down to the current state of 16, so the majority of people were being resettled.

DR. MAXWELL: But it's not a linear --

A. No.

DR. MAXWELL: There is quite a slow down in the curve over the years though, isn't there?

A. Yes, yep. I think that it is a challenging process and it's a challenge that exists in other jurisdictions, I mean England still has a significant problem with long stay patients in these kind of hospitals, they actually have an additional problem, which not because of any virtue on our part, but probably more to do with geography what we don't have which is out of area placements, at least our resettlements are, the people that are in hospital are not 200 miles away from their home, but we take no credit for that, that's just geography. But people were being resettled. Facilities were being developed. I mean it was a proven concept. 11:36 11:37 11:37

DR. MAXWELL: But is 20 years a reasonable time scale? It seems quite long.

A. It is quite long, it is quite long. I mean you have to consider if someone they were 20 when they were admitted and 40 when they are discharged, that is an exceptional, it is 50% of their lifespan so it is a very, very long time. But the targets weren't being missed massively and indeed Belfast was an outlier and not only were they an outlier with regard to their own targets, they were having an impact on other Trusts because they had committed to resettlement projects which when scrutinised were being told were 11:37 11:37

unrealistic.

38 Q. MS. BERGIN: At paragraph 55 then under the heading "accountability processes", here you refer to information the Department receives from the Belfast Trust including assurance statements, governance statements, and Trust Board minutes. What does the Department do with the Trust Board minutes? We are going to come on to look at the information analysis Directorate in just a moment who you refer to, but can you give us an understanding of what happens when the Department receives Trust Board minutes, does somebody analyse those, is that data collated? 11:38 11:38

A. I don't know what else happens to them but I do know that where an issue was discussed and reported in the minutes that was deemed to be relevant to me as Chief Social Worker that it was flagged to me. You would see "please see the following extract from the Belfast Trust Board minutes that will be of interest to you." 11:39

CHAIRPERSON: Someone was actually reading them for relevance to -- 11:39

A. I can't remember who or where in the Department that came from but I do recall a few times that happening.

39 Q. MS. BERGIN: Then at paragraphs 57 and 58 in relation to the Information Analysis Directorate, you refer to this Directorate which the Department's statistical function and it requests and receives updates from Trusts on a range of learning disability and mental health patient activity including Muckamore, either quarterly or annually. And you list the types of 11:39

information then that is received. Was that Directorate in place during your time as Chief Social Work Officer?

A. Yeah.

40 Q. And at the top of page 20 you refer to the mental illness and learning disability census, an annual census, can you tell us what that is? 11:39

A. I think that was a population census, the number of people who were identified as belonging to certain categories, I'd need to go back and check, I think that was the case. We had a few areas were censuses were the way information was described and that was one of them. 11:40

41 Q. And in terms of the work of this Directorate then, we've talked already about somebody in the office reviewing the Trust Board minutes, and I think earlier in your evidence you referred to analysis of data trends by the Department, can you tell us a little bit more about what the Directorate did, what types of tasks were they asked to do? Was it, for example, that members of your staff team would review notes and flag an issue and then ask someone to go and look at the issue further and create data about that or how did that work feed into the Department's understanding of Muckamore? 11:40 11:41

A. This would have been information that's generated by IAD which is a statistical unit, this is statistical returns that are coming through the system, collated and then being shared in the Department. And I think

it's fair to say, and to go back to I think Dr. Maxwell's point, these were largely quantitative indicators, they weren't qualitative and that's a gap, definitely a gap. I don't know what statistics we should be collecting necessarily, but these were telling you about activity more so than the quality of any service to be honest. At times they would have been flagged to me because someone had looked at them saying there is an issue here you should look at but they are limited by what they are. 11:41

MS. BERGIN: At paragraph 62 then just --

CHAIRPERSON: Before we go on are you okay for about another 10 minutes.

A. Yes, thank you very much, Chair.

42 Q. MS. BERGIN: At paragraph 62 then, in relation to system audit and accountability reports, you describe various reports received by the Department, including from the NIAO, for example, Comptroller and Auditor General reports, RQIA and Northern Ireland Assembly Public Accounts Committee reports, so there was a broad range of information coming to the Department. You say: 11:42

"After the allegations of abuse at Muckamore came to light the Department requested that the Trust provide regular reports about Muckamore." 11:42

And we've referred to those already. Given the Department was then requesting these reports from 2018,

again with the benefit of hindsight, do you think the Department wasn't then receiving sufficient information prior to 2018?

A. I think that if we were to seek information of the level of granularity that we were receiving about Muckamore at this point, because we weren't assured, you know, we had numerous reasons why we weren't comfortable with what we were getting so we were looking for more and more information, but if you were trying to get that information from the whole system to that degree of granularity, I don't think that that would be practicable. But that's not to say there isn't information that we couldn't have been looking for from the whole system that would have been more helpful than what we've got. I keep coming back to your point about information that would be signs of safety as opposed to abuse, we weren't collecting that really. Now the RQIA did inspect against relevant issues to that, they would have inspected against culture, leadership and values, they are relevant to that. But a statistical return measuring those measures, we weren't getting anything like that at all. I would totally acknowledge that as a deficit. 11:42 11:43 11:43 11:43

43 Q. You referred earlier in your evidence, and I am paraphrasing, to I suppose the concept that where there is a riskier service, for example, which is inherent in perhaps learning disability and Mental Health Services that that perhaps requires, I think in response to Dr. Maxwell, a higher level of vigilance or attention. On 11:44

that same vein then do you think again with the benefit of hindsight that the areas of learning disability and mental health ought then to have been a separate category that was subject to higher levels of vigilance by the Department from an earlier stage? 11:44

A. Possibly, although I do think that some of the things that make places safer aren't of those kinds of returns and in particular I think that one of the things that make services like this safer is the relationship that the service provider has with other interested 11:44 stakeholders, and that's an awful phrase to use to describe relatives and people who love and care for the people who are being cared for in that institution. I think that probably one of the most significant protective factors that you can find is do you have a 11:45 culture were things are open and there are a lot of eyes on what's happening. I had no idea the extent to which the culture in Muckamore was closed to that kind of scrutiny until really late on and I will take that as a fault absolutely. 11:45

DR. MAXWELL: But to pick up on your point, you could actually do a regular relative survey so you can --

A. You can and we were doing things in that space, 10,000 voices about different aspects of services.

DR. MAXWELL: You can measure a trend on quite a lot 11:45 of, the proxies for quite a lot of things.

A. Muckamore was so far away from that. I mean I was genuinely shocked and ashamed because it was part of our system, when talking to a relative, sorry, about

Muckamore, who told me that in 10 years she had never been allowed to see her son's bedroom. Now, if the culture is such that that's how you treat people who really should be a resource and asset to you, that is an absolute red flag to me. I hadn't, I didn't know that, I should have known that and other people should have known that. Other people did know that and found it acceptable.

CHAIRPERSON: You say you should have known that. How could that sort of information have filtered to you? 11:46

A. Because we do set standards and the RQIA does inspect facilities and I think it shouldn't be beyond our ken, as Dr. Maxwell has indicated, to have some kind of indicator about those kind of things.

CHAIRPERSON: But you weren't getting that type of -- 11:47

A. No and I wasn't looking for it, I have to be honest, it never even occurred to me that that would be the situation in a facility like that.

DR. MAXWELL: To be fair at that time I don't think people were talking about positive indicators anywhere but since then there is a lot of discussion about it now. 11:47

A. Although in other settings --

DR. MAXWELL: That's true.

A. I mean in children's homes for years we had recognised that you need to have, while respecting it is someone's home and it is not something for people to go in and be voyeurs, but we recognised that it was important to have as many eyes on as possible. And, you know, even 11:47

in learning disability as I think back, I remember in the Down Lisburn Trust I mentioned earlier I was in, I wasn't working in learning disability but I was in that programme of care, we had a facility, Strull Lodge and another one called Hill Hall, two facilities took people out of Muckamore. I think Strull Lodge, the Chair of our Trust would have known the names of a number of the people who were resident in that facility and would have known the staff in that facility and on occasion would have raised merry hell if she wasn't happy about some aspect of what was going on in that facility. Now, maybe we thought that's what advocacy was doing, I don't know, but it came as a shock to me when I spoke to relatives that Muckamore was so far away from that. 11:47 11:48 11:48

44 Q. MS. BERGIN: Can I ask just a final question before we break, just on the topic that you've just being giving evidence on, later on in your statement you come to answer a question about soft intelligence, so things that weren't coming through the official channels but maybe would be reported to you by social work professionals. Given the nature and extent of the abuse uncovered at Muckamore, were you surprised that no-one had come to you even informally and raised any of these issues of concern about Muckamore? 11:48 11:49

A. In terms of soft intelligence, not particularly because it wasn't -- I mean the people who were most likely to have done that and who did do that with me with other issues would have been social workers and there weren't

many social workers and they weren't part of frontline service provision. So I'm not particularly surprised that I wouldn't have received soft intelligence of that nature about Muckamore. And it is a very difficult area by its definition. People conceal abuse and they go to great lengths to make sure that people who they aren't confident will collude with it don't know about it, so it is a difficult thing. But, no, I wasn't surprised by that. 11:49

MS. BERGIN: I think we are going to break. 11:50

CHAIRPERSON: We'll take our mid morning break now, so we'll give everyone a chance to get some tea or coffee but again we will be strict on time. 15 minutes. Thank you very much.

11:50

THE HEARING RESUMED AFTER A SHORT BREAK AS FOLLOWS:

CHAIRPERSON: Ms. Bergin.

45 Q. MS. BERGIN: Yes, Mr. Holland, if we pick up at paragraph 64 of your statement and there's a sub-heading "MDAG"? 12:05

A. Yes.

46 Q. And we're still dealing with the types of data and information the Department were receiving. And at paragraph 64, you outline that: 12:05

"The Belfast Trust received information including about the progress of implementation of action plan recommendations, reports on reviewing historical CCTV,

adult safeguarding referrals and resettlement progress dashboards from SPPG., following concerns raised at MDAG about both the number and nature of referrals at Muckamore the Department commissioned an independent safeguarding audit file review in July 2021." 12:06

And you go on at paragraph 65 to provide more detail about this file audit. You say:

"The team looked at a sample of 60 staff on patient referrals between 2020 and 2021. The Department was then provided with a summary of the team's findings in advance of a formal report." 12:06

The Department then, upon receiving the initial summary findings then took some immediate actions to engage with the Trust about some areas for follow up including reviewing agency staff incidents, incidents involving more than two adult safeguarding referrals for one patient and following up on what the outcome of adult safeguarding cases was. Is it correct that the review of the files in 2021 included reviewing cases which were recent cases, cases up to and including 2021? 12:06 12:07

A. That would be my understanding.

47 Q. Given the nature of the incidents we've already discussed from 2017 and the RQIA Improvement Notices in 2019, was the Department or were you personally surprised that there was still some level of adult safeguarding referrals being received? 12:07

A. I don't think I would say I was surprised there was a level of adult safeguarding referrals being received because I think the nature of this business, the business of running this kind of facility should probably always be generating some level of adult safeguarding where people are using the process to check what has happened in certain instances. I think we were surprised that the volume was high, but also that there were quality issues persisting, even given where we were at. I mean, I can't think of an elegant way of putting this, but you might imagine that if maybe your approach to doing safeguarding investigations had been poor initially, if for no other reason than that the eyes of the entire system were on you, it might be improved at this stage but there were quite -- I mean I recall both the professional nurse and the professional social worker who were sitting on MDAG being consistently and repeatedly concerned about the quality of the information, about some of the process that were being followed, the variability and the quality. That's why we did the audit and the audit unfortunately confirmed they were still struggling with the quality of the safeguarding work they were doing.

DR. MAXWELL: Why do you think that was? This was four years after an index case which, as you said, has put the eyes of the entire system on you, so, presumably the staff, even if they hadn't known prior to 2017, now knew what good looked like. What was stopping them from having good quality records?

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A. I don't
-- I can't answer that comprehensively but, I mean, and it probably wasn't a single factor. I would imagine undoubtedly the destabilisation of the facility was contributing to it, I mean that was a problem. 12:10
There were probably increased volumes of safeguarding because you had inexperienced staff. Either you were getting inappropriate referrals being made because people were inexperienced, or situations were being generated because people were inexperienced. I don't 12:10
know if there was a deeply ingrained culture which didn't embrace safeguarding. It was one of the things that struck me when I sort of met some senior people from the Trust who would have had a responsibility for the hospital at an earlier stage than this was that 12:10
their awareness and understanding of safeguarding wasn't what I would have expected and so maybe that was also contributing to it.
CHAIRPERSON: What level of seniority are you talking about? 12:11
A. Quite senior. Quite senior.
CHAIRPERSON: Director?
A. Yes.
DR. MAXWELL: Are we talking about Directorate or Board level? 12:11
A. I am talking about Directorate of the Trust.
DR. MAXWELL: Yes.
A. And I suppose also one other factor I would also need to say, although, yeah, July '21, the impact of Covid

on the operational efficacy of every aspect of the system shouldn't be underestimated. I mean, sort of, when we were going into the pandemic I think we expected certain things to become very, very challenging, you know, having to shut elective lists through to what do you do with cancer, they were obvious. But there were a lot of things that we wouldn't have anticipated being the problem that they were. And maybe this was also part of the stress that was caused by that. 12:11 12:12

DR. MAXWELL: But there had been two and a half years prior to the pandemic?

A. I know, yes.

48 Q. MS. BERGIN: And, Mr. Holland, you then go on to say at paragraph 67 of your statement that the final report then of the independent safeguarding audit file review was provided on 17th September 2021 and it was shared also with the Trust and RQIA. You then go on to say that updates on the report were provided to MDAG, the Department continued to engage with the Trust in terms of follow up actions for an action plan to put into place the required steps. You say that it was added as a particular item to the MDAG meeting agendas, the outcome of the safeguarding audit. And this report was provided in 2021 and you say that the matter was not signed off as complete until April 2023? 12:12 12:12 12:12

A. Mhm-mhm.

49 Q. Can you tell us anything about that, that's nearly two years, can you tell us anything about any reasons for

the length of time it took to bring matters into line?

A. My memory is that we were repeatedly challenging and asking questions and the problems persisted. And I don't know what the current state of play is because I haven't been there for a while. But it has been suggested to me that problems persist currently in relation to safeguarding. I also have watched some of the testimony of other witnesses which would indicate that there were difficulties in information well post the CCTV being discovered and it's been an ongoing problem and remains. Now, as I say, all of those reasons and I mentioned earlier may be part of it. It also might be the persistence of a negative culture is far more resilient to change than I would have anticipated, I don't know. 12:13 12:14 12:14

50 Q. At paragraph 70 then you say that you thought it was important that the findings from the independent review should be used to inform the Department's work on the new Adult Protection Bill. We don't need to go to it but you have provided some minutes from a safeguarding transformation board meeting where the bill is discussed. I appreciate you are no longer with the Department but are you able to say anything about the progress of the bill? 12:14

A. Yeah, the policy work has been completed, it's been consulted upon and my understanding is that it is in the legislative programme for the Department of Health. I am now running the legislative programme for justice and each department has its programme and the bills 12:14

they want to bring through. It's difficult because we have had several years without a legislature so there is a backlog but my understanding is that the bill is hopefully going through in this period. I think it's also important, though, that I say that problems in safeguarding are not exclusive or were not exclusive, in adult safeguarding were not exclusive to Muckamore. For other reasons I had commissioned a regional file audit of safeguarding processes. And while the problems weren't of the nature that this independent audit found in Muckamore, there were issues of variations, unacceptable variations, interpretation of thresholding in particular between Trusts and you had a situation where the difference in volume of safeguarding referrals was really high and when you looked at it, it was a case of one Trust being excessively rigorous in making sure everything was covered by a safeguarding referral and another Trust being probably excessively exclusive in only accepting very, very definite safeguarding referrals. So there were issues across the system, it just wasn't Muckamore, which is why the legislation was important and why we were moving forward to put it on a statutory footing. But that's my understanding, the current status is that there is a draft bill ready to go before the assembly within the next three years.

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51 Q. From your perspective as the former Chief Social Work Officer, what are the main improvements that you think will be brought about by the bill?

A. Well the first thing is putting things on statutory footings does not fix everything and it's important that people aren't over promised in that regard. But I think the degree of definition and precision that's given by statute is of great assistance in trying to develop a system that operates in a more consistent way. There will always be some degree of variation, some of that is fine, because there is space for professional judgment to be exercised in a range of situations but it should become a much more standardised process. The other thing is that it will place duties on certain people and statutory duties are taken more seriously than good ideas and it will place statutory duties on providers of services. It will also place statutory duties on those carrying out investigations. It will also give additional powers to investigating officers. Those powers will hopefully enable people to be able to take steps which currently they can't take to secure someone's safeguarding and wellbeing, ranging from being able to remove people from situations because they are potential victims, through to orders that might exclude people from situations because they are potential threats. Those would be some of the main benefits that I hope would flow from it. There are other issues that I know we were in discussion at the policy development stage when I was there and I don't know where they have got to. One of them relates to whether, when you have a safeguarding investigation which relates to a service

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being provided by a Trust, the extent to which that safeguarding investigation should be undertaken by staff from that Trust. I don't know where they have got to with that but I think certainly there is a case to be made to say -- I mean certainly I think there are some which a Trust can investigate itself on, a single isolated incident, that's not a problem. But when you reach the point where you're investigating a complex incident or issue within the services that you directly provide, and this is personal view, I am not saying this is policy, my personal view is that serious consideration should be given to a statutory barrier to that being investigated by the same organisation. 12:19 12:19

DR. MAXWELL: Does the proposed bill actually recognise the difference between individual cases where there is a single perpetrator and the more complex cases that might involve a whole institution? 12:19

A. That would probably belong in statutory regulations, the regs and guidance that will go with the bill rather than being on the face of the bill, that will be the case in child protection legislation but it will be something I think there will be far greater clarity on once its on a statutory footing. Certainly in child protection a complex investigation is well understood versus individual -- 12:19 12:20

DR. MAXWELL: And that's the model that you would want to see followed?

A. Not exclusively, not exclusively because things are different between adults and children. I think you

have to be respectful of adult's agency and, you know, sort of safeguarding to some extent is at the discretion, in certain instances, the person being safeguarded. I mean a very salient quote from Lord Justice Mumby, there is no point in safeguarding people if you just make them miserable by doing so, you have to respect that people may make choices that aren't necessarily the wisest of choices whereas with children, the State I think has a different relationship with protecting them. 12:20

52 Q. MS. BERGIN: At paragraph 74 you refer to meeting with relatives of patients and that one of the issues raised with you was of families feeling pressured to accept resettlement options for their relatives. So if we can go to a letter at exhibit 14 on page 159. This is a letter that you wrote. 12:21

A. Yes.

53 Q. On 24th January 2020. And if we go down to the fourth paragraph beginning with "finally", here you say "finally I have to emphasise" -- I should say rather, Mr. Holland, this is a letter that you wrote to the Chief Executives of all of the Trusts, isn't that correct. And you say then -- 12:21

A. I think this communication or a very similar communication also went to independent providers I think. 12:21

54 Q. Okay.

"Finally I have to emphasise that resettlement should

not and must not be pursued with disregard to the possibility of success. The decision to proceed with resettling a patient must be on a sound basis of expectation that a placement will succeed. The simple possibility that it might is not strong enough grounds to proceed with it. Placement breakdowns are very costly and very traumatic for both patients and their families and must be avoided if at all possible. I acknowledge that even the most well planned resettlement placement can break down but I would not expect this to be the norm." 12:22 12:22

Then you go on to ask that the Chief Executives of the Trusts ensure that staff are very clear about this and that consistent messaging is shared also in relation to the first part of the letter which relates to messaging around the closure of Muckamore. 12:22

So this letter, and I'll let you confirm, but this letter seems to read as if there were serious concern on your part that Trusts were putting the resettlement targets we've talked about over the interests of individual patients. Would that be a fair summary? 12:22

A. I have to stress that the volumes of resettlement are very small so this wasn't something that you would necessarily pick from trend data because the sample size would be very small. But I had met with some families in a few different settings. I remember going to a meeting in Antrim, not in the hospital, but in a 12:23

civic facility where I met a number of relatives and I met some other relatives in the hospital. I met relatives who were very pleased about resettlement, including people who said they had been incredibly sceptical about the process and now believed their relative had a much enriched life. But I did meet some people who said the Trust is all about resettlement, resettlement, resettlement and I was told the story of someone being resettled and it being a placement that broke down and the family members said of course it broke down, it wasn't right for them, you need to have something that is tailored to the individual needs, whatever. I heard versions of that story a couple of times. Although the volumes may not be big it is one of those situations where it is not like a moderately bad thing happening lots of times, this is a catastrophic thing for an individual concerned. So I felt that we needed to emphasise resettlement is good, resettlement is the policy but it's not at all costs.

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55 Q. I want to then move down to question 8 on page 27. You were asked when the Department first became aware of allegations of abuse of patients at Muckamore and what steps the Department took. Now, you have helpfully set these out under different headings of historic abuse allegations, Phase 1, Phase 2, then retrospective sampling exercises, then the Ennis Ward abuse allegations and then the 2017 abuse allegations and we are going to try and move through them in that order. So beginning at paragraph 85 with the historic abuse

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allegations, you say:

"In 2005 the Eastern Health and Social Services Board made the Department aware of historic allegations from the 1960s and 70s. This came from legal proceedings taken by a former Muckamore patient against the former North and West Belfast Trust." 12:25

Are you familiar with that? Yes. And if you scroll down please under the preliminary fact gathering review, Phase 1, thank you, at paragraph 87 you say: 12:25

"To investigate the allegations, the EHSSB and North-West Belfast Trust reviewed 64 patient files and these revealed concerns about possible sexual abuse of patients dating back to between the 1960s to the early 1980s." 12:25

And you say: 12:26

"That 2005 review was limited to the files of in-patients identified in the former Muckamore patient's file and related contacts. The Review Team didn't find evidence of any staff involvement in abuse but that is what the patient had alleged." 12:26

So the 2005 review that, only looked at 1960 to 1980 cases, is that correct?

A. My understanding, this is before my time.

56 Q. Yes?
A. Working on these issues. My understanding was it was taking back bearings from the file of the person who complained and that led to other files that were being considered. But I don't know about the exact methodology or the detail of that. 12:26
57 Q. Yes and then at paragraph 89 you go on to say that:

"A review of practice and care at Muckamore was then commissioned in December 2005. That found that safeguarding policies and procedures were in place and the results of that review were then presented to the PSNI." 12:27

I appreciate that some of this is before -- 12:27
A. Sorry, I don't think, I don't think paragraph 90 flows from paragraph 89 quite in that way. I think the review was completed and confirmed that the current procedures, whereas they were, but the results of the preliminary were presented to the PSNI, I mean those are slightly two different elements. 12:27
58 Q. If you could clarify those if you are able to?
A. Sorry I am getting confused. That is saying the Review Report confirmed in 2005 that the relevant policies and procedures were in place. I thought there was an RQIA clarification, but maybe I'm mistaken. And then the next paragraph: "The results of the preliminary fact gathering were presented to the PSNI", yes, sorry. 12:27
59 Q. Do you know if there was a formal report?

A. I've not seen or read a report of that and I'm trying, I know that there was a process, there was a joint group between the police and the Board.

60 Q. The management group?

A. SMG, yes, but I honestly don't know at that point, this is 2005. 12:28

61 Q. I appreciate it's going back and it is before your time?

A. I wasn't involved.

62 Q. Yes. Well if we continue then, the PSNI along with Health and Social Services then formed, as you referred to, the Strategic Management Group in May 2006 and the investigation was then progressed. And you go on at paragraph 92 to state that Dr. McCormick, who the Inquiry has heard from, who was then the Permanent Secretary wrote to the Chief Executives of the Trust seeking assurances in respect of measures in place to prevent safeguarding incidents. At paragraph 93 then, Phase 2, you say that: 12:28 12:29 12:29

"In or around 2006 a further 296 Muckamore case files were retrieved and reviewed in line with police requirements."

The concerns raised were then shared with the police in August 2007. And the SMG put forward two options of how to handle the investigation, either to investigate all complaints or to investigate only the most serious offences. And it was agreed in June 2008 that only the 12:29

most serious offences would be investigated. If we could look at exhibit 18 then, at page 199. I appreciate, Mr. Holland, you have already indicated that some of this was before your time in post.

A. I am assuming that those further files being examined was triggered by Dr. McCormick's letter saying a further consideration, retrospective analysis should be considered. I am assuming that but I don't know for certain. 12:30

63 Q. We can clarify that if we need to. Just on to page 200, please. Apologies, could we go back to page 195, please. Here there is a reference to paragraph 20, scroll down please, yes, thank you. There is a reference to 277 records being examined by the Review Team and these affected 118 people. If you could scroll down then so we can see the table. Mr. Holland, we can see that the first three rows or the first four rows of the table, rather, refer to categories, 1, 1A and 2. If you could scroll down please, the note below the table states that categories, 1, 1A and 2 are the most serious categories. In your statement you outline that the decision that was made by SMG and agreed with the police was that only the most serious categories of abuse would be investigated. Do you know if that is, if those are the three categories of abuse that fall within that? 12:30 12:31 12:31 12:32

A. I don't know, no.

64 Q. That's all right?

A. I think, I could be wrong but I think from looking at

the records it was the police who said that the focus should be on the most serious so I'm assuming that that would have been based on the type of offence that they thought might have been committed but I don't know.

65 Q. And under the heading then "North and West Belfast Trust investigation of 2002 allegations", it states: 12:32

"This element of Phase 2 of the review has been initiated and is ongoing."

12:32

Are you able to assist the Inquiry, did Phase 2 include the review of the 296 files, did that also include more recent case files up to 2002 also or was that primarily focused on historic files, or are you able to assist with that? 12:33

A. I am afraid not from memory, no. I say not from memory, I don't think it is a question of memory, I just don't --

CHAIRPERSON: We may need to follow this up. When I looked at this I couldn't work out whether this was all 12:33 historic or if it included more recent abuse?

A. My understanding was this was historic.

CHAIRPERSON: That may be right but we had better find out. Okay, thank you.

66 Q. MS. BERGIN: I have some further matters to explore in 12:33 relation to this but I think in light of what you have indicated, I think we will move on and we can follow up with the Department in due course if we need to. Just for completeness then, if we could go back then please

to page 30, paragraph 95, and here you refer at paragraph 95 and 96 to the fact that then interviews were carried out with patients and investigations were progressed by PSNI but in 2011 police confirmed that none of those file reviews had resulted in prosecutions. But, the Strategic Management Group did make five recommendations arising from this historical investigation and you outline those at paragraph 96 of your statement. And thereafter at paragraph 98 you outline that Dr. McCormick then engaged with RQIA to seek assurances following this process. And if we could then move to paragraph 104, please, and here and in the following paragraphs you refer to the retrospective sampling exercise and you say that: 12:34 12:34

"In May 2007 the DHSSPS Deputy Secretary wrote to the five new Trust Chief Executives..."

That was of course around the time when the five new Trusts were formed. 12:35

"...and reiterated the need for retrospective sampling and called a meeting in June 2007 in which it was agreed that a 10% record sampling exercise from 1985 to 2005 should be carried out for Mental Health and Learning Disability hospitals in Northern Ireland." 12:35

And these reports were provided to the Department in 2008, 2009. You say that were involved in that review

and you and your colleagues concluded that the exercise had not been done in a uniform or robust way and options on a way forward were provided and the material from this sampling was shared with PSNI in June 2011 and formed part of Operation Damson. Earlier in your evidence, Mr. Holland, you referred to engagement with the Trust in relation to sampling, and I think you said there were issues with that, is that what you were referring to? 12:35

A. Yes. 12:36

67 Q. You then say the police agreed that the matters --

CHAIRPERSON: Which paragraph number so it can come up on the screen. Were we at 107 I think.

68 Q. MS. BERGIN: Apologies, yes, thank you. You then, Mr. Holland, go on to say: 12:36

"The police agreed that matters required further investigation."

And the Strategy Management Group which had been in place from 2006 to 2008 was then reconstituted in 2012 and that was to look at anything arising from this review. And a final Strategy Management Group report which reviewed this retrospective sampling was then provided to the Department in December 2013. 12:36
Are you able to assist at all, Mr. Holland, with the purpose of the sampling exercise? Was the purpose to ensure that appropriate referrals were being made to PSNI, or was it from an initial safeguarding

perspective or perhaps both?

A. My understanding, I mean my involvement was in a discussion about, it was someone came to me and said look, we've asked the Trust do this exercise and they have all done it differently, we should go back and do it again and I said yes, I think you should. But I wasn't actually involved in doing any of the reviewing or investigating. And I can only assume the reason for doing the further retrospective sampling was to determine whether this was a widespread issue, I don't think it was contemporaneous issues, it was more about historically was this more widespread than just Muckamore, I think. 12:37 12:37

69 Q. At paragraph 110 then you summarise the key findings of the final Strategy Management Group report and you list some of the key findings there that 77 incidents were referred to the PSNI for consideration. Then on the next page that there were no prosecutions as a result of the retrospective sampling. Despite the fact that there were no prosecutions, did this cause the Department to have concerns about Muckamore in relation to abuse? 12:38 12:38

A. There were no prosecutions from memory because either people were dead or there was no prospect of success due to capacity issues in relation to the potential defendants. 12:38

CHAIRPERSON: And also if it was historic, it goes back at least 30 years?

A. Some of them were out of scope, I remember that was

also an issue. It certainly would have confirmed that there was a culture, not just in Muckamore but in other facilities, of this kind in the past that was tolerant of practices and behaviour, well tolerant of behaviours particularly between patients that we would now see as not being acceptable. But I don't think -- I mean it was confirmed by this but I don't think that would have been a surprise to many people who were involved in either mental health or Learning Disability Services. I mean there's a lot of academic historical study of the asylum movement and it would be something that has been established and reported on, that there would have been inappropriate sexual behaviour tolerated between patients in those settings. 12:39 12:39

70 Q. MS. BERGIN: If we move away then from those historic allegations and then to the Ennis Ward abuse allegations and that's at paragraph 113 on page 33 of your statement. You say the Department was first made aware of the allegations of abuse of four patients at Ennis by way of Early Alert and you've referred to that already today. That was on the 9th November 2012. You go on to say: 12:39 12:40

"The Department sought and received assurances from the Belfast Trust that a Joint Protocol Adult Safeguarding Investigation had been carried out with PSNI." 12:40

And at paragraph 115 you refer to the RQIA unannounced inspections of Ennis and correspondence between RQIA

and the Trust that you had sight of. We've already heard in your evidence today you have already gone into some detail already about the engagement with RQIA in relation to Ennis.

In terms of the Department's awareness of Ennis, and we are going to come to the timing that of in a moment, but generally did the issues that came out of Ennis, did they make the Department consider that there might be wider spread issues of this nature across not only Muckamore but learning disability hospitals and community placements in Northern Ireland? 12:41 12:41

A. Well the first thing I would say is that I think that everyone should always be alert to the possibility of abuse in these settings and the evidence of any individual safeguarding investigation, while that might add to that evidence, I mean, you know, you should permanently be considering the possibility that there is abuse in these kind of settings. Incredulity at a suggestion that abuse has happened, is not an appropriate response, there should be a permanent scepticism about the possibility of abuse in all of these settings. And I think from the way the information was presented to the Department from the Trust, there was no reason to assume this was anything other than something that had happened and been thoroughly investigated. 12:41 12:42 12:42

I subsequently have talked to the Investigating Officer, because she subsequently, as you know, came to

work in the Department, and she would say that the way the findings the report were characterised to the Department did not represent her understanding of the report at the time. And we then had the Way to Go Report by Margaret Flynn and others who considered the 12:42
Ennis Investigation and they made some very salient points about the conflation of a police investigation and eventual not guilty or guilty overturned by appeal decisions with a safeguarding threshold, which is very different from that. I think that it was represented 12:43
this has been thoroughly investigated and there was nothing to find here. Whereas when -- and this would have been the view of the Investigating Officer but also from the Margaret Flynn review of this, the fact that something does not meet or does not meet in a 12:43
sustained way when challenged beyond reasonable doubt is a million miles away from saying that you've established that there was no abuse. The threshold you would be using to consider whether abuse has happened is far more in the realm of balance of probabilities 12:43
and certainly you would take action on something which you couldn't prove beyond a reasonable doubt, but which on the balance of probabilities you believed to be correct. That isn't the impression I think the Department gained from what was provided. 12:43

DR. MAXWELL: And given the explanation you have just eloquently given, how do the systems to monitor and alert people about this in Northern Ireland work? So, we've heard from various witnesses that because it was

a Safeguarding Report it wouldn't go through the normal assurance mechanisms in the Trust because safeguarding had its own route up to the Local Adult Safeguarding Partnership?

A. Can I stop there, that's incorrect and I know you've heard that, but that is not correct. The Local Adult Safeguarding Partnership would have no role whatsoever in evaluating the implications of an individual investigation. It is a collaborative partnership between a range of organisations. People would be represented on that partnership who would not be authorised to have access for the information that would be contained in an individual Safeguarding Report. It's place would be through the internal Trust processes. 12:44

DR. MAXWELL: So you're very clear that a report, a Safeguarding Report where the Investigating Officer had continuing concerns, notwithstanding the failure to secure a conviction, should have been raised through the Trust's internal governance structures? 12:45

A. Absolutely, the LAPS aren't that kind of organisation.

DR. MAXWELL: Okay.

A. We have had the equivalent kind of structure in, again, child protection services where you bring together the voluntary sector, the police, the Trusts, and they shared common issues. This form is very cumbersome, do you think we could change it? We have seen a spike of referrals that are mentioning this, is that relevant? That kind of thing.

DR. MAXWELL: Not personal identifiers.

A. No, this is an investigation in a Trust facility undertaken by Trust staff. This is the Trust's business and police's business.

CHAIRPERSON: In terms of the internal Trust governance would you have expected that to get up to the Board or not? 12:45

A. If people has been taken to the point of being prosecuted and convicted, albeit overturned on appeal, yes. I am actually surprised it wasn't brought to the Department's attention because it wasn't a single person, you know, a number of people were at the point -- because so often safeguarding investigations are nowhere near conclusive enough to get you to the point where you go to trial. 12:46

CHAIRPERSON: No, of course not. So it would go to the Board and then you would have expected it to come to the Department?

A. I would have expected, yes.

CHAIRPERSON: And through an Early Alert or -- 12:46

A. Through an Early Alert but that would only be what an Early Alert is. I compare it to other instances within Trusts where things happen and it's just not something that would be contained. In my experience senior leaders in Trusts would not rest until they had shared the problem. You know, sorry, does that make sense? 12:47

DR. MAXWELL: Yeah, no, I understand. So there was an Early Alert, we know that.

A. Yes.

DR. MAXWELL: We know at a later date because the investigation took quite a long time, the Department of Health were saying perhaps there should have been an SAI and the Trust declined.

A. Mhm-mhm. 12:47

DR. MAXWELL: But you feel somehow, and that's Belfast Trust's business, the Board should have been made aware of this and your expectation is that had the Board been aware, they would have let you know, firstly because it is the right thing to do and as you have just said 12:47 because they want to share the responsibility?

A. I think the Trust normally would contact you, o the Board would be advised but the Trust would contact you.

DR. MAXWELL: You think, who would that be, would that the Executive Director of Social Work contacting you? 12:48

A. It could be the Executive Director of Social Work, it could have been, I'm sure Charlotte McArdle will be able to tell you of instances where Executive Directors of Nursing have contacted her to advise her of situations like this. 12:48

CHAIRPERSON: You're talking over and above an Early Alert?

A. Yes.

CHAIRPERSON: Not just the Early Alert.

A. The early alert is only what it is, it is not a 12:48 trigger, it is limited. But then in addition you have the issue of the SAI, this met the threshold for an SAI. The Trust repeatedly seems to, and I am basing this on what we read from Margaret Flynn's report --

there are also I think some exchanges.

DR. MAXWELL: To be fair in their evidence they said the guidance on SAIs changed after the event but before the Safeguarding Report was published?

A. In my understanding it meets the criteria and the Board acknowledged it met the criteria both pre-and post. 12:48

71 Q. MS. BERGIN: Yes, Mr. Holland, then if we scroll down to paragraphs 118 and 119, you then in fact go on to say you understand that the Adult Safeguarding Investigation was completed in October 2013 and further down then you say that: 12:49

"I do not believe the report was provided to the Department at that time as it was a report of an ASG investigation carried out by the Trust under the adult safeguarding arrangements. The Department would not routinely have had sight of such reports. I do not recall the exact time I became aware of the report, however the Department became aware of the existence of the report on the allegations of abuse in Ennis following media reports in 2019 and on becoming aware of this requested a copy of the report which was provided then on 17th October 2019." 12:49

We have already dealt with this, but I think would it be fair to say you would have expected a report of this magnitude to have been provided to the Department? 12:49

A. Yes, I would not routinely have sight of Adult Safeguarding Investigations. Adult Safeguarding

Investigations happen every day across hundreds of facilities, not just Trust facilities, independent sector facilities, you wouldn't -- but where you have got, I think it was three members of staff were arrested.

DR. MAXWELL: Two I think.

A. Two arrested, were there three -- well anyway, but there were certainly two arrested.

DR. MAXWELL: More investigated?

A. Yeah, more were investigated. Yes, I don't think my counterpart in Richmond house in London would be advised of this, but this is a smaller place and I am sure there would be points of escalation before that in a constituency the size of England. But I think, I'm sure also if a Trust Chief Executive or a Trust Chair knew that staff had been arrested they would have raised, just even informally with the Permanent Secretary.

72 Q. MS. BERGIN: Is it correct that this was at the same time that the Strategic Management Group had been reconstituted in 2012 and was also continuing with its work?

A. While this was happening?

73 Q. Yes?

A. I presume so.

74 Q. Yes, just before we leave the Ennis matter, at paragraph 117 above you say that you also wrote to the HSCB to draw their attention to the findings of a number of RQIA inspections, including Ennis around this

time and you asked the HSCB to consider whether themes emerging from these inspections were more widespread and might require a regional response. And if we could go to that letter then dated 15th April, that's page 320, exhibit 25. Yes, thank you. If we could scroll down please. The first category is safeguarding and there is references, we won't go through the document but there is various references to Grange Wood and also to Muckamore and to St. Luke's and it refers to RQIA concerns about a number of these facilities, particularly around lack of specialist restraint and learning disability training and lack of recreation activities. Do you know if the HSCB provided a response to you and took forward the suggested consideration of those matters? 12:52

A. I can't recall but I would have expected so. I mean, I honestly can't remember. I can't remember writing the letter but the expectation would be that they would have followed it through. And also I'm not sure who that letter is copied to, can I see? 12:53

75 Q. Scroll to the top please?

A. The CC list would normally be at the end of the letter. No, it's not copied to anyone, I would have thought I would have copied that to the RQIA but I didn't.

76 Q. The next section I am going to go on to is the 2017 abuse allegations, but I wonder if now would be an appropriate time for lunch? 12:53

CHAIRPERSON: Are you okay to keep going or would you prefer a break? Don't be shy.

A. If you were anticipating maybe another 15 minutes or so that would be fine, if it was to be longer than that, may be a break.

CHAIRPERSON: I'll keep an eye on the clock and if we get beyond ten past, we'll stop. But please, if at any stage you want to stop, tell me. 12:53

A. No, I appreciate that.

77 Q. MS. BERGIN: We move then, Mr. Holland, onto the 2017 abuse allegations and we look at page 35, paragraph 120 of your statement. And between paragraphs 120 and 143 you provide, I suppose, what I would describe as a chronology of the Department's actions after it was made aware of the allegations of abuse and if we turn to look at some of those now. So at paragraph 120 you outline that on 30th August Gavin Robinson MP contacted a member of your senior staff team about an allegation of abuse of a patient at Muckamore. And you go on to say at paragraph 122 that your staff member, Mr. Matthews, contacted the Belfast Trust Co-Director for Mental Health and it was established there had been a delay in reporting this to the Department due to leave commitments of Trust staff and the Trust subsequently provided an Early Alert notification on 7th and then 26th September 2017 and those were in relation to both the incident itself and also the precautionary suspension. 12:53 12:54 12:54 12:55

At paragraph 124 onwards you outline then that your colleague updated Mr Robinson in September and the

Trust then provided further updates to the Department on the 20th and 27th October that more safeguarding concerns had emerged following a review of CCTV at Muckamore.

At paragraph 127, then, you say that the Department Policy Lead for Learning Disability Services immediately followed this up with the Trust and due to the concerns the Department had about the Trust's reporting and handling of the allegations, you and the Chief Nursing Officer jointly wrote to the Trust on 20th October 2017 to seek assurances that these issues would be addressed. We can go to that letter then at page 329, that's Exhibit 30. If you just go up to the top of the page please, the top of the letter rather. Thank you. Would it be fair to say that the letter that you wrote to Mr. Dillon of the Trust expressing deep concern and considerable alarm, those are some of the wording of the letter, that's one of the strongest types of letters that you could perhaps write to a Chief Executive of a Trust, would that be fair? 12:55 12:55 12:56 12:56

A. I think it might be the strongest letter I have ever written to a Chief Executive of a Trust with the exception of an occasion when I arranged for a Chief Executive and Chair of a Trust to come in to have a meeting without coffee with the Minister about something we were concerned about, but this is not normal. 12:56

78 Q. Was that then a marker of the degree of concern that you had about how the Trust was dealing with this

matter?

A. Yes.

79 Q. And at paragraph 128 then, if we go back to that, please, you say then that on the 3rd November 2017 the Trust replied to your 20th October letter and they outlined the timeline of actions the Trust had taken and the structures they had put in place to address the allegations and to provide assurances about patient safety. And you say that professional colleagues then met with senior Trust staff on 17th November to discuss the letter. Can you recall anything about who from the Department met with the Trust and what the outcome of that meeting was? 12:57 12:57

A. In between all of the stages from, you know, sort of Gavin Robinson MP raising it with us and us approaching the Trust, getting an explanation, going back to Gavin Robinson, there was concern being raised with me and with Charlotte McArdle by our respective staff who were working jointly on this who were having phone calls and what you have with the Trust asking questions. They, and I have to be absolutely clear, credit does not belong to me or Charlotte for that matter, it was a small group of staff, professional officers, social workers, nurses, who kept saying we are asking questions and we are not getting answers that make sense. Or they are answering the question and it is not the question we asked or what have you and there was a growing sense of unease as a result of these exchanges about what was happening. And we knew that 12:57 12:58 12:58

there had already been -- I think actually and I can't be certain but going back to the original point about the delay in reporting, that maybe two different explanations were given by two different points of contact when the Department had contacted the Trust and that raised concerns amongst the team. Sorry, I have lost my thread as to what the question you were asking was.

80 Q. I think you have answered it in part. I had ask you if you could recall which of your colleagues met with the Trust on the 17th? 12:59

A. I know me and Charlotte did attend meetings with the Trust but I am not sure exactly which meetings and when, whether the fact it says professional colleagues met with the Trust, I am suspecting me and Charlotte weren't in that meeting but I would have expected Chris Matthews to be in that the meeting. There was an LD nurse, very good LD nurse that Charlotte had called I think Siobhan Rogan, she met, might have been at that meeting. There are a few people who might have been at that meeting but I don't recall who if me and Charlotte weren't at it. 12:59 13:00

81 Q. At paragraph 129, you say again you wrote jointly with the Chief Nursing Officer to the Trust on 30th November to seek further written assurances on the range of issues which were discussed during 17th November meeting and also about other related matters. And you requested in that letter that the Trust provide the Terms of Reference for the Level 3 SAI and also provide 13:00

fortnightly progress updates. We have a copy of that letter, we don't need to go to that for the present purposes.

At paragraph 130, you say on 22nd December 2017 the Trust replied to you both with assurances and confirmed that the SAI would look at all allegations of abuse during the previous five years. The Trust then commissioned the independent Level 3 SAI review in January 2018. We can go to the Trust reply if we need to in a moment, but I suppose without going to it first of all can you recall if you were assured by what the Trust were telling you in that correspondence? It's at page 334. 13:00 13:01

A. If I could see the reply. 13:01

82 Q. Yes, page 334. That's Exhibit 32 of your statement, Mr. Holland. So this is the letter from the Trust?

A. Scroll down so I can read. I think there are a few things, I mean firstly, the language where describing "we expect staff acting with the highest degree of professionalism and this is what we overwhelmingly find, notwithstanding these small incidents." I have to be honest, I have managed lots of staff and they do great work, but they don't always act with the highest degree of professionalism, excessive confidence in your staff when you have an allegation of abuse is not an appropriate response so that was concerning me. You could be loyal to your staff and what have you, but scepticism is what is required here. I think that, if 13:02 13:02

we could scroll further on, and on. There was, I wasn't quite clear what was being said. The purpose of the paper to the Trust Assurance Committee where this data appears was not to provide detailed information of each of the incidents, but I can assure you that it has all been followed up properly, not enough. 13:03

They told us they had been talking about a turn around team but they dismissed that but they are only telling us now that they have dismissed that because we've asked, whereas we had been looking for continuous updates. And I have to be honest, the fundamental point about CCTV probably just left us all feeling very uneasy. That you could have had CCTV and not known probably left us very uneasy about the level of assurance we were getting. So we were then into wanting a lot of much more detailed assurance than normally would be the case. 13:03 13:04

83 Q. If I could ask you about that, Mr. Holland. It appears from what you've said that you had some concerns arising from the written assurance that the Trust provided in December 2017, the letter we're looking at. Thereafter, and it doesn't appear in your statement, but it may be that it simply just hasn't been recalled when you were writing your statement, can you recall now if any actions were then taken by you or your team to go back to the Trust? 13:04 13:04

A. There was constant back and forward between us and the Trust.

84 Q. Okay?

A. Was my memory but, I mean, there are other staff who I'd need to check with to verify with, Chris Matthews, Aine Morrison, Siobhan Rogan, were engaged in a lot of dialogue, and probably other officials, trying to clarify. I think the CCTV point was really difficult for us. How you could spend hundreds of thousands of pounds installing such a system and not know -- most people not know it was there and then not know it was turned on, I think that just fundamentally left us in a position where we had lost a lot of confidence. I mean we were very grateful that it did exist and the information was there but it had undermined our confidence. 13:05 13:05

CHAIRPERSON: This letter before we leave it was signed off I think the Chief Executive, Martin Dillon, and copied to the Chair. 13:05

A. Yes.

CHAIRPERSON: That is the sort of level you would expect to receive this letter from.

A. Yes. 13:05

CHAIRPERSON: Yes, is that a convenient moment?

MS. BERGIN: Yes, certainly Chair.

CHAIRPERSON: Or are you going to finish?

MS. BERGIN: No, no.

CHAIRPERSON: Let's take a break there, we'll continue at about 2. How long do you think you've got left to go, just so we could -- 13:06

MS. BERGIN: Certainly less than an hour.

CHAIRPERSON: Yep, okay. Sorry, I can tell from your

reaction that is not the news you wanted.

MS. BERGIN: Perhaps shorter.

CHAIRPERSON: All right, thank you. 2 o'clock please.

LUNCHEON ADJOURNMENT 14:09

CHAIRPERSON: Sorry, thank you very much. Ms. Bergin?

85 Q. MS. BERGIN: Thank you. Yes, Mr. Holland, before the break we were just dealing with the 2017 abuse allegations, now before we come back to that I just 14:09 want to ask you briefly about some of the evidence that you gave in relation to the Department's knowledge of Ennis?

A. Yeah.

86 Q. A document or two documents rather have been brought to 14:09 your attention and if you could bring those up I know you have them in front of you but for everyone else's benefit it is MAHI-STM-298, that is exhibit 1 to Dr. McCormick's statement, thank you. And here, Mr. Holland, we see a message from Moira Brisco and her 14:10 role was what within the Department?

A. Moira Brisco would have been the relevant Director responsible for Learning Disability, Mental Health and Older People.

87 Q. Yes, thank you. And then we see that the recipients of 14:10 this memo include Dr. McCormick and then also yourself, you were cc'd into it and this was sent on 4th February 2013 in relation to Ennis Ward, Muckamore. Without reading all of it out it states:

"Teresa Nixon from RQIA rang to further express concern about Ennis Ward in Muckamore. This is a resettlement ward with many patients having profound challenging behavioural difficulties." 14:11

She refers to whistle-blowing having raised concerns and three staff having been suspended around allegations of potential mistreatment. And it says the most recent picture at that stage is that RQIA did 14:11 another inspection on 29th January and remain concerned and this is their third visit. And it lists the big issues as staffing, safeguarding and use of bank staff and that there was another staff suspension but it wasn't substantiated in terms of police matters. That 14:11 is a document providing information to the Department about Ennis in February 2013. If we can then turn overleaf just before I ask you about these documents, thank you. This is then an update from the Learning Disability Unit from Mr. McGowan on 21st May 2013. If 14:11 we scroll down to paragraph 1, please, this provides the context being that there was an Early Alert to the Department and then at paragraph 2, I think for clarification purposes it refers here to the Ennis matter being converted to a Serious Adverse Incident 14:12 but we know that's not correct, isn't that correct, Mr. Holland?

A. Mhm-mhm.

88 Q. Yes. Then paragraph 3 to 5 then outlines an update of

safeguarding action that was taken in relation to Ennis. Paragraph 4 deals with taking forward the allegations of abuse and then paragraph 5 refers to the police involvement or leading rather on the investigation and that there were sufficient evidence at that stage to take forward prosecutions of two members of staff.

Now, earlier in your evidence, Mr. Holland, you were asked about Ennis and I think to summarise the main points that you had made at that stage were the Department was aware of the Early Alert and then subsequently the report wasn't provided until many, many years after the Ennis Report, I think it was 2019 you said it was provided whereas the report was published in 2013/14. These emails which you were cc'd into, updates rather, both fall in February and May 2013, so that's earlier in the process. Can you recall these and can you recall if anything was done in relation to these? 14:12 14:13 14:13 14:13

A. No, I have no recollection of the emails. I presume these are a follow up to the Early Alert and often you would get a follow up to the Early Alert. Looking at the timeline this is May and the Early Alert was --

DR. MAXWELL: November 2012. 14:13

A. This presumably is a follow up which means the Department had clearly been informed at some level because Neal McGowan from the Learning Disability Unit is providing the update on the Early Alert and I was

cc'd into it and I have no recollection.

DR. MAXWELL: The fact that the RQIA had contacted the Department to express their concerns and listed some ongoing issues, would that have attracted further interest in the Department? 14:14

A. Well I presume there was some dialogue. This is a conversation that the RQIA have had with Moira Brisco.

DR. MAXWELL: Yes.

A. Who would have been the Director responsible in the Department. 14:14

DR. MAXWELL: So unless the Director was concerned it wouldn't have necessarily been escalated to the whole of the Department of Health?

A. Well it was circulated very widely, including to myself, but I have no recollection of it. 14:14

DR. MAXWELL: Okay.

89 Q. MS. BERGIN: And then staying in this time period of Ennis in or around 2011 onwards, that obviously related to Muckamore in terms of the Department being made aware of safeguarding concerns. I'd asked you earlier 14:15 and you have addressed in your statement the issue of triangulation of data and what the Department does in terms of getting big pictures on issues emerging in this field. Were you aware around this time of any issues in relation to Ralph's Close? 14:15

A. Yes.

90 Q. And is there anything further in terms then of, I suppose if we look contemporaneously, you have got Ennis issues which, albeit you didn't have the report

until much later, but certainly we can see from these documents we've just looked at that information certainly about Ennis was coming in some degree to the Department?

A. Yep. 14:15

91 Q. Then at the same time we have issues in Ralph's Close?

CHAIRPERSON: Ralph's Close wasn't this Trust, was it?

A. No it wasn't, it was the Western Trust.

CHAIRPERSON: Western Trust. Just to make it -- similar allegations or allegations of abuse? 14:16

A. It was a learning disability unit, I think it was in the grounds of Gransha Hospital and it was a Trust run facility and, from memory, there was a whistle-blowing allegation that resulted in an investigation and staff were both suspended and some were subsequently 14:16 dismissed.

MS. BERGIN: Okay.

CHAIRPERSON: Right, and just out of interest would that have caused to you have a general or a wider concern about Learning Disability Services if you're 14:16 getting the Ennis information and you've got this other investigation?

DR. MAXWELL: I think they are both in the same year, both 2012?

A. I think as I indicated earlier I would have concerns 14:16 and concerns would be widespread about this type of service because we know abuse happens in these facilities. But I didn't, and we'd asked the RQIA on occasions and we'd asked Chief Executives to consider

their services in terms of safeguarding because we knew there was a known risk associated with these.

CHAIRPERSON: So that would cause a letter to the RQIA and a letter to the various directors of service?

A. Well, a letter requesting that people assured themselves and in the case of the RQIA that they inspect accordingly. 14:17

92 Q. MS. BERGIN: If we move back then to the 2017 allegations of abuse at Muckamore. And before the break we were going through I suppose the chronology of events involving or made aware to the Department at that time. And picking up then at paragraph 130 and at paragraph 131, and we'd already referred earlier to the correspondence from the Trust in relation to assurances that were provided you expressed your view in relation to those. At paragraph 131 then you say: 14:17 14:18

"The Trust commissioned the independent Level 3 SAI review in January 2018."

14:18

And that your expectation, given the gravity of the allegations, was that the SAI process would be handled without any unnecessary delay. And that you then wrote to the HSCB on 4th December 2018 to signal your concerns about the length of time that it took for the report to be signed off. So would it be fair to say that you must have been particularly concerned about the length of time this was taking in order to write a letter of this nature? 14:18

A. Yes.

93 Q. And in terms of the delay, was this out of step with your previous experience of other SAIs in the learning disability field?

A. I have to be honest, I don't recall other SAIs, that's not to say they didn't exist, but I can't think of an incident to benchmark it against. But certainly we were concerned from the initial investigation, as I said earlier, and we're now talking about a significant period of time before we've got more information from the process that was designed to assist in understanding what had happened. So it was chasing that report. 14:19 14:19

94 Q. You will be aware, Mr. Holland, your statement is on the Inquiry website and the Core Participants have all read it so we are not going to go through all the detail, I am going to pick out some parts of it. An paragraph 132 onwards you outline some of the steps that were taken by the Department. Upon receipt of the SAI report on 6th December you and Mr. Pengelly and the Chief Nursing Officer met with families on 17th December 2018 to share that report and the Permanent Secretary apologised to the families for the failings in their relatives care. Thereafter in January 2019 you attended an HSC summit and expectations were set by the Permanent Secretary at that meeting in terms of an action plan and an action plan was submitted thereafter. And if we move then to paragraph 135 you say that the Belfast Trust monthly report for February 14:19 14:20

2019 raised concerns about protection and safeguarding arrangements for patients and that then the Department required urgent assurances from the Trust in respect of these. We can go to that letter then at page 355. The letter was in fact written on your behalf by your Deputy Chief Social Work Officer to the Belfast Trust. If you could scroll down, please. The second paragraph outlines that there were concerns about protection and safeguarding arrangements for patients at Muckamore on which you require urgent assurance. Is that the type of letter that you would typically send or was this an extraordinary type of step for you to take to send this type of letter, or rather your deputy in your stead? 14:21 14:21

A. I don't recall sending -- we have a chain of letters here, the first one from me and Charlotte, this one, the second one from me and Charlotte, they wouldn't be routine. 14:21

95 Q. And further on in the letter then over the page at 356, the letter refers to, at the top second line, 158 reports of concern by CCTV viewers which haven't been processed further and delays in incidents triaged as urgent or category A and that the Trust hasn't been able to find sufficient staff to respond to the safeguarding referrals in a timely manner and also seeks clarification to the approach of bystander staff, some of whom had been suspended. So, is that letter a fairly comprehensive summary of the concerns the Department had? 14:22 14:22

A. At that point in time.

96 Q. Yes. That letter is 2019 and some time after the CCTV viewing had started, it seems to indicate the Department was still having concerns around the fallout of the CCTV viewing even up until that point, would that be correct? 14:23

A. I think, from memory, there was an issue whereby issues were being identified from the viewing of CCTV but then, I don't want to use the wrong expression, but going into a queue before they were then being dealt with by a DAPO, I think that was the issue. So there was a delay between knowing there was potential problem and then addressing it and I think that's what Jackie is trying to seek clarification on there. 14:23

97 Q. Would it be fair to say that the Trust at this stage was in a very difficult position because, further to depleting staff by suspending for example, bystanders who are referenced there, might not have had a beneficial impact on the quality of care being provided to those patients remaining, you've touched on that already somewhat in your evidence? 14:23

A. Absolutely, the more staff that were suspended it was going to make it more difficult to run the hospital, but as we discussed earlier that has to be balanced against any risks associated with those staff.

98 Q. You go on then to refer to the Trust proposing formal monthly meetings with the Department and thereafter MDAG meetings and at paragraph 141 of your statement you say: 14:24

"When the Department considered A Way to Go Report dated November 2018 the Department considered that further analysis of the Trust's leadership and governance arrangements was required."

14:24

And that you and the Deputy Chief Nursing Officer jointly wrote to the HSCB on the 5th July 2019 to ask them to commission a review of the effectiveness of the Trust's leadership, management and governance?

DR. MAXWELL: Just before we get to this issue, what was the response to this letter in February raising all these concerns as a result of the public interest disclosure to you? 14:24

A. I honestly can't recall. I presume we would have got a written response and we can certainly look to see or the Department can look to see if we find it. But I would view it in the context of the ongoing back and forth between the Department and the Trust. 14:25

DR. MAXWELL: But the letter said it was a public interest disclosure, so I don't know if the legislation is the same here as in England, the Public Interest Disclosure Act. Does the Department of Health not have a clear process about how to manage public interest disclosures? 14:25

A. I presume so but I don't know that -- all my time in the Department that's the only occasion when I was aware of receiving a public interest disclosure. 14:25

DR. MAXWELL: Okay, so we don't know what the expected response to the disclosure would be?

A. I don't know what the policy is in relation to that.

99 Q. MS. BERGIN: If it exists in terms of the response at paragraph --

A. If it exists.

100 Q. Yes, 136 and 137 you say that the Trust replied to your letter or your deputy's letter and the Trust proposed formal monthly meetings with the Department? 14:26

A. So they did respond.

DR. MAXWELL: They did but I am just wondering what the Department did in relation to the public interest disclosure? 14:26

A. And I don't know.

101 Q. MS. BERGIN: Picking back up again on paragraph 141 and, as I said earlier, in July 2019 you and the Chief Nursing Officer jointly wrote to request a review of leadership, management and governance in the Trust for the five years prior to 2017. 14:26

You say at paragraph 141 that this came about having considered both the findings of the Trust and the views, sorry the findings of the report and also the views of the Belfast Trust that then the Department took the decision to request this review. Why was it, what were the reasons the Department considered this review was necessary at this time? 14:26 14:27

A. I think that it was felt that these were not areas that had been sufficiently dealt with by the SAI, The Way to Go Report. I mean there was a lot of valuable information in that report but it didn't necessarily

explore the leadership issue. And, this is slightly speculative, but it's possible that the -- I mean one of the concerns I think that was emerging was did the top of the Trust, I mean we had meetings with senior people and I believe they said things in good faith but which turned out not to be necessarily fully correct and I recall also a meeting with senior people from the Trust with Mr.P96's Father and I remember him making points and asking questions which seemed to nonplus the senior people because it was at odds with what they understood the situation to be. I don't think they were being dishonest, they genuinely the position was one thing and then he was explaining it was different. So I am speculating about that second part, whether that was part of the decision. I am fairly certain the first part is true, that it was about addressing a gap that we saw in the SAI report, but this is subject to memory. 14:27 14:28 14:28 14:28

CHAIRPERSON: Well it is made clear in the terms of the reference to the Leadership and Governance Review, that's what it says.

A. Yes.

102 Q. MS. BERGIN: And you then go on to describe in your statement the review of leadership and governance. Now if we can move to page 40, that's question 10 that you were asked, and you were asked whether concerns about ward staffing at Muckamore were raised with the Department and we've already dealt somewhat with staffing. At paragraph 145 you refer to an underspend 14:28

on staffing at Muckamore being linked to the reduction in staffing associated with resettlement and you refer to Mark McGookin's statement. While Muckamore had resettlement objectives, as time went on the patients remaining there were perhaps likely to be most challenging in terms of needs to provide for. Was this taken into consideration when resources were being allocated for staffing. Are you able to assist with that? 14:29

A. Looking at records my understanding is that when wards were closed there was no retraction of funding to the Belfast Trust on that basis. And assuming that that was left there as bridging kind of arrangement because you've got fixed and marginal costs when you're running a facility and just because you have ten less patients out of 100 doesn't mean you have a 10% saving. My understanding was the money wasn't retracted, certainly not in the first year after a ward would close but others might be better placed to answer that from the finance point of view in the Board but that would be my understanding. 14:29 14:30 14:30

103 Q. At paragraph 147 you say:

"The Department is responsible for longer term strategic workforce planning and it overseas long term regional workforce reviews." 14:30

And you refer then to two such learning disability service reviews. One of the challenges the Inquiry has

heard about to resettlement appears to have been a shortage of staff with the skills in learning disability and otherwise. In terms of strategic workforce planning did you or your colleagues in the Department ever query whether there was sufficient numbers of these types of staff being trained with Ulster University or Queen's University Belfast to meet these needs going forward?

A. The skills of the staff who were looking after people and supporting people accommodation were for the most part vocational staff so they weren't being generated with a fixed set of skills from a university course, they were recruited -- now it must be said there are courses and some of them would have done courses that were available from higher and further education providers, but when a scheme was being developed they would be recruited and trained for that scheme would be my understanding. That training would be delivered in house. You would get providers such as British Institute of Learning Disability and more locally there is an organisation called Arc who would do staff training in that and in some instances I understand they would have access to training provided by Trusts. Then there would be the very bespoke training they would undergo in relation to an identified individual. But it's not like, for example, the workforce planning that you would do for learning disability nurses which is population based and I think Charlotte has also made statements about workforce planning at that level.

14:30 14:31 14:31 14:32

DR. MAXWELL: That's an operational response and in Equal Lives they did discuss the strategic workforce needs and they talked about a new type of worker. So picking up on your point that it wouldn't necessarily be a learning disability nurse but maybe a new type of worker with additional skills and they also talked about having support teams that we might know now as crisis support times 24/7. But the Department of Health commissioned DeLoittes to do a review in 2009 and, whether that was to do with the financial climate or whatever, they seemed to row back on that and just said that actually staff in Muckamore could be redeployed as and when the wards closed which assumes that the skill set in the community is the same as the hospital which you have just described it isn't. Was any thought ever given, as the challenges with resettlement happened from 2010 onwards, to whether the DeLoittes conclusions and recommendations should be revisited and shouldn't go back to the Equal Lives strategic approach to workforce? 14:32 14:32 14:33 14:33

A. I have to be honest, until the other day I hadn't heard of the DeLoitte report and it predated my being in post responsible for this. The broader issue about staff working in those settings, and that comes under broader social care staff, is a real challenge across the UK at the moment. I mean the social care work is not commissioned at a level which allows for it to be delivered by pretrained staff who have reached an accredited standard. You know, so most of it is on the 14:33

job and in place. In terms of the recycling staff from Muckamore, I think the answer to that is yes and no. There are staff certainly who were recycled out of Muckamore into community based roles, you mentioned support teams, I knew of nurses who had previously worked in Muckamore who became members of behaviour support teams and I can remember, and again this is going back a long time, sorry. 14:34

DR. MAXWELL: But going back to your point about social care work isn't that the problem. 14:34

A. Yes, massive problem.

DR. MAXWELL: Isn't the problem that there wasn't a strategic approach to the social care workforce that Equal Lives envisaged and part of that was because DeLoittes' report rowed back on that and should there not have been a strategic approach that recognised that actually for some of these very complex patients you needed Band 4 social care workers with quite a lot of preparation, and not just recruit locally people without any training? 14:34 14:35

A. I think the same is probably true of an awful lot of social care roles.

DR. MAXWELL: I'm sure it is.

A. And that is a failing in our current system and it's a failing beyond Northern Ireland. 14:35

DR. MAXWELL: But would that not be something that the Department of Health, Social Services and Personal Safety as I think it was called at the time, was that not something that the Department had the autonomy do

something about? The fact that they weren't doing it in other countries didn't mean that Northern Ireland couldn't?

A. No, and I think it's true to say that there would be certainly Trusts and organisations who did employ people and train them to a higher level of skill. 14:35

DR. MAXWELL: It wasn't a strategic policy in Northern Ireland?

A. No, it is beyond learning disability. There has been a review of adult social care, which would include learning disability but all other types of social care and it has concluded there needs to be a more strategic approach to the workforce but it has to be accompanied by appropriate investment and the investment has not been available to do what we wanted to do in the social care workforce. 14:36 14:36

PROFESSOR MURPHY: Surely the Department of Health could have commissioned such courses from say QUB or Ulster University?

A. We could have. I would have to say I don't know what the marketplace would have been for those courses. There are some courses which are available, we are talking vocational level as opposed to post-qualifying for instance. There are courses available in a number of FE colleges on working with autism, supporting people with learning disabilities, challenging behaviours, there is a market for those courses and those courses are available but it's not driven by a strategic approach by the Department and it's not 14:36 14:36

something that -- I think people who are engaging in those courses are nearly always already working in that sector. It's not something which the level of remuneration in that world is not such that people will fund themselves to do a course speculatively thinking they are going to get a job in that field. That is definitely a deficit and failing in the system.

PROFESSOR MURPHY: So do you regret the Department of Health didn't try and commission that kind of training?

A. I regret overall the underinvestment in adult, well social care generally and adult social care in particular and I know we are focusing on learning disability, you made about the point about the skill level needed, I mean even dealing with social care with older people is a much more skilled job than is reflected in the amount of investment into that job, either at local level through an employer or from government or government agencies in terms of what they commission those services for. We took some steps to try and improve that position during Covid and I have to say we were only forced into it because of the desperate situation of social care during Covid and there were additional funds made to try and increase the remuneration that was available. Even those efforts were outpaced almost instantly by tightening of labour supply and inflation.

DR. MAXWELL: So, recognising all those challenges for the social care workforce but not addressing them, was it helpful to produce the Bamford Review and Equal

Lives knowing that it couldn't be delivered because there wouldn't be the social care workforce?

A. I think it was incredibly helpful because the Bamford Review did deliver 90% of resettlement. You know, if you think about the numbers, it drove resettlement. I mean it socialised a whole community of practice and also a wider society to the notion that it was time to abandon a model of care which was segregationist and exclusionary from society and focused on citizenship. I think the Bamford Review and Equal Lives was really, really important but it also was part of a much wider movement towards this trend of trying to move people out of institutional care. I mean in the case of mental health, the origins were probably in closure of asylums in Italy. In the case of learning disabilities I think it was in Sweden where a phrase that is now considered slightly offensive but at the time it was considered positive, normalisation. It hasn't dated well but there was a journey from those principles all the way through Equal Lives and I think that journey is continuing. As I say, I think that say Bamford or Equal Lives was commissioned knowing it wouldn't deliver isn't borne out by the facts. There are 16 people to my understanding in Muckamore where there were hundreds so these people are in the community. Also there is not enough and there is not sort of the money invested in it, but there are specialist support teams, there are behavioural support teams, there are crisis teams, there are community based psychology

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teams, there are still real gaps. I think the real gap is probably in out of hours support with like an emergency breakdown response service. That is probably where the biggest gap is. That is current today and there isn't funding currently available to address that 14:41
gap. But it was a transformation from when there was no community, no real community multidisciplinary teams, they didn't exist at that point in time. Probably more importantly it isn't just the health and social care report, I think Equal Lives did a lot to 14:41
drive broader inclusion in society. So employment of people with learning disabilities as well has grown exponentially in the period since Equal Lives was written. It is not because Equal Lives was written, it has happened across society and a range of other 14:41
things. Leisure centres, there was a point of time when you wouldn't have met a person with a learning disability in a leisure centre. All the leisure facilities, it was one of the reasons why there was an interdepartmental focus on this, are made accessible 14:41
and provide services for people with learning disabilities. And FE colleges where people previously either were in institutions like Muckamore or went to day centres where they did basket weaving, now are going to courses and are today going to courses and 14:42
training and support and learning life skills in FE colleges alongside non-disabled people attending the same college. I think all of those are benefits from Equal Lives.

CHAIRPERSON: Ms. Bergin next topic I think.

104 Q. MS. BERGIN: Paragraph 148, these two paragraphs, 148 and 149 you say the Department when it's made aware of information, for example by Early Alerts and RQIA inspections alerts the Minister and seeks assurance from the service provider that they are providing services in line with legislative and best practice requirements. What is the actual value of seeking these types of assurance, how does that actually help the Department? 14:42

A. I don't think it's intended to primarily help the Department. I think it's intended to help the recipients of the service.

105 Q. How does it help, if the Department with an oversight role is seeking these assurances to ensure the functions are properly being adhered to, what is the value of this type of an assurance to the Department? So, for example, how often would a Trust revert to the Department and say actually no, we are not acting in line with these requirements? 14:43

CHAIRPERSON: In other words is it back covering?

A. You could certainly view it as back covering but equally I can think of plenty of occasions when the service has approached the Department to say there is a problem and we can't solve it and either we've asked them to come forward with proposals or we've asked the Board to assist them and sometimes we have directly intervened. I used an example this morning about unallocated cases in child protection work so the

demand was exceeding what the capacity was there for. Additional funds were provided.

CHAIRPERSON: This is to elicit, as it were, a response, either they are not meeting service requirements or that they are? 14:44

A. Yes, and now I have to be clear, just because someone rings you up and says we are not managing to meet our requirements we wouldn't automatically resolve it by offering them additional resources you go through in the first instance exploring what has been done, can 14:44 you reprioritise. Bearing in mind Belfast Trust, a multibillion pound organisation. Would you have an expectation that in an organisation of that size if there is a temporary issue of difficulty they can flex or they could reprioritise to a certain extent. But if 14:44 not then it would be escalated to the Board. But on occasions the Department, as indeed was the case post 2017, have intervened with resources but it is not the only example.

106 Q. MS. BERGIN: At paragraph 150 then you say the 14:45 Department might also seek assurances from RQIA and you say that where concerns are sufficiently serious to warrant intervention by the Department, RQIA can make recommendations to the Department and you give the example of RQIA raising concerns, including about 14:45 staffing levels following the 2019 inspections. At this stage in 2019 we know there were staffing level issues at Muckamore which had persisted for many years and Muckamore is a learning disability hospital but

we've heard that it was being staffed by a majority of agency staff who didn't have learning disability training. So how could that level or skill type of staff be meeting best practice?

A. I don't think it was meeting best practice at that stage. 14:45

107 Q. I want to take you very briefly to the statement of Briege Donaghy, that is the RQIA Chief Executive, the reference is STM-185-19. You have had an opportunity to consider this extract briefly, I think it was provided to you this morning by the Inquiry. If we could scroll down to paragraph 82 and here we see that between 2011 and 2021 there were 15 meetings described as serious concern meetings or further escalation meetings? 14:46

CHAIRPERSON: It says 14.

108 Q. MS. BERGIN: Apologies, 14, in relation to Muckamore. And there were seven or eight of these actually occurred between 2011 and 2017. So before the allegations of abuse came to light at Muckamore. This was during your time as the Chief Social Work Officer; isn't that correct? 14:46

A. Yes, although the Deputy Secretary role was post 2012 or not post, but from 2012.

109 Q. We have talked somewhat about data analysis and collating information within the Department, in terms of the volume of these types of serious concerns meetings at that time were you aware of those that you can recall and are continuous meetings year on year of 14:47

this kind something that would trigger an alert to the Department or be of concern to the Department?

A. Having previously said I wasn't aware of something only to find that I was copied into correspondence, which I don't remember, I am somewhat reticent to be definitive about this. But my understanding is that in preparation for this departmental records were searched and they couldn't find us being advised of staffing shortages. Now, as I say, I am reticent to be definitive about that but I don't have any memory and certainly post-'17 where you had these Article 4 reports, that was a contrast, that was new. 14:47 14:48

110 Q. If we move on then, we don't have too much further to go, if we move on then to paragraph 161, that's at page 44 of your statement and at question 13 you were asked about systems in place at departmental level to ensure adherence to relevant professional standards by Muckamore staff. And at the paragraphs thereafter you outline that the responsibility for ensuring adherence to professional standards is the responsibility of the relevant Trust and the Department is responsible for setting the guidance on professional standards. You go on at paragraph 171 to say that: 14:48 14:48

"The scheme of delegation requires that there are unbroken lines of professional accountability from frontline social work practice in health and social care trusts through the SPPG..." 14:48

To you as the Chief Social Work Officer and then to the Health Minister. And at paragraph 172 you say that while the Trust is ultimately accountable to you for the professional practice of social work staff via the Trust's Executive Director of Social Work, you do not have direct line management responsibility for individual social workers. In terms of the unbroken line of professional accountability, and I think you have touched somewhat on this already in your evidence, but how did you assure yourself of those lines of accountability from Muckamore through to the Department? 14:49 14:49

A. Well, we're talking about delegated statutory functions here so that wouldn't have been -- and we are talking about social work staff in terms of that line of accountability. 14:49

111 Q. Sorry to cut across you, and also more generally in your role, not limited to delegated statutory functions?

A. Sorry, could you repeat the question? 14:50

112 Q. So, in your statement you outline that whilst the Trust is responsible for individual staff in terms of their line management, you say that the scheme of delegation, and that's referring to the delegated statutory functions, requires unbroken lines of professional accountability from social work staff through SPPG and then to you. How was it in practice that you assured yourself that those lines were operating correctly in terms of information being fed up through the chain? 14:50

A. This is relating specifically to the delegation of statutory function scheme.

113 Q. Okay?

A. So it's through that line people are accountable for their discharge of relevant statutory functions. 14:50
Firstly to the Board -- well firstly within the Trust, the Trust were required by the 91 order to have a scheme and then in 2006 the circular was issued that set out what that line would be, that was built on by subsequent circulars. So it's a connection to say that 14:51
the Executive Director of Social Work is responsible within the Trust for, is accountable for the discharge of these functions by social work staff. They then have to account for that through the DSF report to the Board and then that report comes to me as accountable 14:51
to me.

114 Q. Again with the benefit of hindsight, reflecting back on your time as Chief Social Work Officer, how effective do you think those reporting mechanisms were?

A. They were very effective at doing what they were 14:51
intended to do which was ask people to account for how they were delegating statutory functions in terms of that they were exercising the functions they were meant to function. They were less effective in giving you a qualitative flavour for how well those functions were 14:52
doing. An example where that was tested was we noticed at one stage that there was very little reporting in the DSF against a provision within the Children Order which required Trusts to provide a response to children

in need, these were children who faced particular circumstances that meant they were entitled to a service but they were not meeting the threshold for child protection; they weren't children at risk, they were children at need. The legislation requires Trusts to provide a service to those. We noticed that one, one of the indicators of that would be a certain kind of payment. You know Article, I am trying to remember 15 or 18, I can't remember, of the Children Order allows for the Trust to make a payment to a family to alleviate the circumstances of a child in need on an exceptional basis. Virtually no payments were being made. So on that occasion my memory is that, having identified that through the DSF reporting, we then reminded the Trusts that this actually is a statutory duty and you're not demonstrating any evidence of discharging it. 14:52 14:52 14:53

115 Q. If we then move on to paragraph 197, here you say that a specific barrier to progressing --

CHAIRPERSON: That's about Covid. 14:53

116 Q. MS. BERGIN: No, I think it's from paragraph 197 onwards, apologies 187 onwards, my apologies. And you say that a specific barrier to progressing resettlement during the comprehensive spending review period of 2008 to 2011 and then also the later 2011 to 2015 periods was the misalignment of budgets between the DHSSPS, who had responsibility for providing care packages, and the DSD who were responsible for housing vision. You say that it was ultimately agreed that between 2012 and 14:54

2015, the DSD would transfer 2, 4 and 6 million from the supportive living budget to the resettlement budget administered by DHSSPS. Why did it take so long for the issue of misaligned budgets to be resolved if the issue came to light in around 2008 that it wasn't resolved until in or around 2015?

A. I can only just say that it takes time for things to reach momentum where you get to the point, particularly to get to the point when you are getting one department to transfer £6 million to another department, it takes a period of build up of energy to make that happen would be my explanation for it. I mean, it certainly wasn't fixed speedily. I know that in the interim there would have been ongoing dialogue between staff in the Department and staff in DSD trying to resolve this issue, then it will reach a point where having exhausted, I presume, other avenues they reached the point and there was a submission from, there was a joint submission I think to both ministers, one from Christine [inaudible] and one from I can't remember the name of the official in DSD. It was joint submission to both ministers saying we have been working at this and the answer is if you agree, a technical transfer.

117 Q. At paragraph 236, we will come to that and I am going to begin to explain it. The point there really is you say that across Learning Disability Services there is a growing need to provide more bespoke accommodation for individuals with very complex needs and you say care packages can range from £500,000 pounds to £1.5 million

per year. So in terms of the period then between 2008 and 2015, would it be correct to say that not only is funding in terms of the amount of funding that's required for resettlement, but also the nature of the funding were two of the key issues in terms of barriers to resettlement at that time? 14:56

A. Yeah, bear in mind that was probably the most successful period for resettlement the period where you are describing those barriers and the two years when targets were met were included in that. I think there is a more general point about the nature of funding for resettlement has caused some difficulty later on and that is DSD funding was very attractive to health because it meant that you could secure capital funding to build new schemes and the capital budget it was coming from was DSD. I think that probably led, this is on reflection, probably led to a bias on the part of Trusts to seek Supporting People's solutions to resettlement and not to explore, because there was nothing precluding a non-DSD solution. So if a Trust had decided we are not having success with supporting people, there could be a variety of reasons why that could be the case, we will build our own and not run it under the Supporting People, but run it as a Trust run facility. Technically there was no reason why they couldn't do that. Actually the People First policy envisioned a mixed economy of care that would have included that kind of provision. And there is some of that provision but it is more historical but I think 14:57 14:57 14:57 14:58

the Trusts tended to not look for solutions outside of Supporting People. It was why at a very later stage I asked the Belfast Trust to consider building a facility on the Muckamore site, a bespoke facility which, you know, would probably not have been able to attract Supporting People funding but just, you know, come up with a proposal and put a business case in but I think there was a self-editing going on where they weren't doing that.

118 Q. That was genuinely going to be my next question to you, so at paragraph 229 you refer to this option that you asked the Trust to explore. Can I just, we only have a few questions left, can I ask you briefly what happened in relation to this proposal or suggestion and did the Trust respond to you in relation to that? 14:58 14:59

A. There was some initial response to it and this was coming again I think the Mongan and Sutherland report. We were getting assurances from the Trust that they had discharge plans in place for named individuals and they were quoting schemes that were on-line, Minnowburn, number of schemes that were going to deliver, and they didn't seem to be making progress. Timeframes were slipping every time you asked about them. Now, Sutherland and Mongan looked at those schemes they said the commitments the Trust were giving were unrealistic, the timeframes from never going to deliver within the point. But going through that process of frustration and also knowing because people were saying there is a cohort of people who have lived here nearly all their 14:59 14:59

lives, they don't want to move, I said can you please look at the possibility of looking at a bespoke facility for them on this site. They agreed to look at it. There were some arguments put up against the idea. One was that if you were promoting inclusion it would be inappropriate to build a facility on the old Muckamore site which, by definition, is where we were moving people away from. I have to be honest, I wasn't that convinced about it if the facility was only going to be for people who really wanted specifically to be on that site. There was another argument to say it would be legally challenging to deregister part of the hospital site as a hospital and then reregister a new facility on that as a social care facility for inspection by the RQIA. I have to be honest, I wasn't particularly convinced by that argument either. And then the argument was because originally it was said there were potentially up to 10 people who might really want to stay on the site, but then as that was pushed and explored the numbers melted away. I think at one stage it is not then, it is four, and then I left post so I don't know if it's gone any further, but it didn't make any progress while we were asking the Trust to pursue it. 15:00 15:00 15:00 15:01

119 Q. Just before we finish if we look now then at page 62 and at question 18 you were asked if you were aware of the Winterborne View scandal in England and the Transforming Care work undertaken by the NHS, from paragraphs 245 onwards you describe some of the actions 15:01

taken following that scandal coming to light in the media in 2011. At paragraph 248 you say that on 22nd April 2013 you wrote to departmental policy and professional leads and drew their attention to the Department of Health England response to Transforming Care which was published in 2012. You say you thought it was important for the Department here to review the recommendations and consider whether there were any lessons arising which might apply to Northern Ireland. And we have a copy, and we don't need to go to it, we have a copy of your memo that you sent that's at exhibit 49 for the record. And you sent that, it says on the document, to the Grade 3, Grade 5 and the Chief Professional Officers. Now, in relation to that, I want to ask, do you know if that would have gone to the Trust Board also or the Trust boards for all of the Trusts? 15:02 15:02 15:02

A. Not that communication because, as far as I recall, that was an internal, that was me asking everyone who was involved in either professional or policy matters of learning disability to say can you please take a look at these recommendation, check to see whether they indicate any kind of lacuna or gap in what we're currently doing and map them against whatever processes we have. My memory was people felt that one way or another there was nothing new, either we had done or were in the process like they were in England of addressing those. 15:02 15:03

Now, I thought, and I could be mistaken, I thought Michael's letter might have been more widely circulated than the RQIA, I thought maybe it was to Trusts but I can't remember for certain.

CHAIRPERSON: We can check that. Would you have expected Trust boards to know about Winterborne? 15:03

MS. BERGIN:

A. I have to be honest, I think not just Winterborne.

CHAIRPERSON: The answer is yes.

A. The answer is yes, you know, I mean no-one contacted me to advise me about Winterborne, you were just aware of it in the media. But it wasn't a unique situation unfortunately. I mean the risks associated as we discussed earlier were well known throughout the system and beyond the system of these facilities. 15:03 15:04

120 Q. MS. BERGIN: There are some matters we may need to follow up with I think in the course of your evidence that maybe other department witnesses will be able to address but very briefly, just before we finish, is there anything else you would like to add in terms of your evidence to the Inquiry? 15:04

A. The first thing I'd have to say is I profoundly apologise in terms of my lack of awareness or my lack of memory about the fact I was cc'd into the follow up to the Early Alert in relation to Ennis. And certainly I hadn't identified that document through our searches and wouldn't have said that if we had identified the document, I certainly don't remember it. 15:04

The second thing I would like to emphasise and it's a point that's come out in discussion, I know you're pressed for time so I am not going to labour it, but I think, and I know that Dr. Maxwell has also identified this, that reliance on investigating abuse is not the most robust way of dealing with abuse. It is post-hoc. It is when a suspicion has been raised or you know that abuse has taken place and so it already accepts that harm has been done but worse than that, it is only the tip of the iceberg because of the nature of abuse. And so I am very anxious that those who succeed me in my position and those who run services are much more aware than we have been in the past of how to proactively take preventative steps. Systems that catch are no replacement for care that prevents and that's really really important and it's probably where I hold the strongest sense of regret in relation to this all my career. 15:05 15:05 15:05

And then the final thing is, and this is related, I'd like to thank Glynn Brown because I think the way that he refused to accept an initial response to his concerns was significant in peeling away more concerns and more concerns and have led us to the point now which hopefully will lead to a safer system, it certainly leads to a greater understanding of what's happened. 15:06 15:06

I would also like to thank, I won't name them because I

don't know if their names are in the public domain, two people who sat on MDAG who were relatives who contributed hugely and I am always conscious that everyone else who attended those meetings probably at times resented being there but were paid for being there. They were paying to be there because it was a difficult experience for them. They had to share repeatedly their thoughts and their feelings and their experiences, including abuse of their loved ones, and they did so for free. So I'd like to thank them. I have a lot of respect for them. 15:06 15:07

CHAIRPERSON: Thank you very much indeed. It may well, I know Mr.P96's Father was here this morning so it may well be that they are watching on the feed, so thank you for those remarks. I don't have anything else. Can I thank you very much for the care with which you have answered. 15:07

A. Obviously not careful enough --

CHAIRPERSON: Our many questions and thank you for your time this afternoon. Thank you very much indeed. All right we'll take a 10 minute break before the next witness. 15:07

THE INQUIRY RESUMED AFTER A SHORT BREAK AS FOLLOWS: 15:19

MS. KILEY: Afternoon, Chair and Panel.

CHAIRPERSON: Right.

MS. KILEY: Chair, Mr. Whittle, the next witness on behalf of SPPG is ready to be called whenever the Panel

is ready.

CHAIRPERSON: Certainly. We'll see how we do. If we finish him, we will finish him and if not we'll have to find time for him. In fact we have seen him before of course. 15:20

MS. KILEY: That's right and he has given extensive evidence previously. We'll see how we get on, I will know by the time we get to a break in the afternoon.

CHAIRPERSON: Okay. 15:20

MR. BRENDAN WHITTLE HAVING BEEN SWORN WAS EXAMINED BY MS. KILEY AS FOLLOWS:

CHAIRPERSON: I'm sure it doesn't feel like it but you were last here 15 months ago I think. 15:20

A. Indeed.

CHAIRPERSON: So welcome back, you know how this works. Obviously this is a different focus in relation to your evidence. But if you need a break any earlier than I say we are going to have one, please just let me know, 15:21 Ms. Kiley.

121 Q. MS. KILEY: Thank you. Good afternoon, Mr. Whittle, we met again just this afternoon and as the Chair said, you previously gave evidence to the Inquiry on 17th May 2023. Just for the purpose of this afternoon's 15:21 evidence I want to check you have some documents in front of you?

A. That's right.

122 Q. You have made another statement which is in fact your

third statement to the Inquiry for the purpose of Module 10 which the Inquiry is looking at, at present. And that has been allocated statement reference STM-277, do you have that in front of you?

A. I do. 15:21

123 Q. You have submitted a number of corrections to that statement. Could we bring up the corrections table on screen please. This is a document which you have helpfully provided I think after having reviewed your statement in preparation for today and you have noted a 15:21 number of corrections to be made, most of which are typing errors and points of accuracy?

CHAIRPERSON: I wonder rather going right through that we can simply print it out and provide it to CPs?

124 Q. MS. KILEY: That's right and we are going to publish it 15:22 Chair. Rather than go through each of those this will be published and will be shared with Core Participants but, subject to those connections you provided and which you see on screen, do you wish to adopt your statement as evidence to the Inquiry? 15:22

A. Yes, I do.

125 Q. We will make that available, Chair. As we have said, Mr. Whittle, previously you gave evidence on 17th May and that was in relation to the evidence modules 2 and 3. The Inquiry now has a different focus but, for the 15:22 record, your first statement has got the reference STM-097. There were a number of exhibits to that first statement and you may touch upon those today. We have them available if we need to call them up on screen. O

think you have a copy of your first statement in front of you, is that right?

A. I do.

126 Q. You can refer back to that if needs be. Following your evidence on the last occasion did you also make an addendum statement to provide some information on queries that arose during that evidence session and, again for the record, that statement has Inquiry reference STM-184. And that statement has been published by the Inquiry on its website with all your other statements, that is the totality of your statements but today I intend to focus on your most recent statement, STM-277. And again just so you don't have to go through it all, I want to take a moment to refresh everyone's memory about your role in the Health and Social Care Board and SPPG and you previously told us about this in your earlier session. You were first employed by the Health and Social Care Board from April 2019 and you held the role of Deputy Director of Social Care and Children from April '19 to April 2021. And then at that time, April 2021, you took on the role of the Director of that department. You held that until April 2022, and as you previously told us, the Health and Social Care Board was dissolved in April 2022 and was replaced by SPPG. Then from April 2022, to June '22, you continued then in the role of Director of Social Care and Children in the newly formed SPPG. Then from July 2022 to July 2023, you became Director of Hospital and Community Care and then in July 2023

15:23 15:23 15:23 15:23 15:24

you became Director of Community Care.
That is the role that you held when you made your most recent statement to the Inquiry but in fact you have now moved on just recently from SPPG; isn't that right?

A. That's right. 15:24

127 Q. You are no longer employed by that body?

A. That's right.

128 Q. But whenever you made your statement and the issues that you address, you made them from the position of Director of Community Care in SPPG. And if we look 15:25 then at paragraph 14 of your statement, you can see there, you explain in fact in your statement you've never had particular responsibilities for Muckamore Abbey Hospital but your personal responsibilities did touch on Muckamore Abbey Hospital in two ways. You 15:25 explain those in paragraph 14. So again, just to summarise those, you say you first attended a meeting of MDAG in February 2021 and you indeed became a full member of MDAG in April 2021. And then you also say, just in the second half of paragraph 14 which I'll read 15:25 for the record:

"As Director of Social Care and Children within the HSCB and my subsequent Director roles in SPPG I have continued to be responsible as director for oversight 15:26 of the statutory functions arrangements within HSCB and SPPG."

So just to pause there, that wasn't a Muckamore

specific role but in that role are you saying you had some responsibilities that touched upon Muckamore Abbey Hospital?

A. Yes.

129 Q. Okay, then just finally to finish off your role, one of the corrections that you have made to paragraph 13 of your statement is at paragraph 13 you had said that you didn't belong to any groups relating to Muckamore Abbey Hospital but you wish to correct that to say you were a member of a Bamford related group. Can you tell us what that was and how that touched upon Muckamore Abbey Hospital? 15:26 15:26

A. Yes, I have since come across records since I wrote the statement that I was a member of the Mental Health and Learning Disability Bamford Task Force Project Board which is referenced in paragraph 106 of my statement which is the cipher page 31. 15:26

130 Q. Okay and how long were you a member of that group can you recall?

A. That was for approximately two years during the period that I was Director of Adult Services as part of South Eastern Health and Social Care Trust. 15:27

131 Q. So this was in your earlier role as part of the, in the Trust, not as part of your Board work?

A. That's right, it was one of my former director roles. 15:27

132 Q. Yes and you explain your employment history in your earlier statement and in fact when you last gave evidence, okay. Mr. Whittle, the statement which you have made in respect of Module 10 is very detailed.

You were asked 23 questions and I'm not to go to go through each one of those, as I have said the statement is published on the Inquiry website, the Panel and all Core Participants have it. Rather than go through each of the individual questions there are three broad topics that I want to ask you about. The first is the effectiveness of structures that were in place in the Health and Social Care Board to oversee Muckamore Abbey Hospital. The second is related to that but in particular I want to focus on the Health and Social Care Board's role in the resettlement programme and the effectiveness of that. Then finally we'll look at the Health and Social Care Board's awareness of allegations of abuse in Muckamore Abbey Hospital. You have covered all those topics in your statement but I just want to pick out some points related to those issues. 15:27 15:28 15:28

So if I could look first then at the effectiveness of structures that were in place for the Health and Social Care Board oversight. You address this at paragraph 16 first of all, if we could go to paragraph 16 of the statement. You can see there that you provide a list of structures and processes which were in place to enable Health and Social Care Board and later SPPG to have oversight of Muckamore Abbey Hospital. You list them there as performance management, service and quality improvement, delegated statutory functions, complaints, legacy adverse incidents, serious adverse incidents, early alerts and safety and quality alerts. 15:28 15:29

Now in fairness to you, Mr. Whittle, those were issues that we touched upon whenever you last gave evidence and I think you used those headings in your earlier statement, so again I am not going to take you through every one of those, but there are some issues that you 15:29
explain later on when you are providing information about those structures and processes that I just have some questions I would like to clarify. So, if we could look first at the issue of delegated statutory functions and you deal with this at paragraph 20 15:29
please, if we could bring that up. You give a summary of how the Health and Social Care Board had oversight through the delegated statutory functions process here at paragraph 20. For the record you also provide more detail at paragraph 90, I am not going to open all of 15:30
those. But just to summarise the delegated statutory function report was something that was submitted annually by the Belfast Trust to the Health and Social Care Board, isn't that right?

A. That's right. 15:30

133 Q. The Inquiry has now seen some of those reports and has heard about them from other witnesses. One of the things the Inquiry has heard is that the delegated statutory function report was a template as it was, are you aware of that? 15:30

A. Yes.

134 Q. Was it the Health and Social Care Board who set that template?

A. It was.

135 Q. You previously told us that whenever the Health and Social Care Board received delegated statutory functions reports every year it would meet with Senior Managers within the Trusts to discuss them and to agree an action plan. But then in this statement, if we could move forward to paragraph 96, you say that a composite analysis of each of the five HSC Trusts was provided by the Health and Social Care Board each year, this was shared with the five HSC Trusts and submitted to the Chief Social Services Officer in the DoH and you provide a sample of that composite report. Can you tell us a little bit more about the composite report that was prepared by the Health and Social Care Board first and then SPPG whenever it received delegated statutory functions reports, how was that prepared and what was its purpose? 15:30 15:31 15:31

A. On an annual basis the Health and Social Care Board and subsequently the SPPG received five separate reports from each of the five health and social care Trusts. Those reports were read by professional officers within the Health and Social Care Board to identify themes and issues. There then followed an individual meeting with each of the five Trusts where the themes and issues would be considered by the professional officers with the Trust Executive Director of Social Work and their senior team. Those issues where used to identify first of all what the issues were for the particular Trust and then actions that would be pertinent for that Trust to take forward in the following 12 years. At the 15:31 15:32

conclusion of those five meetings, there would be an overview report prepared by Health and Social Care Board which pulls together the themes across the five Trusts. That overview report, when there was a health social care board, it was submitted to the board's Board and then forwarded on from that Board to the office of Social Services for review by Sean Holland or his successor who you heard from earlier on today. That overview report under the circular would then subsequently have been used to identify whether there were particular themes that came out of that and, if so, those themes could be shared with the departmental Board, so the Board of the Department and/or the Permanent Secretary or Minister depending on the themes that were identified. 15:32 15:33 15:33

The purpose of the overview report was essentially to provide just that, an overview, because each of the Panel have had an opportunity to look at the length of the Delegated Statutory Functions Report, as you will know they are very significant documents often running to 300 or 400 pages each, it was to give the Department a synopsis of the themes and issues across each of the five Trusts and also some comparison between each of the five Trusts in terms of how they were managing. 15:33 15:33

136 Q. Was there ongoing dialogue between the Health and Social Care Board and the Department about whether, for example, the themes that had been identified or the actions had been complied with, anything of that

nature?

A. Two separate points there. So one point would be the office of Social Services would at times on receipt of the overview report then subsequently write to the Health and Social Care Board to identify what the things were and to seek assurance that actions had been taken. Separately the Health and Social Care Board had an action plan which was taken forward with the Trusts. One of the issues, the Panel will be aware of the criticism that was identified by the Leadership and Governance Review. That criticism had identified that at times the statutory functions report prepared by the Health and Social Care Board were unwieldy, often lacking focus and not identifying the issues that they should have been. Whilst the Health and Social Care Board did have action plans that agreed with the Trusts, those action plans were often times rolled over from one year to the successive year without clarity that the actions that had been identified had been executed by the Health and Social Care Trust. A review of the statutory functions arrangements was undertaken in recent years subsequent to the Leadership and Governance Report, which has been used to refine the template that's been used and, within that, to refine the action plan which is developed with the Health and Social Care Trusts. That action plan is now RAG rated in terms of compliance. It is RAG rated by the SPPG in terms of the SPPG's assessment of how effectively the Trust has delivered against the actions

15:34 15:34 15:34 15:35 15:35

or not and that's then provided on an annual basis and that would have been in place over the period of the last three years.

In addition, since that review was undertaken the SPPG has met on a regular basis with the Trust through the course of the year, so it's not a single event in terms of the DSF report, but it is an attempt to ensure that that action is monitored over the course of the planned cycle within the year. 15:36

DR. MAXWELL: Can I just clarify, SPPG RAG rates the Trust's DSF?

A. SPPG RAG rates the actions.

DR. MAXWELL: Action plan.

A. Actions that are identified. So in Year 1 actions are identified, then when you return to the report the following June you look back at those actions, the Trust will give an assessment of how well they believe have been undertaken, but it is the SPPG that will do the RAG rate which is part of the enhancement hopefully in terms of the rigor behind the DSF approach. 15:36

DR. MAXWELL: Is that rating immediately shared with the Trust?

A. The rating is discussed in the meetings that take place with the Trust at the end of the process, so the meetings take place normally in June. The overview report is prepared and that would normally be available around end of August, beginning of September. At that point as a director within the SPPG I would have 15:36

written to the five Trust Chief Executives to share the action plan and to share the overview report. So after it had been submitted to the Department I ensure that the Trust Chief Executives had sight of that RAG rated action plan. I would also on occasions have met with the Trust Executive Director of Social Work and/or the Chief Executive to go through that RAG rating subsequently during the September period.

DR. MAXWELL: The Chief Exec and hopefully the whole Board would know the rating you had applied to their Trust? 15:37

A. Yes. The reason for doing that was previously, prior to Leadership and Governance Review, all to my knowledge that the Trust Board would have received would have been the Trust's self-assessment of how well they had delivered against the statutory functions. That then went into Health and Social Care Board who produced an overview report. What this has done is it has turned that in terms of saying there has to be some monitoring and analysis of that and also attempted with the overview report to make that more analytical in terms of the use of the data. Previously my concern would have been that as a Health and Social Care Board we had relied on the self report and we've attempted to look at the data that goes behind the report to give us that level of assurance. What I would say is whilst I think that is helpful progress it is work in progress, it's not something which is -- more could be done. I have listened with interest to the evidence that was

given this morning in terms of how that might shape up into the future.

DR. MAXWELL: Relating to Mr. Holland's evidence, he said that safeguarding isn't one of the delegated statutory functions and that's a problem. So does the new DSF framework include safeguarding? 15:38

A. Mr. Holland was quite correct to say that safeguarding is not currently a statutory function. That said, previously under Health and Social Care Board the Local Adult Safeguarding Partnership, the LASP reports which would have been in each of the five Trust areas would produce a report on safeguarding issues within the Trust areas. Those were appended to the statutory functions reports. So the issues and themes that came out of the LASPs were noted in the statutory functions report. That said, no doubt you will be aware that the LASP, Local Adult Safeguarding Partnership, and Northern Ireland Adult Safeguarding Partnership have both been stood down. When they were extant those reports were tabled with the DSF reports. As part of the review that was undertaken by SPPG with regard to the DSF report within the new template that was identified we ensured that there was a particular narrative requested from the Trust about whether or not there are any safeguarding issues that the Trust wish to bring to the SPPG's attention in that report cycle. 15:39 15:39 15:39 15:40

137 Q. MS. KILEY: Mr. Whittle, just to make sure we are correctly orientated in time. The new report, the composite report with the action plans and RAG rating,

that was something that was only commenced following the review of the delegated statutory functions process that happened after the Leadership and Governance Review, isn't that right?

A. That's correct.

138 Q. That was in 2021?

A. That's correct.

139 Q. Prior to that time then, did the Health and Social Care Board create a composite report at all and send it to the Department?

A. Yes, there would have been an overview report that would have been prepared by Health and Social Care Board and submitted. Again, accepting the criticisms of the interim governance report, I fear that that overview report would not have been as robust as it currently is. My understanding, if you go back further in terms of the history of the statutory functions processes at the point when the Health and Social Care Board was established, I believe at that stage the individual Trust reports would have been shared with the Department of Health, although going back to the point of them being lengthy reports, there was a request at a period of time, I don't have the date before me at the moment, rather than receiving five reports and the overview report, they would just receive the overview report.

CHAIRPERSON: Sorry, so I understand, the LASP reports were as you put it stood down, in other words stopped?

A. Yes, the LASP reports are no longer produced because

the LASPS are no longer in operation.
CHAIRPERSON: What has replaced them in terms of safeguarding?
A. The LASP reports related to, I need to refer to my first statement. 15:42
CHAIRPERSON: Is there something that has replaced them?
A. At the point that the Northern Ireland Safeguarding Partnership was stood down the Department of Health asked that the Health and Social Care Board would 15:42 establish an Interim Adult Protection Board. That Interim Adult Protection Board currently meets under the chairmanship of the SPPG and that has replaced the Northern Ireland Adult Safeguarding Partnership with the origin intention would be that would be a 15:42 short-term measure whilst the new legislation was brought in, although you will be familiar the new legislation has taken longer to be --
CHAIRPERSON: We heard this morning it might take three years so at the moment it's the interim -- 15:42
A. At the moment it's the Interim Adult Protection Board.
MS. ANYADIKE-DANES: Could he slow down a little bit, it is quite difficult to follow him.
CHAIRPERSON: It is a fair point, could you slow down a little bit? 15:43
A. I will do my best.
CHAIRPERSON: You have a sort of continuous roll of -- and perhaps make your answers a bit shorter if you can. We are under the interim system at the moment?

A. We are under the Interim Adult Protection Board and I suspect or I believe that will continue until such time as the new legislation comes in because it's likely at that point that a Statutory Adult Protection Board will be established for Northern Ireland, much the same as happens within children's services.

140 Q. MS. KILEY: And can you give us a point in time as to when that change happened, when the LASP was stood down and Interim Adult Protection Board was --

A. Yes, if you just bear with me for one second. The Northern Ireland Adult Safeguarding Partnership was stood down in 2020 by the Department of Health in recognition that stronger accountability arrangements were required. Consequently the Department mandated the Health and Social Care Board to establish an interim Adult Protection Board.

CHAIRPERSON: Yes, you told us t hat, so the answer is 2020.

141 Q. MS. KILEY: And, Mr. Whittle, one of the other things that you said now happens is that there are regular meetings between the Health and Social Care Board SPPG as it now is and the Trusts. Did meetings like that happen prior to the changes that took place in 2021?

A. No, there wouldn't have been formal meetings that would have been established. There may well have been individual discussions between service leads within Health and Social Care Board and their counterparts but that formal arrangement of meetings over the course of the year didn't happen previously.

142 Q. One of the things you say later in your statement, you needn't turn it up, paragraph 242, you say that as a result of some of these changes that have taken place a more robust approach is taken in terms of challenge and holding the Trusts to account. Can you say more about how the Health and Social Care Board now challenges Trusts in the context of the delegated statutory functions process? 15:45

A. Through the process that I have set out, the regular meetings and the better use of data to interrogate the Trust's analysis and those would be the two main measures. 15:45

143 Q. But it is a relatively new process so have the outcomes shown that the challenge that is more robust, as you have put it, is providing better outcomes or is it too early to tell that yet? 15:45

A. I would believe that in all these situations you need time to test the effectiveness of the arrangements. Nothing within Northern Ireland stands still. At the same time as these arrangements are taking place, the Department of Health has been establishing a strategic outcomes framework for Northern Ireland and there is work ongoing to ensure that the statutory functions reporting arrangement is either subsumed into that or reports directly into that, so you don't run with a parallel process in the way that may be we have done in the past. In terms of your question about is it stronger? Whilst I was in post I certainly would have perceived a level of, a greater level of challenge 15:46 15:46

which at times Trusts were not always comfortable with which to my mind I took as an indicator that the appropriate discussions were taking place, whereas previously I think it would have been more of a gentle conversation and I think there has been more challenge to that which I would have experienced in seeing both for myself and my team.

144 Q. One of the other processes that was in your list as operating as a way in which the Health and Social Care Board could oversee Muckamore Abbey Hospital was the complaints process. If we could turn back to paragraph 21, please. You describe the complaints, the Health and Social Care Board and SPPG's role in the complaints process. I won't read all of that out. But at the end of paragraph 21 you summarise the Health and Social Care Board's role: 15:47 15:47

"The revised complaints arrangement outlined a role for the Health and Social Care Board as having an oversight of health and social care complaints analysing any patterns, or trends, concerns or clusters of complaints." 15:48

You then go on to explain the process of receiving complaints and how the Health and Social Care Board operated. Then if we can go to paragraph 24, you set out some statistics about complaints that the Health and Social Care Board received in respect of Muckamore Abbey Hospital. So half way down that paragraph you'll 15:48

see it says:

"HSCB became responsible for the oversight role in 2009. Since 2009 and during the period of the Inquiry, 79 complaints were received in the monitoring returns from health and social care Trusts, spanning 12 years which related to MAH. In the context of more than 6,000 health and social care complaints being received each year, this relatively small number of complaints in relation to MAH did not indicate a pattern, trend or cluster based on the information provided, i.e. repetition of complaints for the same reasons." 15:48 15:48

Then at paragraph 25 you go on to say:

"The format of individual monthly returns received from Trusts did not allow for the manipulation of data over a period of time, making identification of trends over time difficult." 15:49 15:49

So you say there that the 79 complaints that were received in respect of Muckamore Abbey Hospital was relatively small. Can you give the Inquiry an impression of how the number compares to other hospital sites? 15:49

A. No, I don't have that information to hand. The reference to relatively small being in the context of the 6,000 complaints that were received during the period. With regard to paragraph 25 where I have

stated the format of the individual monthly returns received from the Trusts did not allow for manipulation of the data, I think perhaps this would have read better if it had said "did not allow analysis of the data" so potentially a poor choice of words on my behalf. 15:50

145 Q. But what was the issue with the data, was it the way in which it was received by the Health and Social Care Board or was it the capacity of the Health and Social Care Board to analyse it that caused this issue? 15:50

A. It would have been the information we received from the Trust which would not enable us to have that in-depth analysis.

146 Q. But one of the roles that you said that the Health and Social Care Board had in complaints was analysing any patterns or trends, concerns or clusters of complaints, that's what you said at paragraph 21, but are you saying that whilst that was the Health and Social Care Board's role, in reality the nature of the data it received meant that it couldn't properly fulfil that role? 15:50

A. I would refer to the statements that are written on paragraph 25, it made the identification of trends over time difficult because of the level of data that was received on behalf of the -- from the Trusts. So, other than the numbers of complaints or when the complaints were received, if that triggered a further drill down into the complaints, I think it would be difficult to identify a pattern, although in 15:51

preparation for this statement I did have a discussion with Lisa McWilliams and her team with regard to the responsibility for complaints and was given the advice that the information received on complaints did not provide a pattern or a trend on the basis of the information that had been received.

147 Q. You do say at paragraph 26 that a search of the records has identified there were no specific examples of learning or escalations of concerns identified in relation to complaints regarding Muckamore Abbey Hospital. So, having told us that it was difficult to identify trends, it seems that in fact there was no learning or concerns that were in fact identified in respect of Muckamore Abbey Hospital, is that right? 15:51 15:52

A. Sorry could you repeat the question? 15:52

148 Q. It seems that what you're saying is that it was difficult because of the data that was received to identify or analyse trends, although I think what you're saying is that it was possible do that but in reality there were no specific examples of times when the Health and Social Care Board did identify trends and concerns in respect of Muckamore Abbey Hospital? 15:52

A. There were no occasions where, on the basis of the complaints that were received, that trends or patterns or clusters were identified. And further, on paragraph 28 of my statement I have noted that the SPPG has recognised that complaint oversight processes are open to improvement and arrangements are currently in hand to update the process for having oversight of health 15:53

and social care Trust complaints whilst also ensuring that SPPG carries out its mandated role in line with the Department's complaints procedures. Those discussions are currently under way or they were at the point of the statement preparation in relation to the most effective means to store and to retrieve data to enable that analysis to take place. 15:53

I sought an update over the course of the last week with regard to that position and was advised that Southern Trust and Belfast Trust are currently working with the SPPG to pilot coding arrangements within an agreed data set and the SPPG analysis of these two Trusts' monthly returns in order to have a better overview with regard to the complaint data going forward and a decision with regard to rolling that out across the five Trusts will be taken shortly. 15:53 15:54

CHAIRPERSON: Could I just ask in relation to other services, acute services by way of example, has there been any learning from complaints in other areas? 15:54

A. That's not information which I would be aware of because I am, I've previously not been responsible for acute services, so I don't know.

PROFESSOR MURPHY: The long and the short of it is that you weren't worrying complaints from MAH but after all, these are people with learning disabilities who are pretty unlikely to make complaints themselves. Was that being taken into account in any way? 15:54

A. I think that is a very fair comment with regard to

complaints. My view of this is that the Health and Social Care Board looked at the number of complaints that came in and nothing jumped out which identified a trend or a pattern. I think that's very different from saying that one complaint couldn't ultimately lead to a line of Inquiry which could identify some very serious concerns within this institution or others, but that information wasn't obtained on the basis of the analysis that the Health and Social Care Board had undertaken. Hopefully looking to the future in terms of the enhanced complaint monitoring that SPPG has in hand across the two Trusts, that will be rectified, but I think your comment is reasonable. 15:55 15:55

PROFESSOR MURPHY: I mean enhanced monitoring is good and is one thing, but you probably need to go and ask people for their views rather than just waiting for them to complain if they are people with learning disabilities, because they won't complain? 15:56

A. Yes, I would agree.

149 Q. MS. KILEY: Just picking up on that point, Mr. Whittle, you had, as we've seen at paragraph 16, set out the list of structures and processes that were to provide oversight of Muckamore Abbey Hospital, were all of those reliant on reporting up to the Health and Social Care Board or were any of them involving the Health and Social Care Board exercising a function looking outward and being proactive and checking whether issues had emerged? 15:56 15:56

A. If I take the measures in turn just very briefly, how

effective were the processes in ensuring adequate oversight of Muckamore Abbey Hospital? The performance management measures, in my personal opinion they were limited to just the measures with regard to resettlement. The quality improvement team that I have 15:57
referred to in my first statement, its focus was on Mental Health and not on Learning Disability so that wouldn't have been an issue which would have aided the effectiveness. The delegated statutory functions report process lacked robustness, it's now I believe 15:57
somewhat improved. It previously relied heavily on Trust reported assurance rather than data. And whilst work is ongoing to address that, it isn't complete at this stage.

15:58

The complaints process had limitations in terms of the data that was provided and as a consequence, no pattern or trend data was available.

The legacy adverse incident arrangements that I set out 15:58
in my first statement I don't believe were relevant to this question of effectiveness because they only related to one of the former Health and Social Services Board, the Eastern Board.

15:58

The Serious Adverse Incident reporting has largely relied on self-reporting which can be problematic and it brings into question or calls into question the issue of candor by a Trust and whether or not Trusts

are candid in terms of their SAI reporting. Likewise, the Early Alert reporting also relies on self-reporting which can equally be problematic.

The Safety and Quality Alert process, in my view has worked well, reasonably well and I think some of the examples with regard to choking that are set out in the statement would be where I would reach that conclusion. 15:59

Beyond that issues of soft intelligence and correspondence received from third parties can be helpful in terms of getting intelligence to inform the effective oversight and the coverage that is available across the media can also prove to be helpful. If you take those processes in the round my view would be, my view is that the Health and Social Care Board did what it could within the extant arrangements that were in place. Does that mean that those extant arrangements were strong enough? Then I would suggest that they were not. That said, I think that there have been attempts, appropriate attempts over recent years by the Department of Health and the SPPG to address a number of those areas. 15:59 16:00

150 Q. But, Mr. Whittle, if I just pause you there, is it fair to say given the summary and the reflections that you have given that the Health and Social Care Board relied heavily on self-reporting and that in doing so that limited the effectiveness of its oversight? 16:00

A. That's my personal view.

151 Q. One of the other particular processes that you refer to that I want to pick up on is the SAI process. You address this at paragraph 32 onward of your statement and again you did address this in your first evidence session, Mr. Whittle, so I don't want to ask you to cover old ground. Just to remind us in your previous evidence session you said SAIs were reported to the Health and Social Care Board from 2006 onward. Prior to that they were only reported to the Department, isn't that right? 16:01

A. That's right.

152 Q. And I want to look at a particular example that you give here of a time when the Health and Social Care Board was advised of an incident by way of Early Alert and asked the Trust to submit an SAI in respect of that incident. If we could look at paragraph 36 onward, please. I think what you're describing here, Mr. Whittle, onward is the incident and the Early Alert that related to Ennis Ward in Muckamore Abbey Hospital, isn't that right? 16:01

A. That's correct.

153 Q. And again you go on to give detail about that through to paragraph 48. Again I won't ask you to repeat it all but in short summary, the Trust submitted an Early Alert in respect of an incident in Ennis Ward and the health and social care Board later determined that the incident met the criteria for submission of an SAI and asked the Trust to submit an SAI but the Trust didn't ultimately do that, isn't that right? 16:02

A. That's right.

154 Q. And you do provide some emails between the Health and Social Care Board and the Trust. I just want to look at those briefly. Could we turn up page 2541 of the exhibits, please. STM-277. That's it, thank you. Can we scroll out so we can just see the whole page. You have exhibited to your statement a whole chain of emails between the Health and Social Care Board and the Trust. I am not going to go through them all but we can see here an e-mail sent from serious incidents on the 3rd of February 2015 and if you can just zoom in please to the body of this, this is an e-mail where the Health and Social Care Board is drawing the Trust's attention to SAI criteria. 16:02 16:03 16:04

"The DRO would draw the Trust's attention to section 4 definition and criteria within the procedure for the reporting and follow up of serious adverse incidents October 2013. This incident would appear to meet the criteria set out at 4.25 and 4.28." 16:04

Now we needn't go to it, but in your first statement, Mr. Whittle, you did exhibit those criteria, the October 2013 ones and for the record they appear in the exhibits to statement 097 at page 652. But am I right in saying, Mr. Whittle, that here this is the Health and Social Care Board saying to the Trust we think that this meets the criteria for an SAI? 16:04

A. That's correct.

155 Q. And then if we could scroll down then, please, to page, well scroll up in fact to 2537. Thank you. And just scroll down a little please, yes. Can we see the top half of that page, the first e-mail?

A. I can. 16:05

156 Q. And can we look just at the top so we can see the addressees, that's it, thank you. Again an email from the Serious Adverse Team. When it says there Serious Adverse Incident at Belfast Trust, that's someone from the Belfast Trust emailing into Serious Incidents, 16:06 that's the Health and Social Care Board, isn't that right?

A. That's right.

157 Q. And then we can see there if we scroll down to the text, this is 1st September 2015: 16:06

"Dear colleagues, further to the e-mail below, the Trust wishes to clarify that this incident will not be reported by the Trust as an SAI. This is because the safeguarding investigation found the allegations were 16:06 not substantiated and it therefore does not now meet SAI criteria for reporting as such."

Then there is further text. Then just to complete the picture then, if we could look at page 2545 please. 16:06 Again then here we see 9th of September, this is from the Health and Social Care Board to the Trust.

"The Health and Social Care Board are content to close

this Early Alert on the basis Belfast Trust have advised the safeguarding investigation found the allegations were not substantiated. It should however, be acknowledged at the time the Early Alert was reported an SAI notification should also have been submitted which could been subsequently deferred pending the outcome of the safeguarding investigation."

And there is reference to an attached flow chart. The Health and Social Care Board ultimately did close the Early Alert without having received an SAI. But just to be clear, was it the Health and Social Care Board's position that the Trust was wrong not to submit an SAI in respect of Ennis? 16:07

A. Yes and I believe that's borne out by the records that we have submitted which identified that six reminders were sent to the Belfast Trust to request that the SAI's was undertaken, the dates of those reminders, I can give them to you if you want but they were submitted on six occasions. So, yes. 16:07 16:08

158 Q. But whose decision ultimately is it as to whether something should be submitted as an SAI? It seems here that the Trust, any Trust if it doesn't agree with the Health and Social Care Board or SPPG can simply say we're not submitting one and the Health and Social Care Board or now SPPG have to accept that? 16:08

A. It's my view on this occasion that this was accepted, as you've seen by the e-mail correspondence by Health and Social Care Board, after the six reminders. I

believe that that was -- was not what should have happened. I think things would have been stronger had there been an escalation from director to director at the time to ensure that the SAI was forthcoming.

159 Q. This is an escalation within the Health and Social Care Board that you're talking about? 16:09

A. From the Health and Social Care Board to the Trust, I think that potentially could have been an escalated arrangement. The emails which have gone out have gone out from Serious Adverse Incidents' e-mail box to the Trust's Adverse Incident box, I believe that when the SAI wasn't forthcoming in my opinion it would have been appropriate for the Director at the time to have a conversation director to director with the Trust or beyond that from Chief Executive to Chief Executive or then to subsequently raise that with the Department of Health. I suspect that had that have happened the SAI may have been forthcoming. But as happened in this circumstances, that wasn't forthcoming and the SAI wasn't completed and I think that was a potential lost opportunity in terms of learning for the Trust and also potentially regionally. 16:09 16:09

CHAIRPERSON: The question was whose ultimate decision was it?

A. Whose ultimate decision was it -- the ultimate decision not to complete the SAI was the Belfast Trust's decision. 16:10

CHAIRPERSON: Thank you.

A. That said, you can see from that e-mail they have

written to the Department of Health and saying we are not going to it, there has been a response back saying --

CHAIRPERSON: I understand but the question was whose ultimate decision was it? 16:10

A. It was the Trust's decision not to do it.

PROFESSOR MURPHY: The fact that they were saying that they weren't going to do it because the allegations were not substantiated, they were really talking about prosecution not resulting in convictions, were they? 16:10 Is that what they meant by allegations not substantiated?

A. I don't know if I can answer. I believe so from what we've soon on the e-mail.

160 Q. MS. KILEY: But you described a potential escalation 16:10 that could have happened but didn't happen. But ultimately there was no mechanism for the Health and Social Care Board to compel the Trust to submit an SAI, is that right?

A. Well the only mechanism that potentially could have 16:11 been used would have been a direction under, I forget the particular legislation, but the Health and Social Care Board did have powers to give a direction to a Trust. So ultimately had it gone through an appropriate escalation arrangement from director to 16:11 director within the Board to the Trust, Chief Executive to Chief Executive, raised to the Department of Health, potentially up and including to the accountability meeting with the Trust and then beyond that if the

Trust still didn't do so and it was believed that an SAI would have been required, the Health and Social Care Board could have approached the Department of Health to seek approval for a direction.

161 Q. Are you accepting then, in accepting that this wasn't escalated by the Serious Adverse Incident Team in the Health and Social Care Board, are you accepting that that was an error and it ought to have been escalated? 16:12

A. In my view it should have been escalated.

162 Q. More generally then in respect of SAIs, there is a requirement, you say, to submit an SAI notification within 72 hours of the organisation becoming aware of the incident. Thereafter how long does a Trust have to submit a full report in respect of an SAI? 16:12

A. I can't remember off the top of my head. 16:12

163 Q. Is it something that is a set period of time or is it something that is discussed between the Trust and the Health and Social Care Board?

A. There is a designated reviewing officer who would discuss the arrangements with the Health and Social Care Trust and they would agree the parameters for the review and the time scales beyond that, I can't remember. 16:12

DR. MAXWELL: Doesn't it depend on what level SAI because there are three levels, aren't there, and they would all have different time scales. 16:13

A. There are three levels. I need to go back into my first statement to see the -- -

DR. MAXWELL: When you look at them they will require

different time scales?

A. Well they will because the first is a serious event audit which would be much lighter touch than the Level 3 which is an independent review with external folk to do that and that will take time to set up and deliver. 16:13

DR. MAXWELL: It is negotiated with the DRO?

A. Yes.

164 Q. MS. KILEY: You give us some statistics about SAIs in respect of Muckamore at paragraph 39 of your statement, this is page 14, paragraph 39. While we're waiting for 16:13 it to be brought up I see you have it in front of you, Mr. Whittle. You say there that in relation to MAH:

"Most notifications were not reported by Trusts within the 72 hour timescale. Of the 38 SAIs reported in 16:14 respect of Muckamore Abbey Hospital, 34 were from Belfast Health and Social Care Trust, one was from Northern Health and Social Care Trust and three were South Eastern Health and Social Care Trust. Only nine were reported within 72 hours, eight by the Belfast 16:14 Health Social Care Trust, one by South Eastern Health and Social Care Trust. Of the 30 reports received in respect of MAH only two, one each from Belfast Trust and South Eastern Trust were submitted within the agreed timescale. 17 have been delayed longer than six 16:14 months consequently delaying potential learning being shared and implemented. There remains to date seven SAIs where the SAI Review Report remains unsubmitted. All seven of these are outstanding from the Belfast

Health and Social Care Trust."

You give the statistic at the start of that paragraph of 38 SAIs reported in respect of Muckamore Abbey Hospital. Can you give detail as to the time span in which those were reported? 16:15

A. Between 2010 and 2021.

165 Q. And how does that number compare, 38 then in just over 10 years, how does that compare with other hospitals? I appreciate you won't have figures beside you but can say is that a small number or a large number? 16:15

A. I think there is -- I can't give a comparison to other hospitals because I wouldn't that information, although I would be concerned about the delay in the reporting of SAIs by Trusts and I think that's borne out by the figures here. That concern with regard to the delay in reporting serious adverse incidents is an issue that I continue to be concerned about up to and including the point that I left SPPG. If I may -- 16:15

166 Q. What was the reason for it, was it issues with reluctance of the Trust to report or was it uncertainty about what should be reported, have you got any insight? 16:16

A. Some of the answers to those questions are particularly pertinent but they are not something which I directly know the answer to. What I do know is that by way of an example an incident occurred on the 17th October 2022, so quite recently within Muckamore Abbey Hospital. That incident, which was serious in nature 16:16

and clearly met the criteria for reporting as a serious adverse incident, wasn't reported as an SAI until the 16th of May 2023 so that would be over six months later. At that point in terms of the concern about the delay in receiving an SAI in the context of the figures that I have just set out, so this would have been fresh in my mind in terms of evidence that I have given to the Inquiry about concerns with regard to SAIs, I met with the Director of Mental Health and Learning Disability in the Belfast Trust along with their Executive Director of Social Work to understand why it had been that such a serious issue wasn't reported to the Trust. The reasons that I received I didn't believe to be appropriate because I was advised that there had been an internal Serious Event Audit undertaken by the Trust, so the Trust had effectively looked at the issue itself but there had been no external scrutiny of that by the SPPG or the Department of Health.

16:17

16:17

16:17

167 Q. But just moving away from that individual incident, Mr. Whittle, it sounds like what you're describing is there was a recent incident where you were concerned about the timing for the submission of a notification of an SAI and you therefore met with the Trust to discuss that. Was that something that was routinely done before the particular incident that you're talking about, because what you have described are concerns about delays across a period of time. So, was the Health and Social Care Board having meetings such as

16:18

16:18

that with the Trust to try and ascertain the reasons for the delays?

A. So those meetings had not been happening previously which was why when this came to my attention I met. I was concerned that there was a general pattern which -- I was concerned there may be a general pattern of late reporting or under reporting so as a consequence of that I advised the Trust that I was concerned that the lack of reporting could be perceived as a lack of candor on the part of the Trust and I advised the Trust that I would write to the RQIA and ask if they would consider undertaking a look back exercise and if that look back exercise could give the Department of Health the assurance with regard to the appropriate management of the SAI reporting going forward. 16:19

The RQIA subsequently agreed that they would look at the issue but not via look back exercise, that they would do --

CHAIRPERSON: We do need to record this is outside of our Terms of Reference as well. 16:19

168 Q. MS. KILEY: Just returning, I appreciate you are explaining what happened in this particular incident, you have explained you met with the Trust and the RQIA it appears took action but why was it not possible or why was that not happening prior to 2022? Why was the 16:20 Health and Social Care Board not looking into what the reasons were for late submissions of SAIs?

A. I can't give -- I am not aware of the reason behind that. What I can advise is that during that period,

during the recent number of years the escalation arrangements by the SPPG to the Trust included the chief, sorry, the Deputy Secretary of the SPPG writing to the Trust Chief Executive with regard to the late submission of RQIA reports. There was improvements in terms of the follow up of the late reports, but the issue in terms of the delayed reports, I don't know the reason why that wasn't followed up previously but I believe it was a weakness that has begun to be addressed. 16:20 16:21

DR. MAXWELL: Can I ask, it sounds like in these instances, as indeed with the index case in 2017 as though an incident is reported by staff within a Trust and then the severity of the incident isn't clear and it sounds like the one you were talking about just now, it had been reported by staff but at some point it isn't considered to trigger an SAI, it is not serious enough for an SAI and then at some point in the process somebody goes actually this was serious enough to be an SAI. Would that be an accurate reflection for at least some of these? 16:21 16:22

A. I think, potentially yes. To mitigate against that, the Health and Social Care Board and subsequently SPPG provided a matrix to the Trusts that they could apply in terms of identifying the threshold. 16:22

DR. MAXWELL: I understand that but maybe that's not filtering down to service level.

A. I think that's highly likely that it is not filtering down to service level.

DR. MAXWELL: At service level they don't know what the criteria for an SAI is, or they don't know what the current criteria is. It is reported and then at some point somebody who does know what the current advice from SPPG looks at it and says no, this is an SAI.

A. I think the issue of concern for me within that would have been that that learning was contained within the Trust and I think it would be stronger if it had that external oversight and I think that's what it lacked.

DR. MAXWELL: I am not saying it is right, I am trying to understand what one of the processes might be and it might be not that they are not reporting it but they don't know that it triggers this extra level which is reporting to you?

A. Yep.

169 Q. MS. KILEY: Mr. Whittle, I want to move on from SAIs. You later refer in your statement to the Risk Register that the Health and Social Care Board maintained. Can I ask you to look at paragraph 153, please. You say there:

"The Risk Register process is the means by which risks can be highlighted, graded and then plans to manage those risks set out. March 2019 is the first occasion that risks in relation to MAH are included on the HSCB Corporate Risk Register having been escalated from the Social Care Directorate Risk Register. The risk at this point is graded as extreme and relates to the allegations of abuse of patients by staff in MAH.

Trust responses to this include acceleration of its resettlement programme."

And you have exhibited the relevant copy of the Risk Register which we needn't go to. 16:24
You say this was the first time, March 2019, that MAH was included on the HSCB Risk Register. The Inquiry has heard that an SAI was first submitted in relation to the adult safeguarding issues in PICU in September 2017 so it appears it takes 18 months then for it to 16:24
get onto the Health and Social Care Board Corporate Risk Register. Can you say anything about why there was that delay in it making its way onto the Corporate Risk Register?

A. No, I can't other than to say that the matter was 16:24
initially submitted to the Directorate Risk Register and was held at Directorate Risk Register level and subsequently escalated to the Corporate Risk Register on review.

170 Q. When was it submitted to the Directorate Risk Register? 16:24

A. I believe it was December 2018.

171 Q. And so, just to be clear then, are there two levels of Risk Register in the Health and Social Care Board, Directorate and Corporate?

A. Yes. 16:25

172 Q. Does the issue remain on the SPPG Risk Register?

A. The issue currently remains on the Directorate Risk Register within SPPG not the -- there no longer is a Corporate Risk Register because Health and Social Care

Board no longer exists as a legal entity. So after the Health and Social Care Board was dissolved, then it was Department of Health Risk Register that applied. To put this into context, the Health and Social Care Board would have had some 20 risks I believe on its Corporate Risk Register. That would be a similar number to the whole of the Department. So when the Department, when the SPPG became part of the Department there was an exercise undertaken to filter which risks held by the SPPG would be owned on the Department's Risk Register which would be held at an SPPG level by Directorate so at that point it was moved from the Board's Corporate Risk Register to the SPPG's Directorate Register.

173 Q. And that's where it remained?

A. That's where it remains today.

16:25 16:26 16:26

174 Q. I want to move onto the second topic which I referred to which is the effectiveness of the Health and Social Care Board's oversight and role in the resettlement process specifically. You deal with this at a number of points in your statement, bear with me as I may jump through various parts. If we could look first at paragraph 163 in response to question 12 posed by the Inquiry, you refer to the HSCB's role after Bamford. Half way through paragraph 163 you say:

16:26 16:27

"The Health and Social Care Board promoted the pledge to resettle all people with a learning disability from hospital to community living options with appropriate support by putting in place arrangements for financial

support, resettlement oversight arrangements, communication strategy to support resettlement, quality of life questions to show betterment for those resettled."

16:27

I want to ask you a bit more about the financial situation and you address that at paragraphs 164 and 165. I want to read those because you explain the structures there. You say at 164:

16:27

"The Health and Social Care Board ensured that the appropriate levels of funding were made available to underpin the resettlement process. The financial model for resettlement included funding service development for community infrastructure as well as the community packages required for the patient's resettlement. During the period 2011/12 to 2021/2022 a total of 86 million was invested to increase and enhance community infrastructure for the learning disability population. This was wider than the resettlement programme. Within this amount the direct costs of resettlement which totalled £38 million with £27 million invested in additional community infrastructure staffing and services and a further investment in infrastructure development for young people transitioning to adult services of £21 million."

16:28

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16:28

You do include there is reference there to Exhibit 46, you do include some underlying figures. I don't want

to ask you to take us through those all, Mr. Whittle, but I want you to explain in layman's and summary terms the various elements of that funding. So for example, first of all what is meant by the description of direct costs of resettlement? That's the figure that is mentioned there at paragraph 165 if we can just scroll up, you say "the direct costs of resettlement totalled £38 million" and that is compared with £27 million invested in community infrastructure. 16:29

A. So the direct cost of resettlement as set out in exhibit 46 and within that set out the funding that was given to the Trust for a number of complex cases. 16:29

175 Q. May I just pause you there, can we bring up, I think you are looking at page 2051, are you?

A. Yes, 277, 2051. 16:30

176 Q. Is this the document you're looking at?

A. Yes, that's the document I'm looking at.

177 Q. What are you explaining?

A. If I briefly take you through the document or not --

178 Q. Well the document is there and the Panel have it and core participants have it but what I really want to understand is what is meant by each of the components of funding. So you refer to direct costs of resettlement, what sort of things are included in direct costs of resettlement? 16:30 16:30

A. Those are set out on 2053.

179 Q. If we could go up to that please, 2053. And just pause there. Zoom in, are you looking at the left-hand column here?

A. Yes, you will see there from the period 2011/2012 through to 2015/2016, there are a number of investments made each year for resettlement. So the first one there is £4.9 million. The first thing to say on that, that is a recurrent investment, that's £4.9 million which was made in 2011, the same £4.9 million then follows through 2012, '13, '14, '15 and so on. You will see in subsequent years there was 5.5 -- 16:31

CHAIRPERSON: Rather than focusing on the figures can you just tell us what are the direct costs? 16:31

A. The direct costs are the costs of providing the support packages for people once they have left Muckamore.

DR. MAXWELL: A lot of that would be staff costs?

A. Staff costs and where there is accommodation being provided. 16:32

CHAIRPERSON: Accommodation.

A. Either the accommodation or the heath and social care staff cost in terms of looking after people when they have left Muckamore.

CHAIRPERSON: So those are the direct costs. Then separately -- 16:32

A. Separately we've invested in other areas of learner disability community support. So you've got direct costs for people who have left Muckamore and in addition to that there is additional community infrastructure costs, so that's things like establishing a community forensic team for learning disability. It's additional costs for out-of-hours and crisis support costs. There are additional costs in 16:32

place when packages, support arrangements break down for individual people with learning disability in the community --

CHAIRPERSON: Stuff that goes around?

A. It's the total investment in Learning Disability Services across Northern Ireland of which resettlement is one element. I suppose the one point I would make is the £86 million is not an £86 million over 10 years. That is £86 million at the end of '21, '22 and that will be another £86 million next year and the year after and the year after. 16:32 16:33

180 Q. MS. KILEY: We'll just perhaps, Mr. Whittle, if we move away from the figures themselves and look at the actual funding model. You describe that at paragraph 184 of your statement, if we could go back to page 51. And you say that: 16:33

"The financial model for resettlement was premised on permanent retraction of budget from wards targeted for resettlement and subsequent closure which took into account a lower level of service to be provided in the ward as patients moved into their new homes in the community to ensure that there was sufficient funding for both the community infrastructure and resettlement packages and the hospital during this transition period, budget was retracted permanently from the hospital to fund the community packages and infrastructure and at the same time a proportion provided back to the hospital to ensure there was 16:33

sufficient funding to deliver their service to those remaining within the wards targeted for closure. The fund provided to Belfast Health and Social Care Trust for the hospital support following permanent retraction was known as bridging."

Then you refer again to your exhibits. So you say there the funding model was based on a presumption that a lower level of service would need to be provided as patients moved out of the hospital, but the Inquiry has also heard that as patients were resettled from the hospital it was often those with the most complex needs who remained within the hospital setting and those patients with particularly complex needs required in fact more intensive support in the hospital. Did the financial model take that into account? 16:34

A. Yes, it did.

181 Q. How did it do that?

A. So the financial model, in addition to the €86 million recurrent into the community, there had to be a model that was put in place with regard to the bridging arrangements which was broadly -- sorry, which meant that when a ward was to close the money for that ward was permanently retracted. So the Trust no longer had the funds to run that ward. 16:35

DR. MAXWELL: On a recurrent basis.

A. On a recurrent basis, because the money was taken out recurrently. To address that 90% of the ward costs were continued in year one --

DR. MAXWELL: On a non-recurrent basis.

A. On a non-recurrent basis and 50% on year two. There was a further agreement that if the Trust struggled to meet the 90% or the 50% basis, they would come back to Health and Social Care Board and that could be made back up to the 100% on either of Year one and two and the appendix 57 shows where that happened. That there was a non-recurrent bridge back in over a two year period. The intention for that would be to give the Trust the headroom to be able to resettle people without destabilising the ward. 16:36 16:36

The third element of this was where the Trust identified additional pressures over and above the running costs, that could be we want, we need additional support with occupational therapy, then they could come to the Trust, sorry they could come to the Health and Social Care Board and that funding would be made available. And I know that you have heard evidence from John Veitch in this space. This exhibit, in my view, shows very clearly that the Health and Social Care Board did make appropriate non-recurrent bridging back into the Trust and met pressures, which I think accounts for some of the oral evidence that you have heard, where there were discussions at the time between John Veitch and late Aidan Murray in terms of particular pressures that the Trust faced into. 16:36 16:36 16:37

It is also significant I think to note that whilst that bridging was going in, in each of the financial years

the Trust achieved financial break-even at the end of the year, often times with additional support from Health and Social Care Board to put in money and in the final month of the year to enable them to do so. When I looked at these figures with the Director of Finance in the Health and Social Care Board (now SPPG) I personally assured that the appropriate funding went in to ensure that the services weren't destabilised on the ward. 16:37

I'm also minded that there has been subsequently some look back by the Department of Health to look at the budget that Belfast Trust had during the number of years which identified that the Trust was reporting a surplus in Muckamore on the same years as it was approaching the Health and Social Care Board to seek additional funding. 16:38

DR. MAXWELL: Sorry, say that again, they were reporting a surplus at the same time they were asking for more funding? 16:38

A. Yes.

CHAIRPERSON: I think we heard about this, wasn't that in relation to positions they couldn't fill?

A. Yes. I had a conversation last week with Tracey McKeag who is the Current Chief Operating Officer of SPPG, formerly Director of Finance in SPPG, and she advised me it should be noted in the years 2016/2017 through to 2018/2019 the Trust subsequently advised the Department of Health that the Muckamore Abbey budget was in 16:38

surplus where the request had been made to the Board to provide additional funds of some £5.6 million.

CHAIRPERSON: Can you remember if that was to do with places that were funded but which couldn't be filled?

A. No. 16:39

DR. MAXWELL: The point is if you say you haven't got money.

CHAIRPERSON: No, I understand that point.

DR. MAXWELL: And you have money.

CHAIRPERSON: We have heard evidence about this. 16:39

DR. MAXWELL: We have heard evidence but it didn't make sense.

A. But to my mind, to my reading of these figures it appears to me that there was a wholly appropriate bridging arrangement put in place, that's what it 16:39 appears when I look through the allocations that went in. I am also mindful that in addition to that bridging arrangement, there was additional funds which went in to Belfast Trust during those years. And in addition to that, I'm now advised that at the point 16:39 when significant additional investment was going in the Trust had advised that they were in surplus in Muckamore Abbey.

DR. MAXWELL: I understand. We might have to ask Belfast Trust for clarification of that but I 16:40 understand what you are saying.

182 Q. MS. KILEY: Mr. Whittle, that's the position in respect of the funding that the Health and Social Care Board was providing to the Belfast Trust and to the hospital

in particular. One of the other things that the Inquiry has heard is that one of the other challenges in respect of resettlement was a lack of funding for community infrastructure and services. In simple terms, the needs of patients who were to be resettled from Muckamore Abbey Hospital were complex and often bespoke and there wasn't the infrastructure or the services in the community to be able to appropriately address those needs. Was that something that Health and Social Care Board was aware of? 16:40

A. Absolutely and certainly wouldn't make light of the challenges of any Trust in terms of them putting in place the bespoke placement arrangements that are required. What I would point to is the investment of the £86 million on recurrent basis for community infrastructure of which a sizable proportion of that relates to the direct costs of resettlement. 16:41

183 Q. So you're saying that figures that we looked at previously covered essentially some of the funding for community infrastructure in the community to try and address that problem? 16:41

A. The £86 million on a recurrent basis was broken down to £38 million towards resettlement costs, so that would address did the Health and Social Care Board put money towards resettlement, £38 million, plus an additional £27 million for community infrastructure and a further £21 million for young people transitioning to adult services. 16:41

DR. MAXWELL: But Mr. Holland this morning acknowledged

that there wasn't funding for a 24/7 crisis support team which would have been a key piece of community infrastructure that wasn't a direct cost but was critical because he said there wasn't the funding for it. 16:42

A. Yes, I heard him say that this morning. Can I just check into my figures here because I believe there may be something of relevance?

DR. MAXWELL: Well maybe that's something you can come back to us on. 16:42

A. The figure that I was going to draw the Panel's notice to is on page 2051.

184 Q. MS. KILEY: Can we bring that up please, 277, page 2051. This is the document we were looking at earlier?

A. This is the investment on a recurrent basis. You will see there that on the fourth line down, Learning Disability additional community infrastructure for crisis out of hours. So if you read across that line there you will see from 2018/19 there was £1.7 million invested in additional community infrastructure for crisis and out-of-hours, a further £506,000 on top of that in 2019/20 and a further £84,495 in 2021 making £2.295 million. 16:43 16:43

DR. MAXWELL: But in terms of staffing a service, 84,500 wouldn't staff in year a crisis support team, would it? 16:44

A. No, it wouldn't but the point I'm making there is it wasn't a matter that there was no funding which I think was the evidence this morning --

DR. MAXWELL: That looks because of the reduction over the years looks like a capital spend rather than a recurrent staffing spend.

A. This isn't capital. This is recurrent spend.

DR. MAXWELL: Sorry? 16:44

A. This isn't capital spend. It's recurrent spend, goods and services, £2.295 million on a recurrent basis.

185 Q. MS. KILEY: Mr. Whittle, it may have been that there was an investment and we can see how that's broken down from the tables that you have referred us to. But was 16:44 the Health and Social Care Board of the view that this was sufficient investment in the community or was it aware that there continued to be issues with resettlement because of the lack of community provision? 16:45

A. Sorry, can you give me the question again?

186 Q. So, I'll perhaps rephrase it better. It's clear that there was investment in community infrastructure but what I'm really trying to get at is, did the Health and Social Care Board think that that was sufficient or was 16:45 it aware that one of the main challenges in resettlement was that there was a lack of community infrastructure and services?

A. I had asked the same question of Tracy McKeag, again who was formally the Director of Finance, was advised 16:45 that finance has not been an impediment to resettlement. My own view on this is it is more likely it is the ability to attract staffing. I know you covered some of this this morning in the evidence, the

ability to attract staffing and timeliness on bringing on schemes seems to be more significant delay than the inability to provide funding to do so.

A. I want to look just briefly then at targets, specific issue of departmental targets for resettlement. 16:46

CHAIRPERSON: Could I just ask how much longer?

MS. KILEY: I have about 20 minutes, 30 minutes, I am in your hands.

CHAIRPERSON: Do you need a short break? We have been going for quite some time. We will just take a 10 minute break and then we will try and finish the witness. Okay, thank you. 16:46

THE INQUIRY RESUMED AFTER A SHORT BREAK AS FOLLOWS:

16:57

CHAIRPERSON: Thank you.

187 Q. MS KILEY: Mr. Whittle, before the break we were discussing resettlement and I said I wanted to move on to ask you about targets. I have a brief question about those, you address them at paragraph 18 of your statement and just to put my question in context you say there: 16:57

"From 2009 the Health and Social Care Board performance management arrangements were in place and from 2009 to 2016 the performance management responsibilities focused on ministerial targets and performance indicators associated with the resettlement of long stay disability and psychiatric patients including 16:58

patients at MAH. This was the only ministerial performance indicator at that time. Monitoring returns were submitted by Trusts on a monthly basis which provided an overview of the number of patients resettled or awaiting resettlement. The ministerial target and subsequent indicator were stood down in 2015/16, albeit there was still a cohort of patients requiring resettlement at that time and this remains the case today." 16:58

Just thinking about targets generally, the Department of Health set those but did the Health and Social Care Board have any consultative role in what might be an appropriate target?

A. No, not to my knowledge. 16:58

188 Q. And so was it the case that the Department of Health set those and the Health and Social Care Board then had to administer the funding position accordingly?

A. Certainly in terms of my experience of being a director in Health and Social Care Board and SPPG, I was not consulted in terms of targets that would be set going forwards. So my perception or my understanding is that the targets were set by government, by the Department and those would the targets that would be administered. 16:59

189 Q. And was a lack of consultation with the Health and Social Care Board detrimental to the realism and the achievability of the targets? 16:59

A. I think there are opportunities since the Health and Social Care Board was dissolved in terms of the move

from there being a separate arms length body to a group within the Department, that those discussions may well shape up differently into the future, I think that is a potential opportunity in the future.

CHAIRPERSON: Do you mean they might well become more realistic? 17:00

A. They might well become more realistic, because there will be a direct input. The Chief Operating Officer or the Deputy Secretary of SPPG now sits on the top management group, so they won't hopefully make impossible targets. 17:00

190 Q. MS. KILEY: But just returning to my specific question, was the lack of consultation with the Health and Social Care Board something which you considered to be detrimental to the achievability of the targets? 17:00

A. I was only a Director at Health and Social Care Board for one year so I have to take a view in terms of the records I have seen before that. My view is that the -- I think it's wholly appropriate that there was a target that everybody in Muckamore, and indeed all long stay hospitals should not have hospitals -- completely appropriate targets. The speed and pace that that was delivered with potentially could have been more nuanced is a personal view. 17:00

191 Q. And you then go on to say in the portion of your statement which I have already read out that the ministerial target and the indicator then were stood down then in 2015/2016, again was the Health and Social Care Board consulted on that? 17:01

A. My understanding of that is it was stood down because it hadn't been met. So the target was that everybody would be resettled by this date. The fact of the matter was that they weren't resettled, so that target was missed and therefore it then fell into the issue of people who are living in Muckamore whose discharge was delayed and it became an indicator. But my understanding I put Lisa McWilliams who is the Director of Performance over this to aid my own understanding over this. The way it was described to me at the time was, there was a target, it wasn't met and, therefore, you couldn't just set another target to say we'll do it now in another year which is why the language behind it changed. 17:01 17:01

PROFESSOR MURPHY: It's a good way to get rid of targets? 17:02

A. Potentially.

192 Q. MS. KILEY: You do, Mr. Whittle, in your statement provide a list or more than a list, information about various pieces of data that the Health and Social Care Board received in respect of resettlement. You set all those out at paragraph 75 of your statement. I am not going to go through them all, you give a significant amount of detail on those. But just finally on the topic of resettlement I want to ask you this, at paragraph 179 of your statement you refer to the Independent Review of the Learning Disability Resettlement Programme in Northern Ireland and that was the report of July 2022 and you say there that it 17:02 17:02

referred to:

"The health and social care system not being gathered up to effectively delivery settlement with slow decision making and delays in the resolution of practical barriers such as accommodation adaptations."

You have, as you previously said, whenever the indicator was stood down and the target was stood down in 2015/16 there were people, patients remaining in Muckamore Abbey Hospital, there are still today patients remaining in Muckamore Abbey Hospital. Does the fact that patients remain in the hospital now, in October 2024, demonstrate that the health and social care system, including Health and Social Care Board and SPPG, still hasn't been able to get a hold on this issue to effectively deliver resettlement? 17:03 17:03

A. I think it's clear that there have been concerns about the resettlement programme in so much as it hasn't delivered on time and you referred there to the report that was produced by Ian Sutherland and Bria Mongan. I had the opportunity to read some of their transcript from when they gave their oral evidence and I did note that when they were saying they had identified there had been a changing tone since SPPG and the Department of Health took responsibility following the closure of Health and Social Care Board with more emphasis on performance management. And they also referenced there had been a positive change with greater clarification 17:03 17:04

about the expectations from SPPG in terms of how and what Trusts were delivering.

Now quite clearly, SPPG, just as Health and Social Care before it, hasn't been able to achieve the full resettlement of all people who are in Muckamore, although I do take some heart from the progress that has been made since the independently chaired Oversight Board which is chaired by Dr. Donnelly has been established, and that has seen the numbers of those resettled over the period of I think last 18 months, two years, moving from 34 people to 16 people who are currently in Muckamore. So there has been progress made but I wouldn't for a minute say that progress is sufficient and it won't be until everyone is resettled. 17:04 17:05 17:05

193 Q. MS. KILEY: I want to move on then, Mr. Whittle, to my third topic that I said I was extracting from the issues that I wanted to go over with you from your statement and that was the Health and Social Care Board's awareness of allegations of abuse in Muckamore Abbey Hospital and focusing on the 2017 period. 17:05

Now you address this again extensively in your statement from paragraphs 118 onward right through, I think, to paragraph 137. I just want to pick up on one issue. In paragraph 133 you explain then, just to orientate us in time, that on 8th September 2017 the Belfast Health and Social Care Trust made an Early Alert report to the Department of Health and you go on 17:05

to say the Early Alert was updated on 22nd September 2017 to note further concerns arising from a review of CCTV footage. You then go on to say:

"As a result of this the Belfast Health and Social Care Trust at the request of the Health and Social Care Board commissioned an independent review of safeguarding at MAH between the period 2012 to 2017 and the subsequent report was the Way to Go report." 17:06

Just pausing there, are you able to say anything more about why that period of 2012 to 2017 was chosen by Health and Social Care Board?

A. No, I'm not.

194 Q. Was it the Health and Social Care Board who set the Terms of Reference for the Way to Go Report? 17:06

A. My understanding is the Way to Go Report was written under the auspices of the Serious Adverse Incident arrangements so that would have been set and agreed by the DRO, the Designated Reviewing Officer and the Trust, so I believe so. 17:07

195 Q. And ultimately, as you put it there, the Belfast Trust at the request of the Health and Social Care Board commissioned the independent review, but was it the case that the Health and Social Care Board were asking for this to be done but essentially they handed over arrangements and practical arrangements for the report to the Belfast Trust? 17:07

A. Yes, and that would be what would happen under a Level

3 Serious Adverse Incident. So the Terms of Reference would be agreed and signed off by the Designated Review Officer within the HSBC, the actual operation of undertaking the review would sit out with the Trust that was undertaking the review or, where it was a Level 3 with independent chairs, that they would do it on behalf of the Trust.

196 Q. And then you go on to acknowledge at paragraph 135 that Way to Go was published in November 2018 and, having received that report, the Health and Social Care Board together with PHA and the Department of Health considered that the issues raised required a further review and that led to the Leadership and Governance Review. Can you say anything more on why, speaking for the Health and Social Care Board, it was felt necessary that there was that further review?

A. No, I understand that, no, sorry -- no, other than I understand there were discussions at the time between the Health and Social Care Board, the PHA and Department of Health. You will have heard evidence from Mr. Holland this morning and there were questions, as I understand it, which arose in relation to whether or not the Way to Go report had focused sufficiently on the leadership and oversight on behalf of the Trust and that's why the broader review was undertaken.

197 Q. And ultimately then that resulted in the production of the report that arose from the review of leadership and governance. And, again, you address this later on in your statement in answer to a specific question by the

Inquiry. If we could look at pages or paragraph 240 onward please?

A. 214 or 240?

198 Q. 240, 240. You were asked there to reflect on the recommendations that were made by the review of leadership and governance team in respect specifically of the Health and Social Care Board and you acknowledge there that there were recommendations made. You have set those out in fact overleaf at paragraph 248. The first recommendation was: 17:09

"The Health and Social Care Board and PHA should ensure that any breach of requirements brought to its attention has in the first instance been brought to the attention of the Trust Board." 17:10

And then recommendation two, if we scroll down to 250 was:

"Pending the review of the discharge of statutory function reporting arrangements there should be a greater challenge to ensure the degree to which these functions are discharged, including an identification of areas where there are risks of non-compliance." 17:10

And then the third is set out at paragraph 252:

"Specific care sensitive indicators should be developed for in-patient learning disability services and

community care environments."

You set out there what the SPPG and HSCB before it's response to those recommendations were. Again I am not going to go through them all but there is one thing that I wanted to pick up with you and that was in this context you refer to the Health and Social Care Board working with the Department on a Learning Disability Service Model and you explain a bit more about that at paragraph 244. But I want to ask you if you could explain a little bit more about what that model is and what stage it is at? 17:10 17:11

A. So the Learning Disability Service Model is the arrangements for the future design of Learning Disability Services across Northern Ireland. A draft service model was developed by Health and Social Care Board in collaboration with the five health and social care trusts and a number of independent sector providers, families, carers and their representatives and the draft model set out a framework to provide services for individuals with learning disability and that would include health and wellbeing arrangements, day services, and meaningful activity arrangements, support for families and carers, home and independent living and mental health and behaviours of concern. Now, that draft model has the support of each of the five health and social care trusts and has received positive feedback informally, the pre-consultation feedback from providers and families who have been 17:11 17:11 17:12

engaged. Work is currently ongoing by my former colleagues on the policy side within the Department of Health to produce an implementation plan in collaboration with the Trusts and other partners. And a workshop was held in August 2024, it is one I attended just before I left SPPG to finalise the delivery plan and take decisions on in-patient services ahead of the closure of Muckamore. And there were deliberations at that workshop about whether it would be on one site, three sites, five sites, co-located with Mental Health Services. So those proposals are now sitting with my former colleagues on the party side who are undertaking pre-engagement with a view to there being a public consultation on that service model in the coming months. 17:12 17:13 17:13

CHAIRPERSON: Who attended the workshop? Who was at the workshop?

A. It was health and social care trusts. The Public Health Agency I believe. I can't recall whether the Housing Executive were there or not. Departmental policy colleagues, professional officers from the Department and SPPG. 17:13

CHAIRPERSON: So at that workshop there were no carers, patient/parent involvement?

A. No, there weren't. 17:14

CHAIRPERSON: But it is proposed there will be a consultation?

A. Yes, a full public consultation.

CHAIRPERSON: When is that going to start?

A. It is going to start within the coming months subject to ministerial approvement of the scheduling.

DR. MAXWELL: Can I ask, there was a plan that was still in place until quite late that Muckamore would have closed by June of this year. Had there been a plan about what would happen to people with acute needs had that gone ahead? 17:14

A. Had that gone ahead then those with acute needs would have been met in the other acute resources across Northern Ireland. So there are three places in the Northern Trust. There is the Dorsey Unit and the Western Trust Unit which name has momentarily escaped me. That would have been the interim plan until such times as there was an alternative brought forward. 17:14

DR. MAXWELL: Okay. 17:15

CHAIRPERSON: Sorry, and just coming back to the consultation, presumably a consultation document is being prepared is it?

A. Yes, again by my colleagues on the policy side that would be Mark McGookin's team would be taking that forward. 17:15

199 Q. MS. KILEY: And just in terms of the timing of that, you do say at paragraph 244 that the Health and Social Care Board shared the draft of the Learning Disability Services model dated May 2021 with the Department of Health, that was over three years ago, why is it taking so long to get to a public consultation stage? 17:15

A. Can I come to that question, I just want to pick up something with regard to the Chair had asked about

families and carers. The Health and Social Care Board had developed the Learning Disability Service Model and that had been done in full consultation with service users and carers who had been part of the development of the model. So there had been a number of workshops across Northern Ireland in each of the Trust areas where people with lived experienced directly contributed to what should be the elements of that. So I don't want to give the impression -- 17:16

CHAIRPERSON: You did actually mention that I think as you were going through it. 17:16

A. Sorry.

CHAIRPERSON: You provided the consultation document in draft and I should know this but has the Inquiry been provided with that, do you know? 17:16

A. I believe you have been provided with it. No, you have been provided with draft Learning Disability Services Model, you haven't been provided with the consultation document, at least you hadn't at the point I left SPPG because I hadn't seen it. 17:16

CHAIRPERSON: We will follow that up.

200 Q. MS. KILEY: Returning to the timing point, why has it taken so long to get from the draft in May 2021?

A. My understanding was when the draft was submitted to the Department of Health there was some concerns with regard to the costing of it, that there was a further analysis. Once the Learning Disability Services Model set out the aspiration in terms of what the model would be going into the future, the work in terms of how much 17:16

that would cost, which goes partly to the question you had asked with regards to what would you have done had it closed, there was a significant volume of money, sorry not money, finances wrapped up in Muckamore which potentially could be used to fund part of the Learning Disability Model going forward, that costing exercise had to be completed. Whilst no excuse, there would have been the issue with regard to the HSC's management through the Covid pandemic and we certainly lost a year during that in terms of our focus on this. 17:17

201 Q. You mentioned the public consultation stage. Is there an indicative timetable beyond that, is there for example an aspiration date for the model to be in place?

A. I am not sighted on what that would be, apologies. 17:18

202 Q. Mr. Whittle, those were all the topics I wanted to pick out from your statement. I'll give you an opportunity now if you wish to add anything to your evidence. You have had two full sessions but if there is anything that you wish to add, please do so? 17:18

A. Yes, if I may just add one final point. I know you will have had sight of the fifth statement from Mark McGookin, which was dated 9th October 2024. I have had sight of that statement and I know that Mark was asked, Mark McGookin was asked: 17:18

"Is the Department now aware that there is no record of HSCB raising issues about service provision at Muckamore Abbey to Belfast Trust or to the Department

and if so has the Department carried out an investigation as to why issues were raised?
Having regard to the fact that HSCB was meant to have oversight role in respect of the service provision by the Trust, can the Department comment on whether such reporting ought to have occurred and to provide an explanation why it did not?
Does the lack of reporting demonstrate that HSCB was not carrying out its oversight role effectively?
If it is not carrying out its oversight role effectively was that because HSCB structures or governance arrangements were in ineffectual or insufficient?" 17:19

And the statement notes in paragraph 7.1: 17:19

"the Department has noted at paragraph 9.1 of the addendum statement made by Brendan Whittle on the 3rd of November 2023." 17:19

And that's reference STM-184-11.

"Which states that HSCB has no record of raising issues about service provision at Muckamore Abbey to Belfast or the Department outside of the established performance management and delegated statutory functions reporting arrangements." 17:20

Could I say that I had intended in my statement of the

3rd November to refer to the eight processes that were set out in my first statement about the oversight of quality of care, and that's the eight that you referred to at the beginning of my oral evidence session today. It is the full eight I had intended, not just the two of performance management and delegated statutory functions and I apologise to the Panel that I have given, presented a narrower interpretation of the processes that were available to HSCB to raise the issue than was the case. 17:20

CHAIRPERSON: Okay. Thank you very much for that and we'll take it on board. That is positively your last appearance here at this Inquiry so can I thank you very much. It's been a late evening but worthwhile, so thank you very much for your attendance. 17:21

I am afraid it's another early start tomorrow morning, 9.30 please. Okay, thank you very much indeed.

THE INQUIRY ADJOURNED UNTIL 9.30 ON TUESDAY, 22ND OCTOBER 2024 17:21