MUCKAMORE ABBEY HOSPITAL INQUIRY

SITTING AT CORN EXCHANGE, CATHEDRAL QUARTER, BELFAST

HEARD BEFORE THE INQUIRY PANEL

ON TUESDAY 22ND OCTOBER 2024 - DAY 119

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APPEARANCES

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

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

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THE INQUIRY RESUMED ON TUESDAY, 22 OCTOBER 2024 AS FOLLOWS:

CHAIRPERSON: Thank you.

MS. ANYADIKE-DANES: Thank you, Sir, just before my learned friend starts. I am not making submissions, I see your e-mail about not making submissions, so I am pointedly not making submissions what I am saying, and I'm saying it on instructions from my 46 clients, is that they want certain matters in relation to evidence and so forth dealt with by this Panel in the chamber, so it's in the record and in the public domain. They do not want to resort to letter writing which doesn't ever emerge into the public domain, nor does it always have a response. We have very good examples of that. Nor do they want a private meeting, they want a meeting here so that we can address, and any other counsel from Core Participants who wants to address the Panel on outstanding issues so that it can be done and we would like that, with the greatest of respect, before you close the oral hearings so that if you accede to anything that should be said there is still time to pursue it. 09:31 09:31 09:31 09:32

CHAIRPERSON: I've heard you, thank you. Right, let's move on. 09:32

MR. MCEVOY: Morning Panel. This morning's witness is Professor Charlotte McArdle and she's ready to be brought in I understand. The Inquiry statement reference is 294.

PROF. CHARLOTTE MCARDLE HAVING BEEN SWORN WAS EXAMINED BY MR. MCEVOY AS FOLLOWS:

CHAIRPERSON: Good morning, Professor McArdle, welcome to the Inquiry. Just before you start I want to make a declaration really on behalf of Dr. Maxwell, who you know. My understanding is that you've known Dr. Maxwell since 2012. She was then, I think, a trustee of the Florence Nightingale Foundation when you received an award. I gather you've also done work together on a national project for the Nursing and Midwifery Council and you have commissioned Dr. Maxwell to run programmes in relation to leadership and long Covid and you have occasionally socialised together. 09:33 09:33

A. Yes. 09:33

CHAIRPERSON: Does that cover the relationship.

A. Yes, it does.

CHAIRPERSON: All right, thank you very much indeed.

1 Q. MR. MCEVOY: Good morning, Professor McArdle?

A. Good morning. 09:34

2 Q. We met briefly a few moments ago. My name is Mark McEvoy and I am one of the Inquiry counsel team. I am going to take you through your evidence this morning. As the basis of your evidence you have provided a statement dated 28th June 2024 and then on the 17th October, which is Thursday of last week, you provided by way of addendum to that statement a list of corrections which can hopefully be brought up on screen. Now, taking the statement and the corrections, 09:34

which are largely typographical and grammatical in nature together, are you content then to adopt those items as the basis of your evidence to the Inquiry?

A. Yes, I am.

3 Q. So, Professor, by way of introduction, the statement that you have provided is, as with these organisational module statements a response to questions set by the Inquiry, it's been made public on the Inquiry website and therefore we don't need to exhaustively go through the entirety of its contents. But by way of an introduction of who you are and your background, for the purposes of the record you are a nurse by background and you've set out your career and relevant then for the purposes of the Inquiry, your leadership roles at paragraph 2 on page 2. You moved into leadership roles in and around 2000 when you became or 1998 certainly you took up the role of Ward Sister and Medical Director the Royal Group of hospitals in Belfast. In 2000 you became Divisional Nurse and Lead Nurse For Surgery in the Royal Group and in 2003 became a Deputy Director of Nursing there. In '07 you were appointed Director of Nursing Primary Care and Older People in the South Eastern Trust and you remained there then until you were appointed Chief Nursing Officer for Northern Ireland on 5th April 2013 where you remained until 31st October 2021. Then now you've moved on and you're currently working at NHS England as Deputy Chief Nursing Officer for England, that's where we are as of today's date? 09:35 09:35 09:35 09:36 09:36

A. That's correct, yes.

4 Q. Okay. Well the first of the questions that the Inquiry posed to you asked to you explain the professional reporting lines that existed from Muckamore Abbey Hospital to you as the Chief Nursing Officer. In paragraph 5 you draw the attention of the Inquiry, this is on page 3, you draw the attention of the Inquiry to a framework document which tells us that the hospital is managed and governed by the Belfast Trust, it's under the managerial responsibility of the Operational Director within the Trust and there are professional reporting lines through to the Executive Director of Nursing. You then go on and refer to the Trust Chief Executive as Accounting Officer responsible for the Permanent Secretary and the Chair of the Board to the Minister of Health. You say then that the Accounting Officer signs an assurance statement to the Department of Health identifying key risks and concerns, subsequently discussed then with the Permanent Secretary. 09:36 09:37 09:37 09:37

During your tenure as Chief Nursing Officer did you see the Accounting Officer assurance statements from the Health and Social Care Trusts?

A. Yes, I would have seen mid and end year accountability statements, certainly while we had the accountability processes in place where we met with the organisations mid and end year as the basis for the conversation for those meetings. I don't recall seeing them as 09:37

frequently when those accountability arrangements changed, but I would certainly have been aware that they were submitted and if there were any issues for me to deal with it would have been brought to my attention.

DR. MAXWELL: When were the arrangements changed?

A. In or around 2014.

DR. MAXWELL: Because we heard yesterday from Sean Holland that he stopped attending the assurance meetings around that time. 09:38

A. Yes.

DR. MAXWELL: Was that the same for you?

A. Yes.

DR. MAXWELL: So prior to that would you have had the opportunity to discuss the risks with the Trusts? 09:38

A. Yes, and we would have formulated our agenda for those meetings based on my professional responsibilities and the contents of the mid and end year assurance statements.

DR. MAXWELL: So when that changed in 2014 was there any input from any of the professional officers at the Department of Health into the assurance meetings? 09:39

A. I could have brought things to the attention of the meeting via the Permanent Secretary and obviously I would have been in regular contact with the Permanent Secretary so potential issues to be raised at those meetings, he may have been aware of anyway, but I didn't have any input to the meeting. 09:39

DR. MAXWELL: Okay.

5 Q. MR. MCEVOY: And so you have possibly covered this, but would you have been asked for your opinion or your views on any of the risks identified within the assurance statements?

A. If they pertained particularly to nursing or midwifery, yes. 09:39

6 Q. At paragraph 6 then you're clear that there is no statutory or otherwise professional reporting line between Executive Directors of Nursing and the Chief Nursing Officer and cognisant of that then you strengthened existing forums to promote the opportunity for professional discussion between the senior Nursing and Midwifery communities and to provide the opportunity to raise any matters of concern or professional practice. 09:40 09:40

Although there was no direct line reporting as such, as CNO could you require the Trusts to do things, could you give direction in the absence of line reporting?

A. Officially no, I couldn't have given direction, I would have had to do that through the Permanent Secretary to the Chief Executive. But in reality I had a fairly close working relationship with the Directors of Nursing, I was a Director of Nursing and I was used to being informative. I think we worked from a place of relationship and shared decision making and trust. So effectively usually if I asked for something to be done it would be done, but not in a formal way. 09:40 09:41

7 Q. And you possibly have touched on this then in that

answer, but do you feel that the informal structures that you had worked well?

A. Yes, I believe over the time that I was the CNO I developed those significantly to build up that relationship of a shared decision making model for Northern Ireland from the leaders in Nursing and Midwifery and in the main I believed that we were closely connected. You know, people knew they could lift the phone to me at any time and I had a lot of interactions with senior nurses outside of the formal CNO business meeting and CNMAC meetings. 09:41 09:41

8 Q. Touching on then the CNO business meetings which you mention at paragraph 7 then, these commenced before your tenure in 2006 and you describe it as a long running regularly scheduled means of covering nursing and midwifery leaders from across Northern Ireland's health and social care sector with you as Chief Executive within the Department. 09:42

On down in the same paragraph just about halfway down or just a little bit less you say that: 09:42

"The CNO business meeting allowed me to regularly meet with senior nursing leadership from across the system. The membership was the Executive Directors of Nursing in each of the Trusts and the Executive Director of Nursing in the Public Health Agency, the Head of the Clinical Education Centre, the Chief Executive Officer of NIPEC." 09:42

Alongside your deputies and the Midwifery Officer with the support as necessary from the civil servant team then.

Can you tell us what your relationship was to the Director of Nursing at the Public Health Agency within the structure and process of the business meeting? 09:42

A. The Public Health Agency had, I suppose, specific responsibilities and the Director of Nursing and the Public Health Agency had a cross role with the Health and Social Care Board, was a member of the Health and Social Care Board and therefore intimately involved in commissioning of services but also quality and safety, SAI processes, learning and development. She also chaired the Education Commissioning Group on my behalf for the post graduate nursing and midwifery education budget. That post was one step closer to I suppose care delivery than I would have been at the department and had an oversight role across Northern Ireland. So we had a close working relationship and I would have met with the Executive Director of the Public Health Agency as part of the CNO business meeting, but also outside of that process, to discuss the strategic business of the Public Health Agency, development of commissioned work, for example delivering care which they were lead go on. Again I would say we had a fairly professional relationship. 09:43 09:43 09:43 09:44

9 Q. Prior to taking up post in 2013 did you attend the CNO business meeting in your previous role?

A. Yes, I did.

10 Q. Within the South Eastern Trust?

A. Yes.

11 Q. Do you remember during that period of time, or certainly in or around 2009, discussion of a workforce review undertaken by DeLoitte, does that ring a bell? 09:44

A. No, I don't and the Inquiry has provided me with a copy of the report.

12 Q. Yes?

A. So I have had a chance to look at it I suppose in detail. I hadn't seen it in advance of that. So, I made a number of comments on the report if you'd like me to share them with you now. Having reviewed it I think the intent of the report was to implement Bamford. 09:44 09:45

13 Q. Yes?

A. That was the principle.

14 Q. To see whether it could be implemented or how it could --

A. How you would develop the workforce in order to see Bamford through to its conclusion. And in essence many of the actions subsequently, without knowing about this report, have been implemented from a nursing perspective. I think that at this stage it's 15 years old, it probably is a little outdated, although the core principles are still relevant in terms of Bamford. It would be my view that it over-conflates the relationship or the role between Mental Health nursing or Mental Health Services and Learning Disability 09:45 09:45

Services and I accept that there is often duplication of some work, but they are very distinct roles and I think it underplays the role of learning disability nursing significantly.

09:46

Since then I suppose I would advise the Inquiry that in 2009 it recommended the increase of learning disability and mental health undergraduate nursing places by 50%. While I accept it was some time later during the period of 2016 until I left in '21, we had increased the 09:46 number of learning disability undergraduate places actually in total by 60%. We moved from 30 to 40 which was an increase of 33% and then the Open University developed a programme.

CHAIRPERSON: Just slow down a little bit. 09:46

A. Sorry. Are we okay to go?

CHAIRPERSON: Yes.

A. The Open University then developed a programme specifically for learning disability nursing, for people who are working in the system who may not have 09:47 went to university directly upon leaving school or as a mature student, and we provided another 10 places, so in total it was a 60% increase. We also developed career pathways for learning disability nursing as part of the work which I led around the Northern Ireland 09:47 collaborative. And more recently, in the Nursing and Midwifery Task Group which we will come to, nurse consultant and advanced nurse practitioner post in order to enable that clinical career pathway. There

was quite a bit of leadership development done, both in terms of the work that Dr. Maxwell has referred to, aspiring nurse directors programme, and also from the RCN in middle management, for those in middle management around leadership and creating caring cultures. The health facilitator role that was been identified in that report has been implemented within Learning Disability Services. And in fact, Delivering Together, which was the Department's 10 year plan for the transformation of health services, aligned mental health practitioners in the primary care model so that every GP practice would have a mental health liaison post. 09:47 09:48

So I felt that, I felt that a number of the recommendations, by chance if you like, had been subsequently implemented in the absence of knowing about the report. It does also suggest that staff in Muckamore could transfer to community posts and I don't believe it's ad simple or straightforward as that in reality. 09:48 09:48

15 Q. Yeah, that was the key point that I wondered if you could assist us with. If there is anything you want to develop around that, the Bamford vision was that there would be new roles in learning disability for the care of people -- 09:48

A. Absolutely and I did listen to Sean Holland's evidence yesterday and I would agree that the provision of social care workers is an absolute requirement in order

to facilitate the resettlement of people from Muckamore and they do need a high level of training. I think they also need the oversight of a healthcare professional. In my view that would be a learning disability nurse who would assess and detail the plan of care that would be needed from a health perspective and would include things like, would include mental health and wellbeing, physical health and wellbeing, as well as the issues associated with the person's learning disability. 09:49

And while learning disability nursing is intended to be across the life course, so learning disability nurses, like adult nurses, can care for children with learning disability and adults, I think working in Muckamore is a different context, a different environment. Then to go out into the community would need an element of retraining, particularly as the report suggests that they would care for children with learning disability who, for example, would require a different drug regime, different approaches to their epilepsy and a degree of support and training. 09:49 09:50

CHAIRPERSON: But to put it at its simplest, DeLoittes was suggesting you could take that group of people who used to work in the hospital effectively and plant them in the community? 09:50

A. I think there is some cross over but it isn't just a matter of taking the staff from Muckamore and putting them into the community. There is a process that needs

to be undertaken, a training needs assessment, some training provision and an assurance that they can provide safe care. It also requires the delegation framework to be enabled to allow the registered nurse to delegate tasks, particularly to social care which wouldn't be in their domain.

16 Q. MR. MCEVOY: So, Professor, the next thing then is around the role of the CNMAC, Central Nursing and Midwifery Advisory Committee, which is a statutory committee, and you held that role ex-officio as it were as Chief Nursing Officer? 09:50 09:51

A. Yes.

17 Q. The Department, you tell us at paragraph 10:

"...and/or the Chief Nursing Officer asked the Committee to undertake specific tasks, whether commenting on major consultative documents or deliberating on wider professional topics. It's advice forms a key component in the continuing development of services to meet the needs of patients and the public throughout Northern Ireland." 09:51 09:51

Now, paragraph 11 then, one of the particular pieces of work that the CNMAC conducted that you tell us about appears at sub-paragraph (i) there, and this is a Task and Finish Group to review recruitment and retention difficulties which was completed in 2016. The report provided 11 recommendations to support the increased recruitment of nurses across the system. Within it 09:51

learning disability nursing was referenced as a hard to recruit area.

Had you seen, in the preparation of the report in terms of the information gathering process in the run up to the completion of the report, had you seen or were you aware of any data from the Belfast Trust about unfunded hours, had you seen anything about that issue?

A. No, I hadn't. Between 2014 I suppose, well from 2014 there would be murmurings of issues about staffing difficulties but it would be across everywhere, it wasn't specific to learning disability or Muckamore. In 2014, in November of 2014 I did receive an e-mail from Pat Cullen which I have referenced in my statement that she had received information from the Belfast Trust around difficulties in recruiting, particularly to PICU.

18 Q. Did the Pat Cullen e-mail have a role in the preparation of this or the commissioning of this, this work?

A. Well more specifically in 2015 my deputy CNO was leading a workforce review because we didn't have a workforce plan and it definitely fed into that review. And the outworkings of this CNMAC report would have also been in the workforce review, so in essence yes although not directly if you like. But that was the only knowledge that I had about any workforce issues in Muckamore at the time.

19 Q. Maybe if we open the page up actually just to aid you,

page 109 please. You can see there under "branch of nursing" where learning disability is identified, funded staffing levels of 30th June '15 were 138 and staff in post at the same date, whole time equivalent, is 202.99. Can you help us understand those figures and how they are arrived at?

A. So, as part of the report the authors, which were members of CNMAC gathered data from all five organisations in relation to learning, well to all areas of nursing but we are focused on learning disability obviously. The Belfast Trust reported that their funded staffing level, so on their HR system essentially, the funded level of staffing was 138 but actually in reality the staff that they were using in post as of the 30th June 2015 was 202. And they also had a vacant post, you can see the levers there of 13.69. So that suggests to me that the funding staffing level wasn't meeting the needs and that additional staff were required over and above that at the time.

20 Q. Okay. And one of the other factors that was noted within the report was that there were 27 vacancies and 19 whole time and, going back to your paragraph, agency or overtime posts to supplement the nursing workforce at the time. Can you recall from the CNMAC's examination of the matter, and within this Task and Finish Group, whether the use of temporary or agency staff for a patients and client group for whom routine and stability is key, whether that would have posed an

issue or indeed a red flag?

A. There is no doubt that at the time, as the issue about recruitment became more evident, all organisations were using more agency to cover the gap. And while there was a place for agency staff in our workforce system to provide a flexible solution, the continued ongoing use of agency to replace permanent staff would be a concern and something that all directors of nursing would be attuned to and would try to reduce. 09:56

21 Q. Do you think they were attuned to it in 2015, 2016? 09:56

A. Well I think that, bearing in mind the membership of CNMAC, which included the Directors of Nursing as well as other RCN, other regional bodies et cetera, they were the ones that were telling me there was an issue about recruitment. 09:56

22 Q. Yes?

A. And that we needed to find solutions which was why I commissioned the work. So I think they were definitely aware of the issue.

DR. MAXWELL: Was there a recognition that the use of temporary staff, whether it was bank or agency, would be more difficult for people with learning disabilities than, say, on a surgical ward? The consistency of staff would be more an issue. 09:57

A. Yeah. 09:57

DR. MAXWELL: For the patients of Muckamore than a surgical ward?

A. I don't recall it being discussed in that context but I think it's fairly evident that in an area such as

Muckamore where the client group is stable, so to speak, and has specific needs that the ability, the continuity of care essentially by the permanent workforce will enable a better therapeutic relationship, better outcomes and, you know, an understanding of the family, an understanding of the person, an understanding of what triggers behavioural difficulties, how you deescalate that and how you keep the person safe and how you know them as a person I suppose. That's never going to be achieved with temporary staffing. 09:57 09:58

CHAIRPERSON: Could I just ask, I don't think this is something that we have explored before, but in relation to agency staff, do you know if there was any work or assessment of the number of agency staff that there would be available in total in Northern Ireland who are actually LD trained, because it may be that people who go to work for an agency would be less likely to be LD trained than in other areas of nursing, or is that a wrong assumption? 09:58 09:58

A. I don't think the work was ever done in that context. I think there was an understanding that learning disability nursing is the smallest group of the four branches of nursing. It's a very small cohort. The training numbers are also small, relative to the size of the group. And that there isn't just a cohort of people that you can call through agency. 09:58

CHAIRPERSON: No exactly, because we know that much later on when the hospital was desperately trying to

recruit agency nurses --

A. Yes.

CHAIRPERSON: They actually had to go to England and a lot of those weren't LD trained either.

A. Yes. 09:59

CHAIRPERSON: On just wonders if you are using agency as a back up, as a lot of hospitals do, but if there aren't LD trained nurses you will not be able to find them.

A. They would have been I would suggest, particularly in 09:59 2014, our own staff who were working agency and bank on top of their regular shifts.

CHAIRPERSON: Yep. But that may be a smaller cohort as it were.

A. Yes. 09:59

CHAIRPERSON: Than the wider cohort?

A. Yes.

CHAIRPERSON: Thank you.

23 Q. MR. MCEVOY: And then the next theme, Professor, is the Nursing and Midwifery Task Group which you begin to 09:59 discuss at paragraph 12 and you describe its genesis lying in representations made to the then Minister, Simon Hamilton, regarding the challenges facing the nursing profession, including recruitment, retention and the value of nursing. Minister Hamilton asked you 10:00 to bring forward plans for his consideration to address the issues and the Minister had not agreed the full proposals prior to the Assembly election in May '16 and then after that then Michelle O'Neill took over as

Health Minister after those elections. I suppose before we get into the work of the NMTG itself, diverging slightly, can you give us an idea or flavour from your position as CNO how the collapse of devolved government in 2017 affected policies around the recruitment and training of nurses generally, if you can with any specificity around learning disability in particular?

10:00

A. Well the impact of having no Assembly, so to speak, is that, I mean there are significant impacts on the legislative processes which for this period I suppose its an accumulative effect over years so it's probably a bigger problem in that when the Assembly came in 2020 they didn't have enough time in their two year mandate to deal with the backlog of legislation. So that's a particular problem with not having a legislature but there is also the money, the problem of finance and the budget for the Department of Health which, although Permanent Secretaries were given additional powers to manage things like budgetry requirements during that three year period, it was a roll on, year on year position. So that just made things more difficult in terms of planning and of course Permanent Secretaries were limited in the decisions that they could take. Decisions like, for example, Nursing and Midwifery Task Group needed a Minister to make the decision which was one of the reasons it was delayed to 2020. However during those years we managed to increase the number in the undergraduate programme, given the needs of the

10:01

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10:01

service and the concern about the state of the nursing and midwifery workforce so we were able to do that significantly between 2017 and 2020. And in 2020 the nursing undergraduate programme was at the highest level it had ever been. And then when the Assembly came back in 2020 there was a commitment for three years to an additional 300 which took the training places to 1,300 for those three years.

24 Q. So, the NMTG then was subsequently, and you tell us about it then at paragraph 14 and following, chaired by Sir Richard Barnett as an independent Chair with representatives from across the health and social care system. There were three key themes, but the second of them which you have noted at 14(ii) the stabilisation of the nursing and midwifery workforce therefore ensuring safe and effective care.

You then tell us the report was supported by a five year implementation plan which you have helpfully exhibited. Then at paragraph 16 you talk about work to take forward the NMTG's work. In the plan at 17 you developed a cost plan as part of the New Decade New Approach, Minister Swan agreed 60 million to be invested in Nursing and Midwifery between 2020 and 2025 five. And between 2020 to 2021, 2021 to 2022 you secured £25 million dedicated to addressing the recommendations of the NMTG.

Can you recall how much of that £25 million would have

been dedicated to learning disability nursing?

A. Yes. So it would have been -- well, I can't in monetary terms but in post terms it was the provision of a consultant nurse for Learning Disability, one for each of the five Trusts. And it was the provision of additional senior decision makers in Learning Disability, particularly for the Belfast Trust, at Band 6 and 7 and advanced nurse practitioner posts. Again the intention was to, instead of increasing the numbers by more Band 5 posts, was actually to support the Band 5 cohort of staff working both in Learning Disability but also other specialties with senior decision makers, so people who are more experienced who can facilitate their learning, who can support them in the challenging work environment and who can bring evidenced based practice and ensure that the delivery of care is of a high standard essentially. 10:04 10:04 10:05

I should point out that the cost of the Nursing Midwifery Task Group report was £110 million in total, a significant amount of money, which was one of the reasons why ministerial approval was required. And the 60 million that was agreed with Minister Swan in New Decade New Approach and also in his framework agreement to bring the RCN back from strike action, that 60 million was dedicated to delivering care which was our Safe Staffing Policy and in addition to that the Department had already funded the increase in undergraduate nursing which was agreed under New Decade 10:05 10:05

New Approach. So in total 85 million of the 108 was already kind of in the pot, if you like, and the additionality required was 25 million. However, in real terms the additional investment of 25 million that I secured, the rest of it hasn't been able to be provided because of the challenging financial circumstances, as I understand it, not being part of the system anymore.

25 Q. But, does it remain a commitment as far as you are aware? I know you're not in post anymore but does it remain a commitment? 10:06

A. Well it's my understanding that its extant policy. The current Minister for Health hasn't changed the direction so I would say yes.

26 Q. Okay. And then at paragraph 20, still on the theme of the NMTG and its recommendations and implementation plan, you describe this as providing the necessary strategic blueprint to enable the reform of nursing and midwifery care in Northern Ireland. And you summarise then what you feel were the key improvements and are starting to influence key improvements in learning disability nursing. So stabilising learning disability nursing workforce by commissioning more undergraduate places which you've told us about I think. Improving retention by creating new career opportunities. Strengthening the public health infrastructure by creating dedicated public health nurse consultant roles, which is something which you touched on. Developing and preparing nurses and midwives for 10:06 10:06 10:07

leadership positions and building a nursing and midwifery quality improvement infrastructure. I am very crudely summarising. You say at 21:

"As indicated this was only a start. I also anticipated that, in time, the adoption of a person-centred framework across all nursing services, which was recommendation 727 of the NMTG report would also help to improve a culture of shared decision making and partnership with people with learning disabilities and their families." 10:07 10:07

On that person-centred framework, has that been developed, has that become a work stream of its own and was there an implementation plan for it, if so? 10:08

A. Not that I am aware of. So the Minister launched the report in March 2020, just literally in the mouth of the pandemic, and the implementation phase of the project was then obviously impacted by the pandemic.

27 Q. Yes? 10:08

A. But there is an evidence based around person-centred practice and a model that's been developed by a local senior nurse actually and a growing evidence base in relation to that which demonstrates person-centred outcomes, better experience, better outcomes, a helpful culture, shared decision making, patients and families involved in their care, devolved decision making to the bedside, et cetera, which has been tested in Northern Ireland over many years, this is 20 years of work, a 10:08

lot of which I was involved in both as, from my days as a ward sister actually, but not systematically and sustainably introduced to nursing practice in Northern Ireland.

28 Q. Okay. Moving on then the Inquiry asked you how often Muckamore was discussed within your office and to explain, so far as you were able, what regular information your office received about Muckamore Abbey Hospital, how often was any such information received and who provided it. You're quite clear at paragraph 22 from when you took up your post in April '17 [sic] prior to August '17, your office neither received regular communication about Muckamore Abbey nor was it discussed in your office. The hospital was in the remit of the Belfast Trust, any conversations or information would have been with your team in a strategic professional policy context for learning disability nursing. You don't recall Muckamore ever being discussed at the Chief Nursing Officer business meeting prior to the revelations in 2017. In the period between April '13 and August '17 had you ever visited the hospital? 10:09 10:09 10:10

A. No, I hadn't.

29 Q. Okay?

A. I have on a number of occasions since. 10:10

30 Q. Since?

A. Yes.

31 Q. I suppose between that, in that period up to August '17 you had been working in the nursing field for quite

some time in Northern Ireland and certainly in senior leadership roles, what was your impression of it, what understanding did you have of it and where it sat within --

A. Of Muckamore or of learning disability?

32 Q. No, of Muckamore in particular?

A. My impression was that it was obviously part of the Belfast Trust. I knew that it was a regional facility that provided acute care and treatment for other Trusts as well as Belfast. And, given my role in South Eastern Trust, South Eastern Trust patients were clients of Muckamore, if you like, over many years. I was aware of the resettlement programme. I was aware of the general strategic direction which I absolutely support that people with a learning disability should live in the communities and have equal access to health services, the same as everybody else, and be given the opportunity to reach their full potential. So I support that direction of travel. Other than that Muckamore wouldn't have been, it would be unusual for a single facility to be on my radar across any of the health services. Obviously my background, I worked in the Royal, I worked in the South Eastern Trust so I would be more familiar with those institutions and environments. I was more attuned, I think, to learning disability nursing. For whatever reason, I am not quite sure, it became aware that it probably needed attention. It was a small speciality, a lot of focus been on mental health in particular but not learning

disability. So I built connections with the learning disability community of nurses. I met several of them, I engaged with them, I engaged with the RCN around what they were doing with learning disability. I took forward, I think you can see throughout my statement, a 10:12
number of programmes of work to strengthen the role and to be able to articulate the important role that learning disability nursing plays in our system of health care. They often work in either social care settings or in third sector organisations and I wanted 10:12
to try and strengthen the relationship with me as the senior nurse in Northern Ireland, but also with the profession of nursing to bring them into our family of nursing instead of learning disability sitting to the side, which I felt that it did at the time. I was also 10:13
very, not concerned, but I had a desire to ensure that learning disability nursing was also looking after physical health care needs and that was reinforced to me when I did go to Muckamore actually, the need to continue to do that. So I spent a significant amount 10:13
of my time as CNO investing in learning disability, engaging with them, supporting them because I felt that they needed that support.

33 Q. And we've touched on it a little bit earlier in your evidence but at paragraph 25 you talk about the e-mail 10:13
you received from Pat Cullen?

A. Yeah.

34 Q. Who at the time was Acting Executive of Nursing, Midwifery and Allied Health Professionals, Public

Health Agency, drawing your attention to issues regarding recruitment of learning disability specialist nursing staff for the Psychiatric Intensive Care Unit and acute admissions at Muckamore and asking you then to raise this at a CNO business meeting or CNMAC. She attached e-mail correspondences from John Veitch at the Trust to Molly Kane who was the Regional Lead Nurse Consultant within PHA for learning disability stating a paper was being prepared and would be shared with PHA in due course. Did the e-mail from Ms. Cullen arrive unprompted or out of the blue, so to speak, or had you been made aware of issues on the horizon? 10:14 10:14

A. No, pretty much as you say out of the blue. And, as I've already said, I had -- well I think I had a fairly good relationship with the senior leadership teams and I did have a very, I was always contactable and always willing to engage and work with people. So in some ways that e-mail was just an extension of that relationship. 10:14

35 Q. Yes? 10:15

A. In another way an e-mail about a specific incident and a specific ward of a specific organisation was probably an operational issue which I wouldn't have necessarily dealt with.

36 Q. But, nevertheless however, you did and you say in this same paragraph in response you requested analysis? 10:15

A. Yes.

37 Q. It was your expectation that the Public Health Agency and the Trust would provide deeper analysis of the

problem but in your recollection any further analysis was not shared with you. Do you know what happened, whether that was taken forward, whether any analysis was taken forward and shared with anyone in your office? 10:15

A. Well, I think work did happen subsequent to that because I do remember the Executive Director, Mary Heinz, when she came back from her, we'll call it a secondment, when she came back she did bring an update to the CNO business meeting around learning disability. 10:16 So something happened at the PHA with the Trust in relation to that issue. It was, it wasn't communicated in the context of this e-mail to me or my team, but I was aware that the Trust then subsequently did go out for a recruitment campaign and they had made the 10:16 decision to open that up to Mental Health Nurses in order to increase the supply, I suppose.

38 Q. So I was about to ask whether or not it was on the agenda at the CNO business meeting. I think you have averted to that by saying, Ms. Heinz did mention it? 10:16

A. Yes but that would have been more than a year, roughly a year later.

39 Q. And what about the Trust, did anybody or any representative from the Trust raise it or speak to it at any meeting? 10:16

A. Not that I can recall.

40 Q. In that time frame. Okay. At 26 then you talk about how the Trust developed the recruitment campaign which is what I think you were beginning to tell us there?

A. Yes.

41 Q. From memory and that was for the attraction of nurses to Psychiatric Intensive Care Unit to include both mental health nurses -- sorry to include mental health nurses in the absence of being able to recruit learning disability nurses. 10:17

Now, I know earlier on in your evidence you were quite clear about the distinction between the two fields?

A. Yes. 10:17

42 Q. But, have you any opinion to offer there on the strategy of including mental health nurses in the absence of being able to recruit learning disability nurses?

A. It's a challenging situation. I mean I have been in the post of Director of Nursing and if you're not able to secure staff, you've got to take whatever steps you can in order to maintain the required number of registered nurses to provide a safe environment. So, and I do accept that there is some cross over between learning disability and mental health, particularly for complex patients that might also have mental health issues. But I think parameters need to be set around the number of substitute posts, if you like, from learning disability to mental health because that's why we have -- learning disability nurses are the only group of healthcare professionals at the point of registration who actually have a specialist qualification in learning disability. There is no 10:17 10:17 10:18

other professional group who have that and that makes them expert, I think, in the care that they provide for people and their understanding of learning disability.

DR. MAXWELL: You said that you would expect there to be some sort of rules about how many and how they are used because, for example, I shouldn't imagine you would be happy if mental health nurses were taking charge of medical wards. 10:18

A. No.

DR. MAXWELL: In acute hospitals. 10:18

A. Absolutely not.

DR. MAXWELL: So when you were aware they were doing this, did they, did the Trust tell you what safeguards they were putting in place?

A. No. 10:19

DR. MAXWELL: I understand the difficulties, they couldn't recruit LD nurses, but did you ask for or did you receive any assurances about how this was going to be managed safely?

A. I didn't ask. Maybe I should have. I assumed that the Executive Director of Nursing who is responsible for the care and delivery of nursing services across the Trust and who is providing assurances to the Trust Board would have had that in hand. 10:19

43 Q. MR. MCEVOY: Okay. At the top of page 12, then, still within paragraph 26, you tell us that the deputy Chief Nursing Officer was undertaking a workforce review on behalf of the department and the Nursing Officer For Learning Disability Nursing. Can you tell us what that 10:19

review -- can you remember the title of it and when it would have been approximately, because the Inquiry has been examining whether it has that in its possession and it's unclear from the description what it is?

A. It's exhibited in my evidence. 10:20

44 Q. Okay.

A. It is, I can't remember the name of it.

45 Q. It's all right, we can come back to it.

A. I'll find it. But it was originally 2015 and then there was subsequently an update to 2016 so the one 10:20 that is available on departmental website is 2016.

46 Q. It's the same document?

A. It's the same document.

DR. MAXWELL: Do you know if the exhibited document actually specifically refers to the engagement session 10:20 with learning disability nurses or would that be a separate document?

A. No, I know that we tried to collaborate, I won't say co-produce, but collaborate with the various communities of nursing around their needs and the 10:21 workforce plan. And I do know that a separate event was held with learning disability nursing as part of the gathering of information in relation to that in 2015/16 by my then DCNO. And I didn't have a Learning Disability Nursing Officer at the time. I had an 10:21 agreement with the Clinical Education Centre that their Assistant Director who is a learning disability nurse by background and had worked in the department would support me a day a week with learning disability issues

so he would have also been involved in that workshop.

47 Q. MR. MCEVOY: Okay. So, you had mentioned then the strengthening commitment collaborative at the end of paragraph 26 and you go on to talk about its work in the following paragraphs and the various annual progress reports that you received from it and you have attached an example. The regional collaborative continued throughout your time as Chief Nursing Officer, as one of the main mechanisms to progress strategic work from a nursing perspective in respect of learning disability and you give examples within the bullet points. 10:21 10:22

At 29 you tell us you commissioned a bespoke Senior Nurse Leadership Development Programme to be delivered by the Royal College of Nurses. During your tenure what band of post was considered a senior nurse? 10:22

A. Well I suppose Band 7, 8, maybe experienced 6s, Deputy Charge Nurse, Ward Sister. In clinical practice they would be the grades. 10:22

48 Q. Would you have anticipated would have people, experienced Band 6s and above then would be eligible for that development programme?

A. Yes.

49 Q. And then you describe in October '15 to explore outcome measures relevant to learning disabilities to reach a consensus about the way forward for this specific requirement for the Northern Ireland action plan. In 2015 you established a Regional Learning Disabilities 10:23

Nurses Network to include the Trusts, the education sector and independent voluntary sector in reaching the learning disability workforce in Northern Ireland and it was expanded subsequently.

10:23

At paragraph 32 you refer to an outcomes measurement resource which you launched in October '18 at the Learning Disability Practice Forum. What was done with that resource, did you anticipate that Trusts would -- did you expect that they would make use of it?

10:24

A. Well, yes, it was launched in October but it had been the outworkings of an event in June as I recall where again I was speaking with learning disability nurses about their contribution and their being able to articulate their value contribution to care. As a result of that an outcomes measurement resource was made available for them to use that they could evidence the care that they were providing. An outcomes measurement resource, on reflection, although that's what it is called, is maybe not the correct title. What it was was a range of evidenced based tools that were available to the learning disability community and indeed mental health and other sectors, that were compiled for learning disabilities to pick which one would be most appropriate and then to use that as a framework and an evidenced based tool to, I suppose, justify the care and the decision that were made. That was shared once the resource was made available on the NIPEC, Northern Ireland Practice Education Council

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website of which I had asked them to establish a microsite to gather this information so it was available to any nurse essentially in Northern Ireland.

CHAIRPERSON: Can I just ask when you produce that sort of document is it shared with the RQIA? 10:25

A. They were part of the collaborative.

CHAIRPERSON: So they would know about it?

A. Yes.

CHAIRPERSON: So they would be able potentially to explore whether a Trust was, as it were, meeting 10:25 outcome measurements?

A. Well, yes, they could see it in care plans, see it in assessment and also RQIA senior nurse would have access to NIPEC.

50 Q. MR. MCEVOY: Okay moving onto the next question posed 10:26 to you by the Inquiry where you were asked whether you had received intelligence about Muckamore Abbey Hospital from your professional reporting lines and, if so, what information and what actions, if any, did you take in relation to the information. At paragraph 35 10:26 you defined intelligence from your understanding in this way:

"To be any information received through your professional networks through formal or informal 10:26 means."

We have talked about some of those earlier in your evidence. You say that Muckamore was not discussed at

the meetings and so forth that you have outlined. The purpose was on system level strategic issues. You didn't receive any other intelligence of serious concern regarding abuse or quality of care prior to the Executive Director of Nursing in the Public Health Agency advising you of her concern around mid-November '17 that:

"Four SAIs had been received by the Health and Social Care Board and that all of them were in relation to alleged violence by staff against patients. Two Trusts were involved. One SAI was a mental health setting and the others were in Muckamore Abbey. The concern expressed by the Director of Nursing in the PHA was potential failure to protect patients and that nursing staff were involved in the allegations. It was agreed then that while all four incidents were subject to the SAI process we wished to ensure any regional nursing action which may prevent further incidents could be identified and implemented as soon as possible." 10:26 10:27 10:27 10:27

So, prior to the report from the Executive Director at the PHA, had the Trust raised any concerns with you about Muckamore during 2017?

A. Obviously this was post the meeting with Gavin Robinson and the subsequent unfolding of the abuse in August and September but, leaving that aside, no, I'm not aware that the Trust did raise any issues about abuse. 10:27

51 Q. Okay. And in the following paragraphs then you set out

the various actions that you have taken. I don't propose to rehearse them, they are set out in writing there. But picking up at paragraph 41, you are talking about your commissioning of quality improvement training specifically for nursing led by the South Eastern Trust and provided funding for the Institute of Healthcare Improvement, Improvement Advisor Programme. to ensure further capacity and capability for improvement you invested in six quality improvement leads. You go on and say then that you secured additional investment for Learning Disability Nursing Officer at the department as part of your team. Do you know whether staff from Muckamore or the Belfast Trust Directorate or ASPC attended any of those courses that you have described in that paragraph? 10:28 10:28 10:29

A. Yes, each of the Trusts nominated staff and I do recall that there were, because I did the programme myself, there were nurses from that Directorate in the Belfast Trust.

52 Q. And on the point then about Learning Disability Nursing Officer in your department, can you recall when you secured the funding for that role? 10:29

A. It was 2019 and it was part of the transformation, we had three years of transformation funding and I was able to bid for and secure a Learning Disability Officer. 10:29

53 Q. The role had been vacant I think?

A. Yes.

54 Q. Do you know how long for?

A. Essentially I never had a Learning Disability Officer in post really from I started in the department in 2013 but, as I say, I had an agreed position with the Clinical Education Centre that their Assistant Director, who was previously the Nursing Officer at the department before his appointment to the Assistant Director post, would work a day a week and that arrangement continued for a significant period of time. And then I secured the LD officer in '19.

55 Q. Do you think there was any detrimental impact in not having that post or having that post vacant for a period of time in the ability for your office to deliver? 10:30

A. I can't say it would have been detrimental but I think that clearly we could have done more quickly things potentially when the Nursing Officer was appointed. I wanted her to undertake a review of learning disability nursing which I couldn't have done before that. You will see later on in my evidence, I'm sure we'll come to it, around phase nine of delivering care. Again there was no Learning Disability Officer in the department and none in the Public Health Agency either so in terms of senior nurse learning disability specialism, it was a gap for us. So we might have been able to progress those things more quickly, although delivering care is a complex set of other issues to be considered. 10:30 10:31 10:31

I think the learning disability community, senior

nurses, for example, Professor Owen Barr, Maurice Devine who I have referred to, Siobhan Rogan, who was the learning disability nurse, did a lot of work free because of their commitment to learning disability, to patients and the healthcare system. And so I worked with them and through them to get done as much as we could in the absence of a Learning Disability Officer but obviously that would have been a more ideal situation. 10:31

56 Q. Question 4 posed by the Inquiry references the RQIA: 10:32

"The RQIA frequently reported staff shortages at Muckamore Abbey from 2010 onwards meaning that the prescribed levels of supervision for distressed patients were not achieved. Were you or your professional group aware of these RQIA reports and what actions, if any, were taken arising from the information provided by those reports?" 10:32

You say: 10:32

"Reports of RQIA inspections at Muckamore were routinely circulated to the relevant policy lead within the Department who would in turn share these with relevant departmental professional officers, either for information purposes or to seek professional advice on issues that may have been identified through inspection reports." 10:32

At 45 you say:

"Prior to 2017 I and my professional group were not aware of any RQIA reports in relation to Muckamore. I was aware that RQIA raised concerns about staffing at Muckamore after 2017." 10:33

Looking back, does it puzzle you that your department hadn't seen any RQIA reports relating to Muckamore prior to 2017 as you say in paragraph 45?

A. Within the processes that are there and the policy, I think that's correct. It's my understanding that when RQIA does an inspection of any kind, announced or unannounced, that had they feedback to the Trust, they discuss their findings, there's a quality improvement plan in place for three months and then an assessment made at the end of that period, so that's the process. So, you know, the point of contact is with the Trust. And I suppose it would only come to the Department -- in legislative terms the RQIA have to use the legislation that is there and it's the Article 4 legislation that allows them to bring it to the attention to the Department which they did when they were significantly concerned. I suppose there is a process of support, challenge, support, challenge, interventions between the two organisations and it's only at the point where they feel they can no longer resolve it that they would engage the Department. 10:33 10:33 10:34 10:34

DR. MAXWELL: Do you think perhaps when something is coming up consistently in RQIA inspections but doesn't

meet the threshold for an Article 4 letter, do you think there should be a new process that says we are discussing with the Trust, this isn't resolving and notifies the Department?

A. I think there may be other ways in which that could be managed. So previously, whenever I was in the department in 2013, '14, there was an arrangement that the Permanent Secretary met with RQIA and the PCC for what he termed soft intelligence. And they were just like informal conversations which I have been at on a couple of occasions, so that would have been a mechanism for RQIA to sort of discuss in an informal way what they were finding. So that process wasn't in place lately, more lately, and that relied on sponsor branch in their meetings. But again it required RQIA to actually make the initial contact and raise the concern. So there are some mechanisms already in place in the Department for them to do that. On the PCC I was the sponsor lead for the PCC and we would had those conversations as I'm sure the CMO did with RQIA through the sponsorship meetings and for whatever reason it didn't emerge. But I think that if the -- and I understand the regulations are being re-examined, there may be the opportunity to strengthen that role.

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DR. MAXWELL: And you've been working in NHS England for some while now?

10:36

A. Yes.

DR. MAXWELL: Does CQC have a better arrangement?

A. Well I think given the recent revelations about CQC

suggest that it's not working very well either in terms of its effectiveness. And I think the problem is reliance on regulation actually. Regulation for me is the last step in the process and we need to have a much better focus on improvement using the data, our safety 10:36
data, to drive our intelligence, to identify issues that need another closer look. You know, Key Perform Indicators do that in some way, they take the lid off the can, but they allow you to say this is something I need to do a deep dive on and I think we have to use 10:37
our data to do those deep dives to understand how we improve services and not rely on inspection, because inspection is actually only a moment in time, it's on a day. And there are circumstances around that day which, I know from an operational perspective, 10:37
operational providers both here and in England don't feel that the Regulator always fully comprehend or understand, and it seems to me to be a fairly arbitrary process of black and white which obviously inspection is. So I don't think in the UK that we've got 10:37
regulation or inspection correct and I think we need to really move much more upstream and focus on safety and improvement.

CHAIRPERSON: And when you say "we need to use the data better" which I think everybody will understand, you're 10:38
not really talking about the RQIA or reports to the Department because that's all going to be backward looking. You're talking about Trust level, are you?

A. Well I think it's at all levels. So I think the Trust

need to understand their own data, they need to be interrogating that and producing the basis of their analysis then to their governance structure, up to their Board. I think that at regional level what would have been the Board, now SPPG, the Public Health Agency and RQIA need to be working together to identify issues and bring together their local intelligence. I think then we need, as a system in Northern Ireland of which I am no longer part of, we need a dashboard. We need a high level dashboard that gives us indicators around what I would call quadruple aim which are patient experience, which we have from 10,000 Voices and also other work specifically to nursing that provides real-time data through the development of an app which is in the process of testing. Staff experience and feedback, value in terms of are what we doing efficient and most effective use of staff time, and getting the best outcome for patients. A high level dashboard that gives you indicators of performance in relation to that, that we can all use, at whatever level in the system to identify trends and analysis. 10:38 10:39 10:39 10:39

DR. MAXWELL: So that would have access to the raw data.

A. Yeah.

DR. MAXWELL: Instead of being filtered by the Trust this dashboard would have the data and it would have all the data, not just the data the Trust chose to share? 10:39

A. It would have all the data, and at departmental level I

would not want to see all the data unless I had a specific reason for doing so. So, it might produce for me a high level dashboard but I would have the ability to interrogate the data or find somebody who can.

PROFESSOR MURPHY: Presumably one of the reasons you were trying to encourage outcome measures to be used was part of that thinking? 10:40

A. Yes.

PROFESSOR MURPHY: After you had got together the outcome measures you described a bit earlier on were they actually being used by people? 10:40

A. Were they actually?

PROFESSOR MURPHY: Being used?

A. Not a systematic way. I mean I found that from my time from being a Director of Nursing in South Eastern Trust we did use data, I think still work to be done but we were using data to drive thinking and improvement. And then actually the Executive Director of Nursing, Public Health Agency, Mary Hinds, asked me to Chair a group, a nursing group to develop Key Performance Indicators. I continued in that group because I felt strongly about it as the CNO, but the work was tedious, it was difficult to get agreement. Five Trusts, using different five different systems, couldn't get alignment on the data. You know, with Epiq now, one system for Northern Ireland, we have potentially the ability to be able to do that much easier so I think now is a great opportunity to drive that. The KPI work we did some on the acute side, I mean two years work to 10:40 10:41 10:41

get one KPI agreed. I did ask Mental Health and Learning Disability to look at specific indicators for their services. Again that was tedious for them. The collaborative took a role in that for Learning Disability, they did come back about suggestions about what that would be. But in the meantime systems evolve and we are now at the point of needing a governance framework, essentially an assurance framework for nursing of which Learning Disability/Mental Health would be part of but a more system level governance assurance framework that demonstrate the contribution that nursing is making, that care is safe, that it's effective and getting the right outcomes. 10:41 10:42

CHAIRPERSON: Could I just ask in relation to Epiq, was that rolled out in Northern Ireland at the same time as it was in England? 10:42

A. It's currently being. It is in Belfast Trust and South Eastern Trust and they are moving, as I understand it from social media, to Northern Trust next. But it will provide, it's one healthcare system for all citizens in Northern Ireland. 10:42

CHAIRPERSON: And does it produce, I know a little bit about it but obviously not enough, does it produce real-time data on outcomes?

A. I suspect it does but I am also not close enough to know what the interrogation of its uses will be. 10:42

CHAIRPERSON: It is a patient note system, but it may be much deeper than that.

DR. MAXWELL: But we know it does in other countries

and I know you're an IHI improvement, whatever level.

A. Advisor.

DR. MAXWELL: Senior level of training in that, there are countries that have this data driven approach. John Hopkins has a control centre with live data so it's possible to do.

A. Yes.

DR. MAXWELL: They just haven't quite got there yet here.

57 Q. MR. MCEVOY: The Inquiry then asked you question 5, top of page 19: 10:43

"Are you in a position to express a view on whether the immediate suspension of staff identified following review of CCTV at Muckamore Abbey Hospital made patients at the hospital safer?" 10:43

Before we discuss this in detail, just for context, did you or the Department have any experience during your tenure of course, any experience of institutional abuse investigations prior to 2017? 10:44

A. I don't recall so.

58 Q. In paragraph 50 then you say:

"In the case of Muckamore Abbey the suspension of a high number of staff happened over a short period of time. In this unusual circumstance it was right to take the best course of action to protect individual patients. Consideration must also be given to the care 10:44

environment and the impact of the removal of staff from a continuity of care perspective. This is important given the client group in Muckamore Abbey where meeting their individual needs requires expert knowledge and person-centred approaches to care. I am aware that some activities for patients were restricted or stopped due to the staff situation. This may have had an adverse effect on patients wellbeing."

I suppose thinking in particular about that knock on impact, detrimental impact one could say on patients, on reflection was there a different approach to safeguarding which might have been considered? 10:44

A. I think obviously it is for the Inquiry to determine but this situation was somewhat unique. As you said, I personally haven't dealt with this level of abuse previously. We are used to working in the context of a policy where one person is alleged to do harm, measures are taken to protect the citizens or the patients, to remove that person and then investigation takes place and outcome is dealt with in whatever way it is. So that was the approach we were using but it just kept getting bigger and bigger and bigger. And I am aware that we did discuss with the Trust whether or not people referred to as bystanders I think is the term, who weren't actually involved in direct abuse but who didn't raise the alarm, who didn't challenge what was happening, whether or not they should be, at the start they were suspended and as we moved through the process 10:44 10:45 10:45 10:45

the Trust were able to put an arrangement in place that they weren't suspended, that they were working under supervision which I suppose is a slight deviation from where we were. I think that on reflection, and Sean referred yesterday in his evidence to the legislation being taken forward around safeguarding and the fact that adult safeguarding isn't part of the delegated statutory functions, although in the main I would say people treated it as if it was part of delegated statutory functions. I think there is the opportunity with that new legislation to re-look at the policy and to take our learning from what has happened in Muckamore and to provide a step by step guide, I think, for organisations or co-produce it with the organisations involved, taking their experience to, you know, how you manage an individual, how you manage a small group and how you manage systematic abuse.

Hopefully this will not happen again but we don't know that and I think there is an opportunity to come up with a different set of arrangements. I don't know what they are at the moment. Your choices are obviously limited in this space but I think it is worth thinking about what we could do to maintain the delivery of care and to be mindful of the context of the care environment as well as the individual and protecting, obviously, the person who has been exposed to abuse because it does have a number of foreseen but unintended, I suppose, consequences which I think we'll

come to.

59 Q. Okay. And paragraph 53 on page 20, in keeping with this, the observations you have offered there you say:

"In summary for individual cases the use of suspension can be the best course of action. Where there are multiple cases of alleged abuse by several members of staff the totality of the care environment and delivery of safe care increases complexity and risk. Risk mitigation strategies were used to reduce this risk where possible but the workforce remained fragile and under scrutiny." 10:48 10:48

Do you know there was, and we'll come on to look at it very shortly, but there was the MDAG, the Muckamore Departmental Assurance Group, did it provide a means for discussing with, including among others, relatives of patients, the implications of what was in the CCTV footage in the context of, I suppose, the totality of the care environment and the delivery of safe care? 10:48 10:48

A. Yes it definitely did and we dealt with each of those, I can't say it was in a particularly planned way.

60 Q. Yes?

A. There were monitoring tools available to us to, I suppose, understand the implications of the number of staff who were available for work, not available for work. The implications on the CCTV, levels of seclusion, all of those factors were reported to MDAG. But as a result of that then there were knock-on 10:49

consequences often, which having re-read the minutes of MDAG, were highlighted by families and in my view families provided incredible sources of evidence to us at MDAG and I am really grateful for both their contribution and the fact that they were there. Because it was real-time for them and it was real experience and so they would tell us when things weren't right, when they were concerned about staffing levels, when they were concerned about skill mix, when they were concerned about safeguarding procedures, they would bring that to MDAG. Sean and I, not speaking for him, but we did our absolute best to make sure whatever they raised with us was addressed and done so in a quick turn around time. 10:49 10:49

CHAIRPERSON: Of course it was only through MDAG you were getting that real-time information. 10:50

A. Yeah.

CHAIRPERSON: Are you moving on? We ought to take a short break. We will do the same as we did yesterday. We are going to take a 10 minute break now and we'll take a slightly longer break later in the morning, thank you very much. 10:50

THE INQUIRY RESUMED AFTER A SHORT BREAK AS FOLLOWS: 11:02

61 Q. MR. MCEVOY: Professor, just before the break we had very briefly touched on the work of the Departmental Assurance Group and at question 6 asked you a somewhat specific question about its work:

"Were the consequences of staff suspensions, both intended and unintended, discussed at MDAG and if so please explain."

11:03

You set out a little bit about the Assurance Group and the Inquiry has heard something about it as well from your former colleague, Mr. Holland, yesterday. But, you say then at 55:

11:03

"The intended consequences of staff suspensions were discussed through the standing agenda item for the highlight report. The report provided updates on the numbers of staff suspensions and the current position with police investigations and provided an opportunity to share this information with all participants including family representatives at the meetings."

11:03

You've also then exhibited a sample of the minutes which showed regular updates on staff suspensions, resignations, vacancies and the associated staffing pressures as well as those identified by the RQIA as part of their inspection activity. This was in recognition, you say, of the challenges that related to staff suspensions, including wider staffing concerns and the need to maintain safe care to the remaining in-patient population.

11:03

11:04

Would any of that work have been possible without the

input of relatives of patients or how much more difficult perhaps would it have been?

A. Well it would have been possible because the Belfast Trust obviously were providing updates to MDAG on the staffing situation, their work with the police, the suspensions and the use of seclusion and other matters arising as, you know, as we moved through the process when MDAG was established. And certainly ASG referrals and all of that, the monthly resettlement targets, we were being provided with that information. But I think triangulating the data with families and having families within the room to either support or challenge what was being said was an important mechanism for us in terms of assurance that their experience of care delivery and their experience of being in the hospital was the same as what we were hearing from the Trust.

62 Q. Before the break you were going so far as to describe how they were able to bring information to you and it sounded, if I might say so, it sounded very well informed sources of information based on their experience to you?

A. Yes, so when we were talking about staffing complement, the families, and I appreciate that, you know, it was difficult for them to do, a small number of them in a roomful of, you know, senior people in the health service. They would have at times said we see the number of learning disability nurses reduce even more, we're concerned about the use of agency staff, what mechanisms are in place, how is that being handled and

we would have asked the Trust to respond. They were concerned about the number of mental health nurses that were being utilised and the impact on seclusion policy. So at one point, so the trend was we started MDAG in 2019, in 2020 the Trust were reporting a reduction in 11:06
seclusion which was evidenced in the data and supported by families. In 2021 there was an increase in sickness absence, the use of seclusion increased. That was addressed through MDAG. More information was provided. The families raised their concern about the agency 11:06
staff and how they managed challenging behaviours. In another situation where Erne was being decommissioned and patients were being moved to another ward, the Trust had done some work on safeguarding around the clientele of staff, however families made it known to 11:07
us that they had lost trust essentially in the safeguarding processes that the Trust were employing and as a result of that we asked for the audit to be done and it's in my statement, the outcome of that audit was there were a number of issues to be addressed 11:07
with the safeguarding policy. There were a number of issues to be addressed where agency staff had been involved in poor care or mishandling of patients and how that was fed back or in event what they were saying was it wasn't fed back to the agency. So the agency 11:07
didn't know that their member of staff had been, why they had been removed from Muckamore, no longer had a contract. And that would be normal process for that to happen in a case where a nurse is no longer employed

that we would feed that back to the agency. So they were tightening up processes that happened and reassurance provided to the family as a result of their interactions at MDAG.

63 Q. Okay. Within then the work of the MDAG one of the substrands or subthemes of work that you highlighted for us is the work around admissions and resettlement. At paragraph 60 you say that: 11:08

"A standing agenda item was the Muckamore Abbey HSC Action Plan and it was clearly recognised at MDAG that the current model of care at the hospital was outdated and not in keeping with policy direction or best practice guidance and that a new learning disability model was required. To achieve this a change in culture and practice underpinned by a clear understanding of the role of specialist in-patient care for people with learning disability was needed and supported by a sustainable multidisciplinary workforce plan." 11:08 11:08

Now, we had talked a little bit earlier in your evidence about the 2009 DeLoitte workforce review which was a piece of work following the Bamford, the original Bamford vision. I think the essence of your evidence was that you weren't familiar with the DeLoitte report but by 2019 it had been 14 years, something of that order anyway certainly since the Equal Lives Report had been published. Did that report frame or inform any of 11:09

the thinking and discussion that took place at MDAG? Do you remember anybody going back to it as a sort of a source document for an approach going forward?

A. No. It was never referred to at MDAG. I think the policy intent of that workforce plan was the implementation of Bamford which was obviously our extant policy position.

64 Q. Yep?

A. So essentially that was what we were work to in MDAG but that report was never specifically identified. As I said earlier, by chance if you like, because there are some elements of the report I would agree with, it happened.

DR. MAXWELL: Can I ask then, so clearly certainly for the cohort of patients who were still in Muckamore, the current arrangements in the community were not facilitating their resettlement. Did MDAG think have we got our workforce plan right for resettlement? So there has been a big push since 2017 and dates come and go for the closure of Muckamore, did MDAG ever stop and think have we got the right workforce plan to support resettlement?

A. Not in a kind of direct way as you've put that to me. I think it would have been in our thinking but we were working on the basis of the arrangements that were in place, i.e. that the Trusts were developing plans for resettlement and in their resettlement plan for each individual they considered the specific needs of that individual. I've subsequently learned on reading the

Mongan and Sutherland report that that was not the case and that the plans were over ambitious which I suppose is testament to the fact that the resettlement programme didn't happen even with the targets set by the Permanent Secretary. So no, we didn't, we didn't consider that in that context. 11:11

DR. MAXWELL: The Inquiry has heard about a number, the Mongan and Sutherland report talked about the number of resettlements that didn't work and people had to be re-admitted to Muckamore. Did MDAG actually draw any learning from those and think, well, if we are going to close Muckamore and resettle all these patients what can we learn from failed resettlements? 11:11

A. We did and I am aware of a resettlement that failed, and it has stuck with me, for a person in Muckamore where their family had, facilities were secured. The person's family had essentially decorated the facility. The person had been discharged and over the weekend it broke down and as a result of the challenging behaviour that ensued, everything that had been provided was no longer usable. I remember thinking to myself that is the worst possible outcome. It is so traumatic for the person and it is so traumatic for the family and then to have to be re-admitted to Muckamore on the back of that. So we specifically asked for a review to be done on resettlements, about the process, about being absolutely sure, as best you could, accepting that on occasions things might fail or change, but that the resettlement programme should be in the best interests 11:12 11:12 11:12

of the person and not to meet the target.

DR. MAXWELL: But was some of the resettlement failure associated with having staff who could not manage the complex needs of those patients?

A. I would suggest that it was, because some of the people in Muckamore who were being resettled would have needed like three people for one person. 11:13

DR. MAXWELL: Three skilled people, not just three bodies?

A. Absolutely, three skilled people, and probably different skills in that range of three which clearly wasn't able to cope with the level of complexity of the individual. 11:13

CHAIRPERSON: And sorry, just to understand, was that failure despite the fact that facilities, the facilities were specifically designed for the individual? 11:13

A. Yes.

CHAIRPERSON: So it must have been a person-centred issue as it were? 11:14

A. Well I think, you know, the upheaval and the trauma of moving from a location that you know and are secure in, leaving aside the issues which we now know not to be the case, to an environment that's new, even though you might have been out to visit, but you know to call it one day your home, is traumatic enough I think for -- I mean it's traumatic for any individual who moves home not to mind somebody who has a learning disability and has difficulties in communicating. That alone is 11:14

enough. So managing those issues very sensitively and with the right skills and experience and adhering to all of the personal trigger points, communication difficulties, understanding the person, what might support them to live there successfully, what comforts they would need, what personal belongings they would need, all of that needs to be considered way in advance. I am not saying that it wasn't. In fact I would say I am not close enough to understand the detail of that specifically, but I do know the experience and skills of staff in deescalating behaviour and understanding the person and really being person-centred in the approach is bound to have been an impact. 11:15 11:15

CHAIRPERSON: Do you know if that resettlement was ever reattempted? 11:15

A. I can't say with certainty.

CHAIRPERSON: Okay, thank you.

65 Q. MR. MCEVOY: Right, moving then to paragraph 64 on page 24 then you talk about the decision by the Belfast Trust in 2018 that Muckamore should be closed to new admissions making it unavailable for treatment and assessment for acutely unwell people with learning disability who required in-patient assessment and treatment. Then you make the point: 11:15 11:16

"Given that Muckamore Abbey was the sole provider of specialist learning disability in-patient care for Belfast, Northern and South Eastern Health and Social

Care Trust areas, and regional provider of specialist learning disability low secure and Psychiatric Intensive Care, this created a significant gap in commissioned specialist learning disability in-patient services across Northern Ireland." 11:16

You then exhibit the Early Alert and it provides an overview of the reasons for the closure. Then you go on to say:

11:16

"Although the Way to Go Report recommended a necessary transition to community services and full closure of Muckamore Abbey, it was clear to me that this could not happen immediately or in the short/medium term and that the important role of specialist in-patient care for 11:16 people with a learning disability needed to be recognised and planned for. The HSC neither had the full range or capacity of community based health and social care services required to safely and effectively meet the needs of patients delayed in their discharge 11:17 from specialist learning disability hospitals in Northern Ireland, including Muckamore Abbey. Nor could the full range of assessment and treatment be provided without a specialist learning disability in-patient service such as Muckamore Abbey." 11:17

And then you go on and tell us that you corresponded by e-mail to the Permanent Secretary on 7th December 2018 noting your concern. I think we will find, hopefully

find the e-mail at page 596 please, yes. Zoom in please, thank you. So we can see there is a distribution list, people you have cc'd the e-mail to. Did this e-mail containing these concerns make its way to anyone within the Belfast Trust or is anybody on that distribution list within the Belfast Trust?

A. No, that's an internal departmental list.

66 Q. Okay and did you communicate your views to the Trust directly?

A. I don't recall doing it directly to the Trust but it certainly would have been in meetings where I would have raised the issue, like the liaison meetings, and yeah. My concern was really that the Way to Go Report recommended closure of Muckamore. And while I'm not saying that Muckamore should remain as Muckamore, if you like, a model of care that provides for acute assessment and treatment of people with learning disability is needed and will continue to be needed in Northern Ireland. In the absence of having that available at the time I just didn't see how Muckamore could close. And the direction, I think there was a growing opinion, let's say, that the Way to Go Report needed to be implemented and my reason for raising it with the Permanent Secretary was to say from a clinical perspective I don't see how that can care for people with acute treatment needs. If they were to be co-located, which was the direction of travel, in each of the five Trusts within Mental Health Services then Mental Health Services needed to be able to accommodate

11:18 11:18 11:19 11:19

that and I didn't believe that was the case. The estate in some of our mental health facilities in Trust was wanting at that stage and nor did it have capacity to cope with another cohort of very complex patients. And so I felt that putting all our eggs in one basket potentially to close Muckamore we needed an alternative plan and that was to be developed as part of the learning disability model.

PROFESSOR MURPHY: We understand the Learning Disability Service Model has been drafted and is progressing through the system, but what have they suggested about precisely that issue? 11:19 11:20

A. I can't really comment on that because I am three years out of my post. But I know that the Director of the Board, Social Care Director of the Board was doing an acute review which, from memory, I think was delayed because of Covid, so I can't comment on that. 11:20

CHAIRPERSON: Just to put this into context, if we can scroll down a bit, this is actually a response, isn't it, to an e-mail of the day before to I think Richard Pengelly? 11:20

A. Yes.

CHAIRPERSON: In relation to a meeting that was going to take place with the families the following week?

A. Yeah. 11:21

CHAIRPERSON: So you were making your views felt as it were?

A. Yeah. I was at the meeting with the families.

CHAIRPERSON: Yes.

A. And I just wanted to be sure that my view, and I appreciate my view is one of a number of views and we may not all have the same view, but I wanted to record my view.

67 Q. MR. MCEVOY: Did you get a response from the Permanent Secretary, how did he -- 11:21

A. No I don't recall so and in a way that wasn't my intention, my intention was to make my view aware. I would have also made it aware in a number of meetings that we had and I just wanted to reiterate that position that there was a group of people that we needed to -- 11:21

68 Q. Putting it on the record so to speak?

A. Yeah.

69 Q. You weren't really anticipating a response? 11:21

A. I wasn't, no.

70 Q. Okay. You then go on and discuss the next subtheme which is that of safeguarding. You make the point at paragraph 67 at the bottom of page 25 that as the CNO you didn't have a specific role in decisions in respect of safeguarding under the Northern Ireland Adult Safeguarding Partnership, the adult safeguarding operational procedures and adults at risk of harm and adults in need of protection. But you are able to tell us that safeguarding issues were often discussed at MDAG. You say there was one example at the meeting on 1st October 2019, the initial findings of a report on adult safeguarding processes conducted by HSCB was presented at that meeting with the final report 11:22 11:22

circulated on 27th November and it concluded that adult safeguarding investigations at the hospital had been completed in line with current regional guidelines. And then in 2021 at paragraph 71, you tell us about the findings of a Safeguarding Audit commissioned by the Department due to concerns regarding the number and nature of safeguarding referrals in relation to staff on patient referrals. Those findings having then been presented to the MDAG on 25th August 2021. And you have exhibited or you make the point that minutes are exhibited to the statement of Mr McGookin. The audit found that there were several system issues which needed to improve, being the poor design of the safeguarding form, lack of follow up recording where PSNI involvement was needed and no evidence of protection plans being completed. This was acknowledged at the meeting and would be addressed in the reform of adult safeguarding systems.

11:23

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So I suppose a bystander reading that might be puzzled as to how the conclusion in November 2019 is that adult safeguarding investigations at the hospital had been completed in line with current regional guidelines in 2019 and then about two years later, or just a bit less, there were a number of issues identified in the audit process. Can you help us understand any gaps there?

11:23

11:24

A. Well, I think the Belfast Trust were obviously under significant pressure to, you know, they were responding

to a major incident so to speak and there were many asks of them in terms of their Safeguarding Team. They were reviewing CCTV. They were having to make sure the processes were in place. And I guess over time the position changed, their staff were involved in a lot of 11:24
different areas of work. There was maybe less focus than we had anticipated on the ward situation. And I think the staffing, as I refer to earlier, initially we thought things had improved and that was kind of the trajectory, '19, '20 and then '21 many of these 11:25
concerns started to re-emerge and I think that was because there were more staff on suspension, more agency staff in. There probably needed to be more adherence to the safeguarding arrangements rather than less at that time, but that was difficult for the 11:25
staff. That was my interpretation of it. Someone who is closer to the safeguarding detail -- I suppose that's the point I make about safeguarding, while I understand that, it's very much in the domain of the social work in terms of their understanding of the 11:25
processes, the legislative framework for which they work, I do believe that on some occasions it becomes the domain of social work so effectively the system says that's the social workers, they sought that out. Actually everybody has a role in safeguarding and I 11:25
think we need to be more explicit and provide greater clarity and understanding in all healthcare professional roles that we all have a safeguarding duty.

71 Q. Okay. Onto the theme then of clinical care delivery, paragraph 76 on page 28, you make reference to two unannounced inspections at the hospital by the RQIA in February '19 and then April '19 after which the RQIA raised a number of issues. You wrote to Ms. Brenda Creaney at the Trust regarding clinical care issues. You discuss that a bit later in your statement. 11:26

"In February 2020, as part of the regular highlight report, an update on restrictive practice was provided by the Trust showing a reduction in both the rate of seclusion and physical intervention following staff training. Increased use of reflective practice. A reduction of in-patient numbers and better communication and an increase in multidisciplinary approach to care. I noted formally the work undertaken by the Trust to reduce the use of restricted practice." 11:26 11:27

So, there is a positive, a move in the right direction?

A. Yes. 11:27

72 Q. But then you say at 78 at February '21 meetings, this is about a year later:

"It was noted that there had been a rise in the number of seclusion events and a family representative raised concerns about the current level of care provided and ongoing use of agency staff which was disproportionately weighted towards mental health nurses." 11:27

Your office had begun to receive weekly workforce reports at your request given the ongoing concern around the staffing at the hospital.

11:27

"Although the reports were mainly retrospective at this point it was useful to review the staff situation regularly. My response to this new data was to request an urgent conversation with the Trust through the director, Gillian Traub."

11:28

So an uptick in February 2021. You are making the point in those paragraphs I think that the staffing situation --

A. Yes.

11:28

73 Q. Is an issue?

A. Yes.

74 Q. Are you saying that there is a correlation between the two?

A. Well I'm not saying, because I don't have the evidence to say there is a direct correlation.

11:28

75 Q. Yes?

A. But my intuition and my expertise would tell me that that is a warning indicator that needs to be considered.

11:28

76 Q. Okay, okay. You had discussions with Ms. Traub?

A. Gillian Traub. I would also say Brenda Creaney as Executive Director of Nursing and all the way through this process Belfast Trust assured me care levels were

safe in Muckamore.

77 Q. At 79 then you say that:

"Staff situation was so concerning the HSCB developed a further contingency plan in the event of an emergency, for example, no staff available for duty." 11:29

You were conscious that investment was required in learning disability nursing.

11:29

"As part of the Nursing and Midwifery Task Force Report published in March 2020 prioritised this investment through delivering care."

On 21st May 2021 you received a breakdown and investment plan for -- should that be 120 new posts for learning disability?" 11:29

A. I think that should be 20.

78 Q. "...20 new posts for learning disability funded through delivering care which I prioritised from Rodney Morton who was the Executive Director of Nursing and Allied Health Professionals at the PHA." 11:29

The letter sought your approval for the allocation of funding to specific areas. If we could go to 598, please. 598, thank you. This is Mr. Morton's letter to you. If we can go to the final paragraph of that letter, final half of it. So he is talking about recruitment of required posts: 11:30

"Considering recruitment timeframes and workforce availability there might be a possibility of in-year slippage which we aim to estimate by early June."

11:30

Move on down the page please.

"To summarise as follows: Supplementing of ECG in view of backfill salary costs. Providing some non-recurrent posts to school nursing and health visiting to facilitate the backlog of assessments and referrals. Supplementing the gap of the Band 5 and 6 costings from the transformation project for enhanced levels of senior nurses on the designated wards."

11:30

11:31

If we go down to the next page which is hopefully your response. So that second paragraph you approve the investment plan on the proviso that discussion and agreement takes place with operational directorates in each Trust regarding the additional posts.

11:31

"It is critically important that everyone is clear on the roles and governance arrangements of the new posts including agreement on where they will sit within directorates."

11:31

can you help us understand how there was an increase I think in more senior posts, Band 8, Band 8A perhaps, what thought was given to addressing the critical

shortages at perhaps bands 2, 3 and 5?

A. So at that point we had a limited amount of money, 20 million to be divided among the workforce in Northern Ireland and I made a conscious decision in discussion with the Executive Director of Nursing that that should 11:32 be prioritised for senior posts as opposed to Band 5 posts or indeed support worker posts on the basis that Band 5 nurses, entry grade nurses to the register needed support and were dealing with complex patients both in Muckamore, but also in other parts of the 11:32 service. The provision of additional senior posts at Band 7 and Band 8A will help in supporting them with decision making, in dealing with difficult situations and in taking and shouldering some of the responsibilities for the complexities of care, 11:32 particularly out-of-hours and at weekends to make sure there was senior nurse cover on duty and that was a decision we made. The nurse consultant posts I was completely supportive of. We had one nurse consulting post in South Eastern Trust for learning disability in 11:33 2007 which was removed as part of cost savings and had never been replaced and there were no learning disability consultant nurses in the other Trusts. They provide a really valuable role in senior leadership, in bringing research and evidence to practice and in 11:33 supporting the nursing workforce. I felt it was critical that we provided the career pathway so particularly for learning disability so Band 5s could see a career pathway in Learning Disability Services in

the health sector. Because many of them, and the reports that we referred to earlier from CNMAC in 2015/16 was suggesting that a lot of our learning disability workforce was working in the independent sector and it was important that we maintained enough learning disability nurses in the health sector to look after the most complex patients.

DR. MAXWELL: So were you expecting the nurse consultants to actually have direct contact with patients and be doing assessments and writing plans? 11:33 11:34

A. Well my expectation is that the job profile of a consultant nurse has clinical time in it and that clinical time will be spent working in clinical practice. But in a way that is role modelling good practice and learning and teaching more junior staff the best way to do care plans, the best way to assess patients. They aren't there, so to speak, as another pair of hands on a shift, they are there because of their expertise and to share that learning with others. And I also expected that those five learning disability nurse consultants would come together into some collaborative function potentially with the five or the six quality improvement posts collectively as a group of nurse consultants to start to shape the strategic direction for learning disability. 11:34 11:34 11:34

79 Q. MR. McEVOY: At paragraph 84 then on page 30, reference is made to the development of a new learning disability care model?

A. Yeah.

80 Q. And an acute care review to take place under the leadership of Marie Rolston?

A. Yes.

81 Q. Do you know, you say that was paused due to Covid, do you know whether that was taken forward? 11:35

A. I can't recall, to be honest.

82 Q. Okay?

A. I presume, my assumption is that's part of the Learning Disability Service Review.

83 Q. Okay. And I touched on this a little bit earlier, but 11:35 do you know whether, and you might not be cited on this, do you know whether that model will be at all cited on or taking account of the Bamford recommendations?

A. I don't know for definite but I would assume that that 11:36 remains the extant policy position of the Department and therefore it should do.

84 Q. Okay. Okay. So question 7 posed to you by the Inquiry took you to some data which the Inquiry has received demonstrating a rise in incident reports from 2011 to 11:36 2018 regarding -- page 31, thank you, regarding inappropriate or aggressive behaviour by patients towards staff. Your specific attention was drawn to it and you were asked a number of questions arising. Now, I don't intend to open it, I don't think we need to 11:36 open the data itself but you have had an opportunity to look at it.

At paragraph 92 then you make the point that in your

opinion:

"Data such as this should be used as a surveillance tool and when trends similar to that identified in the document are identified it should be analysed, quality assured in case of error and then discussed at the Mental Health and Learning Disability Directorate Governance Group meeting within the Trust and then at the appropriate forum within the context of the Trust Governance and Assurance Framework." 11:37

Having looked at the data, is that the sort of thing you would have expected to see while in role as CNO or would you have expected that to remain within the Trust in the first instance? 11:37

A. I would have expected the Trust to analyse the data, make assumptions about the data, come up with an action plan and, depending on the severity of the situation, share that detail with the Public Health Agency and the Board both from a commissioned perspective but also from a safety and quality perspective. 11:37

85 Q. You expect them to use it and interrogate and as a basis then to take actions forward to yourselves or whoever else?

A. Yes, in the event that there is something. 11:38

86 Q. Something arising?

A. Something that needs to be fixed.

DR. MAXWELL: But could this, you've said it should be used as a surveillance tool, could this be one of the

things in the dashboard?

A. Absolutely, the Datix reporting system would be one of the validated tools that you would use, along with a range of other sources of safety data along with complaints and compliments, patient experience, et cetera to inform your overall view. 11:38

DR. MAXWELL: So although Encompass wasn't there at the time, electronic versions of Datix have been in place for more than 10 years?

A. And it would be my experience, although not in the Belfast Trust, that the process that I have outlined there, it may not be exactly mirrored in different organisations, but that Datix information would be shared at Directorate governance groups in the first instance and then decisions made about do we need to escalate this, where do we need to escalate it to, do we need to let the Safeguarding Committee know, do we need to take it to audit and risk, whatever in the organisation so that the concern about what's happening is escalated to the appropriate level. 11:38 11:39

DR. MAXWELL: During your time as Director of Nursing at South Eastern Trust, if there had been such a significant climb which, if we are using SPG charts I think would have been outside control limits, would you have expected the Board to know about that? 11:39

A. Given the vulnerable group and the situation that it was happening in, I think yes. But I can understand that it's not essential, if you like, organisations may make decisions about what they do, what they deem

appropriate for the Board. This essentially is a Director of the service, I would consider it within that remit to sort that out, to put actions in place. So in effect when it gets to the Board you are providing a solution to the Board. So that here's a problem, here's what we are doing about it and here's the assurance that it's going to be rectified.

CHAIRPERSON: Could I just ask, it is a slightly technical question, I'm sure Dr. Maxwell knows the answer to this, but does Datix still sit outside Epiq or does Epiq incorporate a form of Datix? 11:40

A. No, I would imagine Datix is a stand alone system.

CHAIRPERSON: It still sits outside Epiq.

A. Yes.

CHAIRPERSON: Thank you. 11:40

87 Q. MR. MCEVOY: Before we move on, the Trust would have been, the Belfast Trust that is, would have been naturally enough the biggest Trust with which you would have had dealings as Chief Nursing Officer?

A. Well it's the largest Trust in Northern Ireland. 11:41

88 Q. Yes, I know I am making a perfectly obvious point but I need to put it on the record?

A. Well yes, it is the largest Trust, it has the complexity of regional service.

89 Q. Yes? 11:41

A. And it has the biggest compliment of staff and the biggest budget and it is effectively bordered by all other Trusts except the Western and Southern probably. It has a very close relationship with Northern and

South Eastern, there is a belt that runs between the three. I may be assuming here, but I have been watching the Inquiry and I understand the conversation about the size of Belfast in the context of its performance et cetera. I did spend some time yesterday on the Internet looking up Leeds Trust as a comparator. I did notice that actually in terms of staffing budget, staff, it is similar, give or take 1,000 or 2,000 staff, budgets not that different really. Leeds Teaching Hospital provides appointments to 1.7 million people a year which is effectively, give or take, a couple of hundred everybody in Northern Ireland having an appointment. But what I think is different about it is it has seven hospitals including Jimmy's which is the largest teaching hospital in Europe which, I suppose, the comparator to that would be The Royal. Then there are four other hospitals in the Belfast Trust, one of which is Muckamore. But what Leeds Teaching Hospital is not doing is providing all of the other services. They have all the regional specialties, everything I notice from penile cancer to trauma and orthopaedics, the whole range is there, maternity, paediatrics. But what they don't have is community mental health and learning disability. And I think to be fair to the Belfast Trust they are dealing with a breadth of services where everybody in Leeds is focused on hospitals if you like. And looking at the Board structures, which I did, they have more non-executive directors in Leeds than would be in the

11:41 11:42 11:42 11:42 11:43

Belfast Trust and a different range of directors at their Board level. I think that the Belfast Trust, from its inception in 2007, has always been troubled with issues, reviews, complications. Part of that is the landscape and complexity of the organisation. But there is part of me that thinks the Belfast Trust genuinely hasn't had, now looking back in time, the right infrastructure to allow it to flourish actually. And you know those hospitals in Leeds that we talk about, Jimmy's and Leeds Teaching Hospital will have directors of nursing of their own reporting to the Chief Nurse which is not a structure that we have here. 11:43 11:43

That coupled with, for example, the Executive Director role, Brenda Creaney is a long time in her post but she has always had a large operational role in addition to her Director of Nursing role. And if we want directors of nursing to focus on safety and quality and patient experience and that should be -- that is the unique contribution that nursing brings to the Trust Board, that is what they are there to provide assurance on. Then we need to focus the role on that and in my opinion have less of the operational stuff. I had a huge operational portfolio in South Eastern Trust as well so I understand that. The difficulty is that whenever I tried to change that as a CNO I ran into grading difficulties and pay. So for me to make changes to the Executive Director of Nursing role, which I tried to do with the Southern Trust at the 11:44 11:44 11:44

time, whenever the job was profiled it came in at a lower pay band than most assistant directors and that actually is a fundamental block in how we recruit executive directors to boards. And I think all of those things now need to be reconsidered. 11:45

CHAIRPERSON: By comparison with Leeds, we heard some evidence the other day that the Belfast Trust has something like 700 plus buildings in terms of an estate whereas Leeds is dealing with --

A. Seven hospitals. 11:45

CHAIRPERSON: A bigger population, it's dealing with a very limited estate. But in terms of its hospitals, presumably it still has one board for the trust.

A. Yes.

CHAIRPERSON: And then in a similar way to Belfast a number of directorates for each hospital? 11:45

A. Yes. And all of the information is not available on the website so I took what I could get, but they do have a directorate structure, a Triumvirate approach, which I think is correct and which Belfast have of a Clinical Director, a Lead Nurse and a senior manager who run the Directorate. But on top of that I think there are also much more senior posts in the Leeds structure. They have an additional layer so for every hospital there is a management team which we don't have here in Northern Ireland. 11:46 11:46

CHAIRPERSON: Thank you.

90 Q. MR. MCEVOY: And in a structure such as that, that Belfast has, where it has Learning Disability, Mental

Health, Social Care Services, as you fairly point out which Leeds doesn't have, is there always a risk that those other services will be overshadowed by the demands of acute services?

A. There is a risk because acute services are always in the domain of the media. 11:46

91 Q. Yes?

A. The ambulances are queued up, the patient experience going through the Emergency Department may not be what we want it to be. And certainly there was a focus on emergency care and I think, as Dr. Jack referred to in her evidence, the CMO and I were tasked with a task group back in 2014 to take actions to help and support the system to do that. So there is clearly a focus because it's in your eyes, in the public domain. Mental Health and Learning Disability and other services are not as featured in that way but I think that is the role of executive directors and the Trust Board to ensure that they have equal sight and equal time on all of their services. 11:46 11:47 11:47

92 Q. Okay. Now, you go on in your statement then to help us with your understanding of the structures and processes in place at departmental level for the oversight of Muckamore. That begins at the bottom of page 34 paragraph 101? 11:47

CHAIRPERSON: I am wondering if you are moving on to, that is under the next question. I am wondering whether now might be a good time to take the morning break, give everybody a chance to get a cup of tea or

coffee and we'll then sit until about a quarter past one, as we did yesterday. Obviously if you don't finish the witness then we can carry on afterwards. Okay we'll just take a short break, I know you will be looked after, thank you very much. 11:48

THE INQUIRY RESUMED AFTER A SHORT BREAK AS FOLLOWS:

CHAIRPERSON: Mr. McEvoy.

93 Q. MR. MCEVOY: Thank you, Chair, thank you Panel. 12:05
Professor, before the break then I indicated we were going to have a look at your understanding of structures and processes in place at departmental level for oversight of the hospital. At paragraph 103 on page 35 then, you tell us about health and social care 12:06
governance arrangements as structured in Northern Ireland at the time you were in post and express the view that it was broadly reflective of current practice and comparable healthcare administrations.
Before the break you used the example of Leeds. Is 12:06
that the sort of comparator you're thinking of there?

A. Well I am thinking more specifically around the governance of the Board and, you know, in most -- across the four countries it is in legislation to have a Nurse Director, Finance Director, Medical Director as 12:07
part of the Executive Team. In that way they are broadly similar. As I've said there is probably a different substructure but at Board level those posts are in there, although I do believe there would be a

bigger range of Executive Director posts in other parts of the UK and that's why I use the word broadly.

94 Q. And in terms of the Belfast Trust in particular and the Trusts more broadly, would it have been part of your role to examine specific governance arrangements within the Trust and to satisfy yourself that they were appropriate and effective? 12:07

A. Well, no, the governance arrangements are set out in the accountability, or the governance assurance, the framework. The legal position, and I suppose my view would be that it needs to be consistent with that framework. If, for example, I felt that governance assurance was an issue within nursing, which I think the report that Mary Hinds did in 2017 alluded to the fact that -- so the governance assurance, the nursing governance assurance from the Executive Director of Nursing is a basically a network across the organisation out into all corners of the organisation across all Directorates. From an Executive Director of Nursing perspective I would want to be making sure I had the right intelligence in each of the directorates and it is responsive and reactive to -- and there is a two-way communication between me and that person. In the work that Mary did I think all of the executive directors assured her they did have those governance processes in place, but actually it relied on a small groups of staff, many of which it wasn't their full time job, they were also operationally managing the service. The operational will always come before the 12:07 12:08 12:08 12:08

professional because it's demanding, it needs to be done there and then. So in that context I think we, I would be, if I had concerns in that regard I would be raising them.

95 Q. At the bottom of page 36 the question proposed to you is: 12:09

"How concerns at Muckamore might trigger a notification to the Department and who would decide or who decided that a notification ought to be made and what guidance was there to identify when that ought to happen?" 12:09

And then overleaf at the top of 37 then at paragraph 111 you say:

"Depending on the nature of the concern these may have been triggered through the Department's Early Alert system, introduced in June 2010 when responsibility for oversight of serious adverse incident reporting transferred from the department to the HSCB and the PHA." 12:09

then you say:

"The system was put in place to ensure that the Department and the Minister were made aware in a timely manner of any significant events occurring within the health and social care system." 12:09

You go and list the criteria. I appreciate this predates your tenure?

A. Yes.

96 Q. But the bullet points speak for themselves but if I can summarise them in the following way: 12:10

"Urgent regional action may be required by the Department where a risk has been identified which could potentially impact on the wider healthcare service or systems. 12:10

The organisation in question is to contact the number of patients or clients about harm or possible harm that has occurred as a result of the care received. 12:10

The organisation is going to issue a press release about harm or potential harm to patients or clients, may relate to an individual, the event may attract media interest, it may include police involvement in the investigation of a death or serious harm." 12:10

The following then should always be notified: Death of or significant harm to a child and abuse or neglect are known or suspected to be a factor. Death or significant harm to looked after child or child on the 12:11 protection register and so on. Finally there has been an immediate suspension of staff due to harm to patient/client or a serious breach of statutory duties has occurred.

So I suppose, the query Professor is whether, excepting maybe the first one which just deals with the facts and what the basic facts are of a situation, might one be forgiven for forming the view that a lot of those, a lot of those bullet points are really about damage limitation for the Department?

A. I think some of them are about public confidence rather than damage limitation. So I think it is important that we maintain public's confidence in the health service because of the implications of them not going to an appropriate place for treatment should they require it, and I think that's the intent. Obviously the Minister is in a very public role accountable to the executive and it would be important that he is on top, he or she is on top of the information and could answer questions in that regard.

And obviously where things leak to the media, sometimes they are not always accurate and correct. It isn't always possible to share the accurate and correct information because in the interests of the person involved in the SAI, so it's important that we have an Early Alert and we can line things up and be prepared to deal with the consequences of a media Inquiry. And often times in the Department when an Early Alert comes in we will prepare lines for the Minister and lines for the Press Office should we need them.

CHAIRPERSON: But we heard -- sorry to interrupt you.

But we heard yesterday that an Early Alert doesn't actually trigger any action by the Department other than potentially informing the Minister; is that right.

A. Yes, yes, so we would --

CHAIRPERSON: So that's as far as it goes. 12:13

A. As part of informing the Minister we would also usually inform them immediately by way of e-mail and then say lines to follow so we would back that up with a bit more information.

CHAIRPERSON: Ye. 12:13

DR. MAXWELL: So that means you would go back to the Trust to get more information to get the lines to follow?

A. Usually that would be -- so with the alert process it's usually a telephone call to the Department from say the 12:13 Executive Director of Nursing to me. I will deal with that, I'll ask questions as I need to and then I will correspond with the top management group and the Minister's office and say I have had an alert, this is what it is, more information to follow. And then as 12:13 the alert comes in, there will be more information on the alert and should we need any more clarifying information we would go back to the Trust.

97 Q. MR. MCEVOY: Okay, thank you. Then on page 39, then, the question posed to you to you is whether the 12:14 Department received regular data or other reports in respect of Muckamore Abbey and ask you then to provide details, if so, including how often they were received and who provided them. One of the subthemes you have

identified is performance management, paragraph 117. You say that before you were in post as Chief Nursing Officer but within the HSC as an Executive Director of Nursing you were aware of the operation of the service delivery unit from 2006 until 2009, patient administration system, pass downloads and BSO data warehouse extracts on activity were received from the BSO on a weekly basis and used to track progress on the achievement of the departmental targets including resettlement from long stay hospitals such as Muckamore. The function was absorbed into the information function of the HSCB when it became established in 2009. 12:14 12:14

So, from 2007 to 2009, correct me if I'm wrong in my understanding of this, but from 2007 to 2009 BSO received information directly from the PAS, from PAS. 12:15

A. Yes.

98 Q. Tracking delivery targets including resettlement?

A. Yes. 12:15

99 Q. Did that stop then, did BSO stop that in 2009?

A. Well, it went to -- it went to the Board when the Board was established roughly in 2009 so it took over the performance management function.

100 Q. I suppose I was trying to gain an understanding of the final sentence where you say the function was absorbed into the information function of the HSCB? 12:15

A. Yes, so I think, again it's both some time ago and before I was in post.

101 Q. Of course?
A. But my understanding of it was that the Board then worked closely with BSO systems to extract the information. It wasn't that -- it was just the format of reporting was changed, it now went through the Board and it took over the responsibility for the reporting.
DR. MAXWELL: So the HSCB was still getting raw data from PAS, it wasn't relying on self reporting from the Trust?
A. No, it had data from PAS on a number of fronts do with -- 12:16
DR. MAXWELL: So whether or not Belfast Trust had reported it, HSCB had the data because it got it from BSO?
A. As I understand it but that's my recollection. 12:16
102 Q. MR. MCEVOY: Thank you. And then on the subtheme of accountability processes on page 40 at paragraph 120 you tell us that:

"Between 2013 and 2014 the Department held meetings with RQIA and PCC to assist with system intelligence gathering." 12:17

You were present at them and found them helpful to receive a system overview from both organisations' perspectives. 12:17

"In addition at the time the Department held mid and end year accountability meetings with each Trust.

While time consuming, they were another useful source of evidence gathering."

You go on to say:

"Over time these processes were undertaken more by the individual organisations sponsor branch with input from professional officers."

Did you and the other chief professional officers stop attending them from 2015 and if so, what was the reason?

A. Well the meetings were effectively stood down and a different arrangement was put in place where the Permanent Secretary would have met with the Chief Executive and sponsor branch essentially.

103 Q. You found it helpful as a Chief Professional Officer to attend them?

A. Well I think, I think both have their Pros and cons because on the pro side obviously, yes, you have the chance to voice concerns to the full Executive Team.

104 Q. Ye?

A. Not just the Executive Director of Nursing and to make sure that the Executive Team is focused on the strategic priorities as I saw them. But they were very long and there was a lot of people at them and it did feel a bit us and them and maybe would you argue that's the purpose of an accountability meeting. So in the second arrangement obviously the need for that big

meeting and that, a lot of that preparation and performance on the day was negated and a more direct conversation, I suppose, between the Permanent Secretary and Chief Executive who are the two accountable officers. And I suppose, there was still the opportunity to feed things in through sponsor branch if any of us felt that was an important thing to do, we weren't at the meetings.

DR. MAXWELL: Can I ask, you said that there were meetings with RQIA and PCC and I think you said you were the sponsor for PCC? 12:19

A. Yeah.

DR. MAXWELL: Were these separately or did you have them, both RQIA and PCC in the same room?

A. These are meetings that I recall Dr. McCormick had with both in the room together, with both sponsor branches. I'm not sure at the time I was the official sponsor for PCC but I became so fairly early on in my tenure as CNO. But they were both in the room together and it was to triangulate their data I suppose. 12:19 12:20

DR. MAXWELL: That's what I was going to ask, were they able to triangulate whether if RQIA had not expressed any concerns but PCC had, would that have triggered a discussion and some actions.

A. Yes. 12:20

105 Q. MR. MCEVOY: On the question of triangulation, moving to page 43, it's page 43, thank you, if you just move on down to paragraph 128 please. So you were asked about triangulation of soft intelligence with data and

how were different data sources integrated, for example, staff shortages and patient outcomes. And you say at 129 you would:

"..triangulate any such information with advice or data from a range of sources, for example advice from departmental professional officers, information from the sponsorship branch for the relevant Trust including sponsorship checklists, minutes from Trust Board meetings and accountability meetings with the department and relevant RQIA reports." 12:21 12:21

Then at 130 overleaf:

"Where necessary I would seek advice and professional judgment from the PHA, the HSCB and the Trust involved. This might include taking sounding from the executive directors of nursing, NIPEC or the RCN." 12:21

Over the course of the Inquiry, the Inquiry has heard that nursing staff at Muckamore raised concerns with the RCN at various points in time and indeed you have taken us to Pat Cullen's, certainly you have discussed Pat Cullen's e-mail to you in 2014 about the staffing issue. Outside of the e-mail did the RCN come to you about any other Muckamore related concerns? 12:21 12:22

DR. MAXWELL: I don't think she was --

A. Just to be clear Pat was the Acting Executive Director of Nursing at the PHA.

106 Q. She did later become --
A. She did later become the Director of the RCN. And what I would say is that the RCN raised, its on record in several forums, their general concerns about the state of nursing workforce which has progressively escalated over years. I am not aware specifically, and particularly before 2017, that it raised concerns directly about learning disability or Muckamore. Learning disability would be a feature of any workforce conversation but not specific to Muckamore. And post 2017, again I am not -- the RCN would have been involved in representing some of their members so our conversations would have been different at that stage. 12:22 12:22
107 Q. Okay.
DR. MAXWELL: But we have heard from at least one member of staff that raised concerns that it wasn't staffing, it was about standards of care at Muckamore. They never raised standards of care concerns with you? 12:23
A. Standards of care? No.
108 Q. MR. MCEVOY: Paragraph 132 then, you say: 12:23

"As Chief Nursing Officer I often received soft intelligence from my professional networks and from clinical visits."

12:23

That includes visits to Muckamore, does it?
A. Yes and, as I said earlier, it was post 2017 but I was in Muckamore I would say on at least four or five occasions.

109 Q. Okay, can you tell us something about those visits?
A. Yes. So I initially went to Cranfield and the PICU wards. On my first visit I was accompanied by my DCNO at the time. I was struck by the environment as a non-learning disability nurse or mental health nurse even and I know that the Inquiry is aware of this, the noise was significant. It's a closed environment as in the doors are locked. Every time the door opened the noise of the door closing was enough for me to go like this [indicating], plus it echoed around the facility. I remember thinking that must be extremely difficult for people who have sensory, heightened sensory or deficits. I observed a number of clients or patients, I know it is a hospital, I know they are technically patients but it was their home, and young adult males, similar age and stature to my own son, and thinking I could be one of the mothers who has a son in Muckamore in another time, and thinking how lucky I was not to be in their position but also to understand. They are walking around expounding energy in what seemed to me to be a meaningless way and that that energy would be far better channelled into some kind of physical activity that would both release endorphins and manage the behavioural difficulties and positive to their mental and physical health and also in their nutrition, their diet, general health and wellbeing. I remember asking why, with all of the green space that's around Muckamore, why it couldn't be used for some sort of physical recreation, accepting that not everybody wants

to go and play football but there could be some enjoyment through some kind of game development outside that would support. They said many years ago they used to do that but because of staffing difficulties et cetera, et cetera, they were no longer able to do it. 12:26
When I went back on a subsequent visit and the Belfast Trust had appointed a Divisional Nurse, I asked the same question of her and she assured me they were reconsidering that and they were considering how they could provide opportunities for the residents to go 12:26
into town, to go shopping, to go to the cinema, et cetera.

I also, I think I said earlier that I was very, what's the word, passionate, if you like, about the added 12:26
contribution that learning disability nursing brings to physical health and I wanted to be assured that was being managed, which is why we brought over people from England who had developed the health outcomes framework to share their work with us in Northern Ireland to see 12:27
if we could progress that. Indeed that was one of the KPI recommendations that came forward from the collaborative, that it would be in the nursing care plans, how many residents had an intervention from a nursing perspective on their physical health. 12:27

On another occasion when I went to Muckamore there was quite a lot of media attention on the use of seclusion and it had been on the Stephen Nolan Show and he wanted

photographs of the seclusion room and he wanted to see. I went to Muckamore to observe for myself the seclusion room and what it looked like so I could speak authentically about the seclusion room and how it was used. I engaged quite a lot that day with the staff and their feelings about the use of seclusion and why it was used, et cetera. 12:27

I was there for a number of Muckamore meetings, we held Muckamore meetings on-site. So I believed I was visible but outside of that I was also working with the learning disability community. When the public became aware of what had happened in 2017, I had two phone calls from nurses in the learning disability community to say to me they were appalled by what had happened and they wanted to assure me that learning disability, that was not what learning disability nursing was about and they would do anything they could to help. People who didn't work in Muckamore, but wanted to be clear about the purpose of learning disability nursing. 12:28 12:28 12:28

CHAIRPERSON: These visits that you made, they were all post the revelations, were they?

A. Yes.

CHAIRPERSON: And it sounds as though what you saw post revelation was not what you expected or shocking, what? 12:28

A. I was surprised. I was very taken with the atmosphere. The heightened sense of noise. The unproductivity of people. I was also, you know, I spoke to some of the clients. I noticed that they had created single

bedroom space at the bottom of the ward that people could retreat to instead of having to use seclusion, which I thought was positive. There was a sensory room which was also very positive. So there were positives and negatives. But I was left with the feeling of there is more that can be done to support, particularly young people who are living in Muckamore.

CHAIRPERSON: Thank you.

110 Q. MR. MCEVOY: So at 133 on the next paragraph you deal with work carried out to examine patient outcomes. You don't recall any specific work carried out while you were in post to examine the impact of staff shortages on patient outcomes. Your intention, you say, when developing a Nursing Assurance Framework in 2019 was to provide the triangulation using a quadruple aim approach of patient experience, 10,000 Voices from the Public Health Agency. Staff experiences, 1,000 Voices In Developing the Nursery and Midwifery Task Group and staff surveys, workforce data and clinical nursing KPI data and that work was suspended because of the pandemic.

Work on patient outcomes, might I suggest to you, is something that maybe could or should have been commissioned by the Department of Health because you had so much awareness of the effective staff shortages, particularly in learning disability, or is it the case that such work might not have made any practical difference to the issues at hand?

A. I think that the nursing -- so I think Muckamore had difficulties, learning disability had difficulties but in reality they were no different from the workforce shortages across nursing.

111 Q. Yes. 12:31

A. So I am looking at kind of a strategic approach and taking actions that can actually help to change the situation. Advocating more undergraduate places, increasing the training budget, providing career frameworks, all that kind of thing. And at the same 12:31 time wanting to very much develop an Assurance Framework which the Nursing and Midwifery Task Group Report, of which I wasn't a member, suggested the recommendation was that it should be on a statutory footing so that it would have prominence, it would be 12:31 adhered to and it would address those early indicators that would inform the Department. So in totality, yes, I was addressing the issues but it takes time and it's slow to deliver.

112 Q. Question 8 then, on page 45, you are asked when the 12:32 Department first became aware of allegations of abuse of patients at Muckamore Abbey and the action taken in response. You say then:

"The Department became aware of allegations of abuse at 12:32 Muckamore Abbey on a number of occasions during the period covered by the Terms of Reference."

You set those out. The question isn't specifically

posed there to you in terms of abuse but I wonder if I can raise this topic with you, one of the other aspects being examined in THE Terms of Reference in addition to abuse is also neglect. And, for example, the types of things that may be considered within that rubric are 12:33
those identified by the RQIA AT junctures, for example, standards of health and hygiene being unsatisfactory, cleaning schedules not adhered to, insufficient bathroom hygiene, unsatisfactory windows, inappropriate coverings to safeguard patients' dignity or privacy, 12:33
ill fitting mattresses on beds, lack of duvet covers and pillows, et cetera. Would you consider those sorts of issues to be co-terminus with neglect or indicators of it?

A. Most of them. I think there are some things like duvet 12:33
covers and pillows, there are reasons in a clinical environment why you may not be able to provide those. With the exception of that, I think most of the things you read, I would add to that, denying people their rights and not providing them with the opportunities to 12:34
have activities and visit outside facilities, I would also in some ways consider to be of greater neglect to their physical health and mental wellbeing.

113 Q. And, I mean, you were obviously getting plenty of information about allegations of instances of abuse but 12:34
do you feel you were getting the same degree of information, you've given very vivid description of your own observations on visiting first hand, but did you feel you were getting the same degree of

information and throughput on the question of neglect in addition to abuse, or what could count as neglect?

A. So again prior to 2017 there was no information coming forward.

114 Q. Yes? 12:34

A. Post 2017, no, I don't believe we got a lot of information. A lot of what I have described is my own interpretation and opinion of what I found and saw and what I understand to be good about nursing practice and not so good. 12:35

115 Q. Thank you. The 2017 abuse allegations then and how you came to be aware of them, and at 141 then you say that around late August 2017 you received a phone call from the Nurse Manager at Muckamore on behalf of the Executive Director of Nursing to go report that a 12:35 healthcare support worker was suspended for historical inappropriate behaviour in around 2012. There was no suggestion at that time that this was other than an isolated incident and you advised that an Early Alert should be submitted and you have exhibited that. The 12:35 Nurse Manager advised you that the appropriate precautions were being taken by the Trust and the Early Alert provided in November '17 detailed this was one of four historical incidents disclosed by a Band 2 swimming pool attendant at the hospital. 12:35

Given that the Director of Nursing in the Trust had informed you in late August '17 about an incident in 2012, are you puzzled or surprised that you weren't

informed about an incident in the middle of August at the same time?

A. Well, yes, I suppose if the incident happened and had been reported in August then I would expect that the process would be followed in terms of alerting me, particularly when it had been raised about -- and I have to say that is my best recollection of what happened. I haven't unfortunately been able to find a record of the conversation so it is my recollection of what happened. But I do remember the call and I do remember the context of the call. So yeah, it seems a little bit out of context but at the time I felt this was a historic issue that had come to rise, it was being dealt with as an isolated incident. 12:36 12:36

CHAIRPERSON: Could I just ask, how, why the call came to you because it wasn't an Early Alert or was it an Early Alert? 12:37

A. Well it was a precursor to the Early Alert. So it was phone call to say to me that a support worker or healthcare support worker was suspended for historical abuse. And I did say to the Nurse Manager I'm not sure why you're telling me this because there is nothing I can do with a healthcare support worker, I can't issue an alert or anything. I said to her make sure you fill out the Early Alert process and send it int o the Department. So it became an Early Alert. 12:37 12:37

CHAIRPERSON: Did you have the understanding that an Early Alert was going to be sent to the Department in any event about this?

A. No, I asked for it.

CHAIRPERSON: You triggered it?

A. Yeah.

CHAIRPERSON: So what was the point of the call?

A. I'm not quite sure. If it had been a registered nurse I can understand why because subsequently they may have asked me to take action on a professional letter, but I don't have those, I don't have any role. I advised the Nurse Manager to do the Early Alert and also to make sure it went through the appropriate safeguarding mechanism. 12:37 12:38

116 Q. MR. MCEVOY: At 143 then you recall then that Gavin Robinson MP contacted Chris Matthews, then Director of Mental Health, Disability and Older People on 30th August 2017 about an allegation of abuse by staff of a current in-patient in Muckamore. The allegation had been brought to his attention by the in-patient's father who was a constituent of Mr. Robinson and Chris Matthews made you aware on the 30th August. 12:38

Would you have expected that the Department would also have advised the Trust and its CEO at the same time? 12:38

A. That we would have advised the Trust?

117 Q. Yes?

A. Well I think, I think Chris needed to find out more information so he contacted the Trust to try and ascertain what actually happened, what did we know, what did we not know, what processes had been followed et cetera, before we would even escalate it to the Trust Chief Executive because I think we needed to 12:39

understand the problem and the issue first.

118 Q. Were you cited on any of those discussions or actions that took place?

A. Well Chris Matthews and my DSCO, Rodney Morton worked very closely on this together. My recollection of events is that following the meeting Chris immediately went to Rodney, they were beside each other on the floor, and as a result of that then they both came to see Sean and I to make us aware of the situation. 12:39

DR. MAXWELL: And who, how would they get that additional information, who would they speak to get more information about this? 12:39

A. I assume that Chris in his policy role would have went to his counterpart in the Directorate of Mental Health and Learning Disability in the Belfast Trust. 12:40

DR. MAXWELL: Okay and did Rodney contact anybody?

A. I'm not sure that he did at that point until we got more information but we then quickly, later in my statement I talk about contacting Brenda Creaney.

DR. MAXWELL: Sorry, say that again. 12:40

A. Later, further down I refer to making contact with Brenda Creaney fairly soon, a day or two later.

119 Q. MR. MCEVOY: Paragraph 146.

A. And I remember that again, that is my recollection of events but I do remember it was a Friday evening, it was late on Friday evening and I rang Brenda to ask her what arrangements had been put in place, following the revelations from the family and Gavin Robinson, to safeguard clients in that environment until we 12:40

established the actual facts of the situation and were clear about what had happened. And as a result of our conversation Brenda had agreed to improve the level of senior cover to be available in the ward 24/7.

120 Q. Okay. If we move to page 49, please, and to paragraph 155 at the bottom. Back to the topic of MDAG which we discussed in a bit of detail earlier on but here you say that one of the intentions behind it was to provide support to the Trust staff team at Muckamore and provide a mechanism for escalating any issues they may encounter. 12:41 12:41

"The group also overseas through the action plan the actions arising from the A Way to Go Report and the Leadership and Governance Review report." 12:42

The first MDAG meeting took place as we discussed in August 2019. You say at 156 then that a letter was then sent jointly from yourself and from the Chief Social Worker in May '19 in relation to the findings of an RQIA inspection, especially around staffing concerns. 12:42

"The letter requested that the Trust's priority should be to stabilise current position to include contingency planning should Muckamore be unable to sustain safe and effective services." 12:42

One of the other topics that are examined by MDAG and

one of the things I think you say gave the Department a direct line of sight on progress was with the resettlement programme as well. Had you a line of sight on the resettlement programme before 2019 on the same visibility or degree of visibility of it? 12:43

A. I didn't personally because it wasn't my policy area of responsibility. I mean I was aware that there was a resettlement programme and I was aware it was slower but I wasn't close enough or involved in it as the Chief Nurse. I really became more involved in the 12:43 resettlement programme as my role as co-Chair of MDAG.

121 Q. Okay. At paragraph 158 then, here you talk about writing to the Trust on 24th February 2020 and again on 15th June 2020 because you hadn't received a response to the Trust to arrange an urgent meeting with the 12:43 police, the Trust, the Department's Director of Workforce Policy and yourself to address issues relating to the handling of cases of staff who worked in Muckamore and the issuing of professional alert letters and you have exhibited those letters in your 12:44 statement. Did that meeting ever take place?

A. No.

122 Q. Can you help us understand why?

A. Ye. So the context of this is, there was a growing number of registered nurses who were suspended and the 12:44 alerts policy at the time, and it was the Workforce Policy Directorate's policy which I implemented as the CNO was to issue an alert letter to the system as a safeguard during the period from referral to the NMC

until the NMC took action. At this time there were, and there still is, a backlog of fitness to practise cases at the NMC so there sometimes could be a significant time delay. So as another assurance mechanism I suppose the letter was to ask employers to check the NMC register or to contact the director in whatever organisation, in this case the Belfast Trust, before they would employ that member of staff so they could have a conversation about the referral and what stage it was at, et cetera. But there was a growing number of these, there was no action happening at the NMC because they were unable to act which would impede the police investigation. At the same time there had been a number of issues identified with the professional alerts policy, not least the Commissioner for Human Rights had been in contact with me to say it was a breach of people's human rights to have this policy in place as the nurse had no right of reply really. It wasn't making accusations, it was simply stating there was an investigation and a referral to the NMC, significant enough to be referred to the NMC. There were a number of other issues with the alert policy. I had spoken to departmental solicitors in relation to that. They had advised there were some issues with the policy and actually recommended the policy was stood down. The Department was considering that at the time. I was very reluctant to do it in the context of not just Muckamore but in particular the consequences of Muckamore. But I needed more

12:45 12:45 12:45 12:46 12:46

information so in making a decision to issue the alert I needed some information on which to base that decision. I was unable to get that information because the police, rightly so, were trying to manage their investigation and didn't want to jeopardise that in any way. So I had asked the Trust could I meet with the police to get a process aligned that would allow me to do the alert letters and also protect the integrity of their organisation. That meeting never happened. The police did speak to the Trust and the Trust did put an alternative arrangement in place for me to elicit slightly more information but, to be honest, it was never satisfactory and I don't believe that in the context of the policy that we were working in that it was going to ever be satisfactory, so it didn't happen. 12:46 12:46 12:47

CHAIRPERSON: I'm slightly lost, what was the alternative arrangement that the Trust put in place?

A. They agreed at their joint meetings with the police what information could be shared with me in order to inform the alert process. But -- 12:47

CHAIRPERSON: But in the meantime their safeguarding process was obviously continuing.

A. Oh, yes, their safeguarding processes and disciplinary processes, but it was the fact that nurses were being suspended from duty for a significant period of time, one of which we know worked in another environment, and there was no process to kind of prevent that from happening in any way without the alert letter. Because it's not recorded on the NMC's until they have taken 12:47

action that they have taken action.

CHAIRPERSON: And was the Department in touch with the NMC separately or not?

A. Yes, we had regular updates with the NMC, we went through every case file and asked for an update on them, most of which was the status quo, so every six months I would review the alert and it just rolled over. 12:48

CHAIRPERSON: It was rolled over.

A. Yes. 12:48

123 Q. MR. MCEVOY: Paragraph 161 then at the top of page 51 talks about the Way to Go Report after which then a decision was taken by the Department, further analysis of the leadership and governance arrangements in place at the Trust was required. You take us through the background to that. From your recollection and from your perspective as the CNO at the time, why did the Department feel that a Leadership and Governance Review was needed after the Way to Go Report? 12:48

A. Because I think it was clear, certainly clear to me, the Way to Go Report, although it did address some of the issues there were gaps in both the leadership and governance elements of the report that needed more details, understanding and explanation. Given the responses that wed with the Trust, the issues we had had with dealing with the original alert letter and the findings of the Way to Go. 12:49

124 Q. Moving then to page 53 and to paragraph 174, here you pick up on the theme of ward closures and staff

reductions. Looking at the second sentence there, the main issue -- you refer us I should say initially to Mr. McGookin's addendum statement of 26th May setting out the reasons for an under spend on staffing. You say:

"The main issue was the retraction of wards and cohorting of patients in line with resettlement which had an impact on staffing. It appears in response that Belfast had a reduced spend on staffing due to retraction. There were also issues with staff recruitment as staff became aware that there would eventually be less services at Muckamore and possibly associated employment risks."

So it is a short paragraph but sets out fairly succinctly what the essence of the staffing problem was. As Chief Nursing Officer would you have been advised about that or asked for your advice about the appropriate approach going forward?

A. No. No, as I say, before the revelations in Muckamore I had really very little direct communication or involvement about issues that affected Muckamore and I highlighted earlier the work we did on the workforce review which indicated the Belfast Trust were spending more on staff than they were funded for. So I think while the intention was to retract and reduce the funding, it would also be fairly common knowledge that less patients doesn't actually mean less staff and

smaller units actually have the same overhead costs and actually are slightly less efficient than bigger units of staff. So you actually, in some cases, need more staff rather than less staff to manage smaller units with more complex patients. I think that it's pretty true to say that the patients or the clients in Muckamore that remained were of the most complex.

125 Q. Okay, can we look at page 70 please?

"Attention is directed to the Equal Lives. The Bamford Report in 2005 recommended improved community services and stated all people with a learning disability living in a hospital should be relocated to the community by June 11. Transforming Your Care (2012) recommended the resettlement of all people with learning disability from hospital to community living options with appropriate support by March 2015. What did the Department do to promote that pledge and what were the barriers to achieving it?"

Again you refer us to Mr. McGookin's first statement but substantively at 238 you say:

"Whilst I was not directly involved in resettlement policy or implementation of the policy, from both my role as Executive Director of Nursing and commencement of my role as CNO in 2013 during a comprehensive spending review period I am aware that there have been ongoing funding pressures in a CSR period 2011 to 2015.

The drive to increase resettlements meant the misalignment of budgets. This meant DHSSPS and HSC could not commit to such schemes and DSD and the NIHE could not invest the capital monies to build them which significantly delayed resettlement schemes." 12:53

Do you know whether the Department of Health was able to bring pressure to bear on the treasury to make an exceptional funding provision for that purpose?

A. This is an historic position and when I was the Executive Director of Nursing in the South Eastern Trust I had responsibility for Community, Primary and Older Peoples' services so we did redevelop, we did essentially close a number of older people's homes, we went from 11 to 4 and in place of that we established community supported living facilities which were co-funded by DSD. So I am aware of the difficulties in relation to that co-funded model and I am aware it wasn't easy and it was severely delayed and hampered by the CSR periods, 2009-12 and 2012-15. I am aware that more latterly the Department of Health and DSD got together and agreed a funding stream that was transferred to the Department of Health to ease with that problem, but not in relation to treasury. 12:53 12:53 12:54 12:54

126 Q. I'm not sure if you can help us based on your current, new role in England but do you know how funding in England for learning disability resettlement per head of the patient population compares to that in Northern Ireland?

A. Not off the top of my head, I don't, sorry.

127 Q. There are a number of matters arising from your exhibits, I would just like your thoughts on. If we could move to 543, please. This is part of the business case for pay uplift in 2019 for staff at Muckamore and indicates consideration had been given to moving all the patients at Muckamore to alternative placements. Can you help us understand where that was discussed and whether the families were involved in that discussion? 12:55

A. So the discussion would have mainly taken place in the Department. I think that we were hearing information at this point. It is fair to say that I had asked for and received consent for Francis Rice, a colleague, a senior nurse and previous Chief Executive of the Trust, to work alongside the staff at Muckamore to understand some of the issues at ward and department level and to provide me with further reassurance really around the safe delivery of care. And Francis highlighted to me his concerns about in the short-term the staffing situation at Muckamore. Collectively within the Department we were trying to figure out how could we get more support. We had asked the Trusts if they could free up their learning disability staff to go and provide extra support in Muckamore, and that, for obvious reasons, wasn't very doable, I suppose, in terms of an ask. And in order to incentivise that we thought let's look to see what we could do. When we looked at the Agenda for Change terms and conditions

with our workforce policy colleagues in the Department there was provision and we would have discussed this with the Belfast Trust HR Department as well. There was provision for an enhanced payment at various rates and we agreed that it needed to be significant enough, 12:56
10% would normally be -- so if you are temporarily promoted in the health service would you get a 10% kind of increase in salary for temporary promotion. We agreed it needed to be more than that in order to attract people and we agreed it needed to be for 12:57
everybody, that we couldn't differentiate between staff coming from other organisations in the Belfast Trust. And so we sent a submission to the Permanent Secretary who agreed to the enhancement of pay for a period of time which had some success but, to be honest, it was 12:57
limited success.

128 Q. And we know --

A. Sorry, you asked me about families, they weren't involved in that decision but we did discuss it at MDAG. 12:57

129 Q. MDAG was the means for conveying discussion about or information about the proposals.

A. Yes.

130 Q. And we know from this document and at 596 as well please, if we bring that up. This is the e-mail we 12:57
looked at a bit earlier, but we know that all options were considered from the status quo to the possibility, I think, that business case talks about potentially having to transfer patients to Great Britain. Does

that mean that in reality if the hospital were to have been closed, particularly in the light of the Way to Go Report, say for example, that hypothetical example, that would have meant that a realistic possibility would simply have involved the transfer of patients to Great Britain, was that a realistic --

A. It was an option that we considered and there is provision for that in the commissioning process. It's by special case and it would be high cost cases where we can't provide the care that's needed for particular individuals who might have to go to Great Britain. Given the numbers that we had in Muckamore at the time I don't think we would have found that number of places to be honest in England specifically for learning disability, given that England were also going through the same process of providing care closer to home and in communities. So I'm not sure, but it would have -- I imagine that had push come to shove on that we would have prioritised those of the most complex patients and whatever number of people that could have been accommodated in Great Britain, with families' input and agreement.

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CHAIRPERSON: I was going to say, I'm sorry, Dr. Maxwell, you would have received significant push back, wouldn't you, from the relatives?

12:59

A. I would imagine so.

CHAIRPERSON: Having their patients moved to England?

A. Yes.

DR. MAXWELL: My question was, was moving 60 patients

to England the only feasible option, however undesirable or unaffordable, for closing Muckamore at that point in time?

A. Well I think when we asked for the contingency plans, and we did ask on a number of occasions for contingency plans, we didn't feel that they had explored all options. I think that we would have potentially had to find alternative accommodation in Northern Ireland, either through mental health units or through other facilities in other Trusts. But for a group of patients of 60, I think it would have needed more than one approach. We would have needed a number of options and I'm not sure that we explored all of those. 12:59 13:00

DR. MAXWELL: So I think Dr. Flynn was surprised that her recommendation about closing the hospital didn't happen immediately but you're saying these, the options to do that were not desirable and hard to do and possibly not affordable? 13:00

A. But also for the individuals.

DR. MAXWELL: Yeah, no -- 13:00

A. For those people, as I said earlier Muckamore was their home, unless you are providing a better option.

DR. MAXWELL: No, I understand, it's just that was that recommendation feasible and it sounds like you're saying it wasn't on a number of levels to immediately close the hospital? 13:00

A. Well, primarily why I wrote in 2018 to the Permanent Secretary to say in my professional opinion this isn't going to happen and it's 2024 and, while the numbers

have reduced, Muckamore is still -- and my concern about that was both for the quality of care that patients were receiving but also the pressure it was putting on the nursing team in Muckamore being told that the unit was closing, patients were being resettled, but yet they had a complex cohort of patients that they were still being asked to care for.

131 Q. MR. MCEVOY: Can we look then at page 642 please? Bring it on down please, thank you. So you probably recognise this letter, the 20th October '17. This is your letter to Mr. Dillon. The contents of it are familiar to the Inquiry and to Core Participants and I suppose, if I can put it this way, it constitutes a very serious and unambiguous ticking off, to put it mildly. But, I suppose, the Inquiry would be keen to know what teeth you would have had in the circumstances of this letter, what could you have done to give what the letter says real meaning? 13:01 13:01 13:02

A. I think the first thing to say is that it's probably, as Chief Professional Officer, I don't normally write to Chief Executives, I write to my equivalent, so this was exceptional. I think that we were clearly -- well I personally was shocked about the revelations in Muckamore and found it hard to comprehend. But then when I realised that it was actually the situation, being quite angry about the situation and how our system had let people down and obviously nursing had a role to play in that. And while the Permanent Secretary did apologise to families for what they had 13:02 13:02

experienced, I would want to reiterate absolutely my apology, as the most senior nurse dealing with the situation, for the role that nursing had in causing harm and abuse. It is what shocked me most, I suppose, the profession that I hold in very high regard and I have spoken about for many years in leadership roles about the privilege of being a nurse and the privilege of being with vulnerable people, either sick or complex behaviours or needing support, and to be invited into somebody's life in the way in which we are as nurses, is an absolute privilege. And to think that that privilege has been abused has made me reflect on do we rightly deserve the title as the most trusted profession, one that we've earned around the globe for many years and has my role of senior leader been for nothing, if you like, in terms of espousing this very high quality of care, supporting staff to do the best that they can do. It is in that context that we are writing this letter about our unhappiness about the situation and the response and the gravity of the situation and the response we're getting back from the Trust who feel at this stage a little bit uncoordinated and not aligned in terms of their information and their response. So it would be a very unusual step for us to take. 13:03 13:03 13:04 13:04 13:04

Our line of making things happen is through the Permanent Secretary to the Chief Executive and the Minister which we didn't have at that time, to the

Chair. So it's through the Permanent Secretary to the Chief Executive so we are reporting back to him on the actions taken. And, as I recall, the Permanent Secretary followed up with a letter of his own to the Trust.

DR. MAXWELL: Was your concern that the Trust was not coordinating its responses, it was a bit, you know, somebody over here and somebody over here, or was your concern that they didn't seem to understand the seriousness of the issue? 13:05

A. Both I think.

DR. MAXWELL: Both?

A. I think what they were relaying was this is an isolated case, you know, we'll sort this out. But the uncoordination of, I suppose, or even alignment to the processes that they should have followed around the Early Alert and then the wrong dates and the delay and the response from the Trust to our letter, all of that made me think, No.1 they don't understand the gravity of the problem and No.2, they're not -- there is nobody centrally controlling this and making sure that what they are doing is actually aligned to what they should be doing. 13:05 13:06

DR. MAXWELL: So did you feel you were getting false reassurance that they were saying it's a single incident and we've sorted it? 13:06

A. I wouldn't go as far as to say it was false, I think the Trust acted in good faith. I think they told us what they knew but --

DR. MAXWELL: But they felt it had been dealt with?

A. My sense was they weren't deep enough in the situation to know.

132 Q. MR. MCEVOY: Finally Professor, could we look at, you made reference to him in passing a few moments ago, could we look at a report that you commissioned from Francis Rice. It starts I think or the material part of it starts at page 787, please. While it's coming up on screen, and it is now, can you tell us a little bit about who Francis Rice is? 13:06 13:07

A. Yes. Francis is, he was a colleague of mine as an Executive Director of Nursing. He was the Executive Director of Nursing for the Southern Trust. He later became the Chief Executive of the Southern Trust and subsequently retired. His background, he is a mental health nurse and he has run Mental Health and Learning Disability Services for a considerable period of time. He would be highly credible in the system, well thought of. To be honest, I couldn't think of a better person to assist me with providing the assurances that were needed in Muckamore. And as Brenda Creaney referred to in her evidence, I contacted Brenda to kind of, if you like, sound her out on how she would feel about Francis going into Muckamore and she was totally open to the idea and credit to her for that. And Francis was welcomed by the Trust, by the staff in Muckamore and certainly did provide us with the level of assurance that I was looking for. 13:07 13:07 13:07

133 Q. Okay. And we can see there then at sub-paragraph J of

his report, he has isolated a number of bullet points wherein his view, there needs to be focus or renewed focus on staff appraisal, supervision, reflective practice, the development of Key Performance Indicators, which you have talked about during your evidence, for nursing, the development of a professional nursing forum, the development of nursing practice, the implementation of research and development to inform clinical practice. And he has also then made the point professional training and development plans require updating. 13:08 13:08

If we could move to 791 in the same document hopefully. Just go to the bottom of the page please. Yes, so he has enumerated, or lettered anyway, a number of actions A to K, but we'll touch on his conclusion, or his concluding remark first of all. 13:09

"I am aware that some of these issues are being taken forward in the Muckamore Abbey Hospital action plan, which is reported at the Department of Health MDAG. The Trust in conjunction with the appropriate stakeholders may wish to consider taking forward those issues that are not currently in the MDAG or the action plan in this report." 13:09 13:09

If you could scroll up please. You can see there, maybe the next page, 790. So (B) if we can look at a couple of these:

"The development of a comprehensive needs assessment of our learning disability population in Northern Ireland to inform the development of a regional strategic approach to an integrated hospital and community service model, clinical practice, standards of service provision and future accommodation needs."

In your view I suppose the same question is going to follow in relation to each of those I have identified, but do you feel that that work is moving in the right direction in relation to that? 13:09 13:10

A. Well I understand the review of learning disability, the model essentially, which should be based on a population health approach is still under development. So yes, I think that it's, I haven't seen it so I can't comment on the content of it, but it's in development. As one of the recommendations in the Nursing Midwifery Task Group Report was to develop more upstream public health nursing and a model for public health nursing which hasn't been taken forward, it is one of the outstanding recommendations and I think that would assist public health nursing being involved in the learning disability population health approach would be an added benefit. 13:10 13:10 13:11

134 Q. And as for (D) then, the provision, I suspect we might be able to predict what your answer might be to this, but:

"The provision of suitable accommodation to facilitate the complete resettlement of the complex patients who are currently cared for in the Muckamore Abbey Hospital."

13:11

As we sit here now what is your view on work to achieve that?

A. Well I think, I noted the Mongan and Sutherland Report that sets out a number of recommendations in that regard. I note that there is a reduction in the number of people still living at Muckamore and I think it requires a reassessment of the needs of those people in Muckamore and the skills that are available or not available, I suggest not available, and how we then provide those skills and the facilities in a joined up coordinated way with a costed implementation plan. I still think, and I don't have the detail on this, but based on the history of Muckamore, I think it's unlikely to meet the needs, the community services are unlikely to meet the needs of that last cohort of people any time --

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CHAIRPERSON: Unlikely to?

A. Unlikely to. What I mean is I think the current service provision in the community remains unlikely to meet the needs of the last cohort of people in Muckamore without some kind of injection of momentum, workforce plan, financial package and implementation plan to get the accommodation agreed.

13:12

CHAIRPERSON: And is that largely because the

complexity --

A. I think it is due, I think they are genuinely very complex people. I think they are, they will be high cost packages in the community. I think the financial situation in Northern Ireland is as bad as it is in the rest of the UK and further afield and negotiating that financial package will be for the Executive and the Minister of Health to take forward. But without that investment it is hard to see how those facilities and services can be provided. 13:13

DR. MAXWELL: But even if the money is found, are there the people to do -- the staff?

A. Well that's, it's in tandem, it has to be in tandem, we have to do the workforce plan, agree it is what we need and find a way to train those people so when the accommodation and money is aligned we can move. 13:13

135 Q. MR. MCEVOY: Okay. And on (F) then, he recommended or identified:

"The establishment of a modern multidisciplinary community learning disability care and treatment model for learning disability patients to include forensic, home treatment, crisis response, assertive in and outreach multidisciplinary teams with clear lines of professional accountability." 13:13 13:14

How about progress towards that objective?

A. I think that's all part and parcel of the model. So I think you need the model before you can decide on the

multidisciplinary team structure and the professional accountability. I would note when the Nursing Officer for Learning Disability joined me in 2019, her first task was to develop a new model for learning disability nursing in preparation for this so that we would have the nursing component of that ready. And again you would have to check with the Department about where that is at the moment, a draft plan was ready at the time that I was leaving.

136 Q. Okay. And finally, and perhaps certainly most pressingly or acutely for perhaps many of the families at patients at Muckamore, at (K) he talks about: 13:14

"The further development and review of the multidisciplinary assessment and care planning in Muckamore to ensure the holistic needs of patients are being identified and appropriate therapeutic interventions are being carried out to ensure an optimum level of patient functioning and independence and address any patient trauma issues identified as a result of the alleged abuse." 13:14 13:15

So clear there, on any reading, that that's something that would require urgent attention. You might agree or disagree? 13:15

A. Yeah. And the Trust have taken steps to put in Positive Behaviour Support, as I did, and the Public Health Agency did. Caring Cultures is another piece. The multidisciplinary assessment and care planning

needs investment from the Belfast Trust. As I said in my statement, Muckamore Abbey is primarily run by nursing, it doesn't have the support of the multidisciplinary team and it badly needs that. And I guess its difficult for them because their focus is on resettlement and, you know, closing Muckamore. So that's why I say a plan needs to be developed now for that last cohort. Timeline, understanding how long it is going to be to be, what it's going to cost and then the consideration of how do we keep things going in the meantime and what support is needed for that group of staff that are going to remain in Muckamore until such time as they can be moved out. 13:15 13:16

137 Q. Specifically around trauma and the identification and assessment of trauma issues, from your professional perspective is there a way of achieving that that families and public can have confidence in with a measure of independence and so forth so that those issues are dealt with objectively and independently? 13:16

A. Well I think there are a range of psychological supports that could be put in place for both clients and their families to deal with the issues and the legacy of the trauma and the hurt that has been caused. And the Trust have a psychological department who should be able to lead and develop that. 13:16 13:17

138 Q. And would there be any justification for stepping outside the Department do you think in your -- or stepping outside the Trust and the Department in Northern Ireland perhaps even for that as a solution?

A. Well I think that we have the expertise in Northern Ireland through psychological, clinical psychology, mental health practitioners, learning disability many of which are trained in a number of psychological therapies and behaviours. And again, organising that, seeing what's available and if there is a deficit then to look elsewhere for that, but there is certainly a cohort of staff and skills in Northern Ireland that could deliver on that. 13:17

139 Q. Professor, I don't have any further questions, thank you very much, thank you. 13:17

CHAIRPERSON: Can I thank you very much for your, if I may say so, careful and considered and full responses to the many questions that you've been asked. So thank you very much for your attendance this morning. 13:18

I gather that Professor McBride can be here a bit earlier than was expected, so we'll start him at 2.30. Okay. So also I should say if anybody is watching on-line, please be aware it will be starting not as advertised at 3.00 but at 2.30. Thank you. 13:18

LUNCHEON ADJOURNMENT.

THE INQUIRY RESUMED AFTER THE LUNCH ADJOURNMENT AS FOLLOWS: 14:34

CHAIRPERSON: Thank you. I think we're ready for the witness to be sworn.

PROFESSOR SIR MICHAEL MCBRIDE HAVING BEEN SWORN WAS EXAMINED BY MR. MCEVOY AS FOLLOWS:

CHAIRPERSON: Professor McBride, thank you very much for coming to assist the Inquiry, we've met very briefly downstairs and you probably watched some of the proceedings before, you know the format. 14:37

A. I have, yes.

CHAIRPERSON: You've also been, I think, furnished late last week with a list of issues that you're likely to be asked to speak about. 14:37

A. Yes.

CHAIRPERSON: Okay, thank you very much, Mr. McEvoy.

140 Q. MR. MCEVOY: Thank you Chair, thank you, Panel. Professor, we met a few moments ago, as you know my name is Mark McEvoy and I am one of the Inquiry counsel team. As the Chair has indicated you were furnished with a list of issues but the first order of business I suppose is just to ask you to identify your statement of the 28th of June to the Inquiry and whether you want to adopt that statement as the basis of your evidence to the Inquiry? 14:37

A. Yes, I'm happy to adopt that statement, yes.

141 Q. Thank you, if we can just unpack these issues one by one. They thematically run throughout what is a very comprehensive witness statement and the first of those touches on the challenges and the feasibility of discharging both roles of Chief Medical Officer and 14:38

Acting Chief Executive of the Belfast Trust at the same time. You have been Chief Medical Officer since September 2006 and then, as the Inquiry has heard, for a period between December '14 and February '17 you were Acting Chief Executive of the Trust. 14:38

It might be helpful if you were able to give us a little bit of background about the circumstances in which you were appointed to the Acting role?

A. Yes, very happy do that. I think as you've heard from previous witnesses and certainly from the former Chair of the Belfast Trust earlier this week, Peter McNaney, it was a particularly challenging time for the Belfast Trust at that stage. It was an organisation which in 2012 or thereabouts had just come out of special measures as a consequence of concerns the Department had in relation to its performance across a wide range of areas. 14:38 14:39

There were also, as Mr. McNaney indicated, concerns that had been raised by the professional medical staff within the organisation about the safety of Emergency Department services. There were concerns around the performance in relation to the particular targets around elective care. And there were also concerns about the escalation of issues and matters which the Department had significant concerns about. Now, at that time also the former Chair had recently retired. The Medical Director had retired and there was a new 14:39 14:39

Chair in place. So I think it was, whilst an unusual arrangement, I believe the view of the Minister at the time and his subsequent successor was that there was a need for a stabilisation in what was the largest Trust in Northern Ireland and actually a Trust that provided, in addition to local services to the population in Belfast, provided almost all of the regional services. So I believe it was felt that, given my experience within health and social care, my leadership experience both as a medical director, previously, and also as Chief Medical Officer as you've indicated from 2006, that I could provide that stability for an interim period. 14:40 14:40

Now it was viewed as being for an interim period. There also had been the circumstances where the post been advertised, as I recall, on two occasions, and there had been no appointments made. I'm happy to go on and elaborate but it was certainly a position I was very hesitant to take on in the first instance for a number of reasons. 14:41 14:41

142 Q. Okay, maybe we'll get a chance to explore those. Two busy portfolios, presumably, at the same time. Did you face challenges in managing the two roles simultaneously? 14:41

A. Well, I think that I at first did not believe that it was possible to adequately or fully fulfil the responsibilities of what are both extremely challenging roles. I suppose I had the advantage that I had been

in the role as Chief Medical Officer for quite a considerable number of years. I was supported in that role by two extremely experienced Deputy Chief Medical Officers, one of whom had previously held the same role in an interim capacity prior to my appointment. I did have discussions with the Perm Sec and the then Minister and I was persuaded that additional support arrangements would be put in place in terms of both my role within the Department, and also additional support arrangements within any potential role within the Trust and that appropriate firewalls would be put in place, obviously matters that I would recuse myself from providing advice on or within the Department as would be appropriate. 14:42 14:42

As I recall, although I haven't yet been able to retrieve the document, that was written down in a format of those areas of responsibility on which I would no longer provide advice within the Department, my deputies would provide that advice. And I also had informal conversations with my CMO colleagues across the UK that if there was a potential conflict of interest of a significant level where advice was required at the level of Chief Medical Officer, that one of them would act as a sounding board to support my DCMO colleagues. 14:43 14:43

So I think, you know, there was considerable effort given to managing those conflicts. I did, you know,

certainly it would not have been appropriate for me to sit on the top management group which was, I suppose, the senior leadership group within the Department during that period so I recused myself from membership of that group. Similarly I recused myself from any responsibilities with respect to sponsorship of the Regulation Quality Improvement Authority because obviously that was an organisation which was inspecting the Belfast Trust and other Trusts and regulated services. And, as I say, I also recused myself from certain aspects of Trust business and would have delegated as appropriate those to the Deputy Chief Executive who I appointed to address any potential matters of conflict within the Trust. 14:43 14:44

143 Q. It's clear that you anticipated potential conflicts and took measures then to anticipate them should they have crystalised. Were there ever any situations where you found yourself in a situation of conflict which was unavoidable? 14:44

A. No. I mean I think that because -- I mean we had, myself, my colleagues within the Department and colleagues within the Trust had put a considerable amount of time and effort into trying to map out where those potential conflicts would arise, because those potential conflicts were both real and material and also perceived, and I think we had a robust mechanism for managing those. You know, and I don't mean to be flippant, but at no stage did I write myself a letter as Chief Medical Officer to myself as Chief Executive, 14:44 14:45

I mean I was very clear to make that clear demarcation between the respective roles and responsibility. I had separate e-mail accounts, I had separate mobile phones. You know, I was very clear in my own head where the boundaries where and others were very clear where the boundaries were and respected those. And I don't recall at any stage any material conflict. I have to say the situation, however, was far from ideal. Even though there were firewalls put in place and it was only intended that it would be for a short period. 14:45 14:46

144 Q. And setting aside questions of conflict for a moment, were there ever situations or did you ever indeed have the impression that doing one role hindered your ability to do the other?

A. Not that I recall, although, you know, as I have said in my statement, the professional and personal demands at that time were excessive. And, you know, there were not enough hours in the day, days in the week. But I have to say I believed it was a privilege to serve as Chief Medical Officer. It was also a privilege at the time, although extremely demanding, to serve the population of Northern Ireland and indeed the greater Belfast population as Chief Executive of the Belfast Trust. And I fulfilled both responsibilities to the best of my ability, although recognising there are only so many hours in the day and days in the week. 14:46 14:46 14:47

145 Q. Turning then to your recollection of the specific context of the work of the Trust Board. I'd like to ask you about the issue of whether governance

structures within the Trust and Trust Board were adequate to detect potential risks to patients and I suppose for the purposes of this Inquiry specifically in Muckamore. Within your statement at paragraph 313, I'll just give you the quote:

"The robustness of governance arrangements were dependents on matters that required Muckamore staff, clinical and managerial including at director level, to escalate concerns and to ensure appropriate intervention and action."

CHAIRPERSON: Can you just give us a page number each time just so that I can find it. It's 129.

MR. MCEVOY: It's 128 in fact. 14:48

CHAIRPERSON: 128, 129.

146 Q. MR. MCEVOY: AT the top of 129 then is what I have just quoted from. And I suppose the proposition might be, good governance requires the Board to apply downward curiosity? 14:48

A. Absolutely.

147 Q. To seek assurance for itself rather than simply wait passively for matters to be escalated; would you agree with that general proposition?

A. Absolutely wholeheartedly. I think my recollection of 14:48 the Assurance Committee, of which I attended, and indeed the Assurance Group was that there was no lack of scrutiny, that any perception that it relied upon passive upward assurance without actually oversight and

scrutiny of the information that was provided, both in terms of the quality, the depth of the information, but actually identifying gaps in that information, it would be incorrect. My recollection of the Assurance Committee meetings, and I know you have minutes of those and I have exhibited some of those, was there was robust, and appropriately robust, challenge of those of us who were in attendance. Because again that downward scrutiny by non-executive directors is absolutely a crucial part of the governance of the organisation. And indeed at that time my role as Chief Executive and Accounting Officer was to ensure that the Trust Board and the non-executive directors had at their disposal adequate information, appropriately detailed information so that they could execute and exercise their function in providing that challenge.

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So, you know, there were, as I recall, and I can't think of specific examples but there were robust exchanges and challenges that occurred at the Assurance Committee. And similarly I Chaired the Assurance Group which was there to assist and to advise the Assurance Committee. But equally I think it was very clear and it is exhibit 84 if you look at the Terms of Reference of the Assurance Group, if you look at the role of the Assurance Group, if you look at the authority which is described of the Assurance Group to basically have meetings in private, to exclude those who are not members, to bring in external expert input independent as they wish; I think that the role of the Assurance

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Committee and the importance of that scrutiny function was fully recognised and appreciated.

148 Q. Okay, we will look at that in a bit more detail maybe in a moment. But would it be your evidence then to the Inquiry that you feel the Trust Board applied that downward curiosity in respect of Muckamore do you feel? 14:51

A. As I said in my statement I have considered anxiously whether or not I was too accepting of the arrangements which were then in place given subsequent events. I mean obviously the governance of any organisation, irrespective of the scale of that organisation, the governance arrangements have to be appropriate and have to be effective. Scale, complexity are not excuses for having appropriate governance and oversight arrangements in place or appropriate downward challenge and ensuring that there was robust assurance in relation to the services provided, particularly around the quality and safety of those services, particularly in relation to the performance management of those services and the systems, both internal control within an organisation and the external assurances that the organisation should be seeking from regulators. But also triangulating all of that information from complaints, from Serious Adverse Incidents, from staff surveys and everything else. Now, I do recall, and it is quite a considerable time ago, but I do recall that we did have very detailed reports coming through both to the Executive Team, to the Assurance Group and on to the Assurance Committee. However, it is absolutely the 14:51 14:51 14:52 14:52

fact that they did not detect the abuse and the systematic failings that were clearly occurring within Muckamore Abbey Hospital, I mean, and that I deeply regret. I had no reason for concern at that stage that there was any shortcomings in those arrangements. And whether it was the arrangements themselves that were in place were inadequate, were not appropriately used or utilised or both, ultimately obviously the Inquiry will wish to consider. But they singularly failed to detect, to identify, to detect and escalate the abuse that was going on and that was a fundamental failure. 14:53 14:53

149 Q. You've just quoted in fact in terms of your reflections at paragraph 315 of your statement. At page 130 and 316, paragraph 316, sorry, thank you. You made reference as well to the Leadership and Governance Review, we'll come on to look at it shortly. But you have noted from its findings the reference to loyalties of people working at the hospital as reflected in the previous report, the A Way to Go Report. You have identified and isolated the quote, if I could pick up on the second sentence: 14:54 14:54

"The Review Team considers that the problem was not in governance processes but rather in people's response to working in a closed environment with its own set of norms and values and with loyalty to the group rather than the patients or their employing Trust." 14:54

Then you observe in the next paragraph:

"Whilst ultimately a matter for this Inquiry this may be an important point with significant wider implications with respect to systems of assurances in certain environments."

You may feel that that quote and observation speaks for itself but is there anything else you would want to add to it?

A. I suppose I did, I considered both the Learning and Governance Report and the independent review of the resettlement programme in great detail and I think those are very balanced reports. They are very thoughtful reports. I think that I selected that quote because it was perhaps one of the most troubling quotes to me from the point of view of the systems and processes that we put in place to assure ourselves of the safety of the care that we provide and the quality of care that we provide. And, you know, as I reflected on that one can think of many, many other failings that there have been, not just in health and social care but across other systems that, and again this is a matter for the Inquiry and something which I have also indicated in my statement, that whether, and I use the word advisedly, normal, because I think we'll probably come back to that in terms of what I mean by normal, governance arrangements of any nature would be sufficient to detect such abhorrent and reprehensible behaviour in a facility with extremely vulnerable

patients, many of whom are unable to voice their concerns or the harm that's caused to them and those perpetrating that abuse are determined to conceal the abuse itself.

That, I have to say, is something which I find deeply troubling and I am not certain that I have an answer to that but it is something that I have earnestly reflected upon.

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CHAIRPERSON: If you have been watching the Inquiry you will have seen that one of the things that the Panel I think have struggled with is the suggestion that governance systems were satisfactory but failed to detect the abuse. Are you suggesting that no governance system, no matter how good, could have detected this abuse?

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A. That's a difficult question to answer. I think that as Chief Medical Officer and as a former a Chief Executive in the system I have to believe in the systems, the robustness of the systems we put in place to ensure ourselves of the quality and safety of care that we provide. I think that it would be misplaced for us ever to assume that those systems are perfect, that they are not in need of continuous review, and that we continually update those and revise those as we identify issues where there have been shortcomings or failing. As I've said in my statement, one cannot conclude that the systems of governance and oversight were sufficient when such abuse took place, was not

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identified, was not escalated and was not acted upon. So I mean ultimately it's a matter for the Inquiry to determine, but I can only conclude that those systems were not adequate.

Whether or not there could have been different systems or a different proportionate approach taken, given the vulnerability of the service users, the particular system challenges within the service, I think that's another question and I'm happy to expand upon that. 14:58

150 Q. MR. MCEVOY: Turning to page 133, and in your statement you were responding to a query from the Inquiry about the receipt by the Trust Board of reports on a series of issues. There are 135 identified. At 323, paragraph 323, thank you, you say to your recollection 14:59 the Trust Board did not receive any reports specifically relating to Muckamore Abbey in your time as CEO and the service was not a standing agenda item. Thinking back, was it the case that the Trust Board would not have expected to hear specific reports on 14:59 individual sites?

A. That's my recollection at the time, that the -- I mean the Executive Team nor indeed the Trust Board would have received Trust specific or, sorry, site specific reports. But again the Executive Team and Trust Board 15:00 would fully have expected, certainly I would have fully expected as Chief Executive that if there were site specific or unit specific problems that were arising, for those to be raised and to be escalated.

151 Q. Indeed to that end I think there had been issues around waiting times and Accident & Emergency departments and so on which would have -- would those have come to the Trust Board, acute setting related issues if I can put it that way? 15:00

A. Yes, I mean I think that, I mean I have followed some of the evidence over the last couple of days, I have not had an opportunity to read as many of the witness statements as I would have wished, but I think there is always a challenge in trying to maintain that focus and 15:00 balance on that which is not immediate and urgent within an organisation as opposed to that which is really, really important but perhaps not as immediately urgent. And I think that, and I know a number of witnesses have referred to that in their evidence. The 15:01 focus on the acute and the elective was at times, in my view, detracted from the focus that perhaps could have been focused on other services. Now that's not to say there wasn't a focus on other services, Mental Health services, Learning Disability services, Social Care 15:01 services, I think there was less, shall we say, prominence of that both in terms of political scrutiny, media scrutiny and perhaps less focus, while certainly there could have been greater focus on it looking back than there was. And particularly when I reflect on 15:01 subsequent events and what we now know, there clearly was a case for greater scrutiny and greater focus and I am happy to expand on that, some of my thoughts and reflections.

152 Q. Very happy for you to do so and I suppose if you were to, could you include maybe any reflections you may have on whether the sheer diversity of issues facing the Trust and it's, facing the Board that is to say and the size of the Trust, the diversity of issues that were thrown up maybe belied a lack of capacity on the Trust Boards's ability to deal with issues?

A. I think the organisational span of the organisation was significant. But, referring again to my earlier point, that does not excuse having appropriate governance and oversight arrangements in place across the totality of the Trust's responsibilities. I mean, that's the primary purpose of the integrated governance approach which I recall was in place within the Belfast Trust at that time, the primary purpose of the Board Assurance Framework and the structures that were in place.

So I don't accept that organisational span or indeed complexity of services provided is a rationale for there not being adequate arrangements in place. It's incumbent on the Executive Team, it's incumbent on the Trust Board to be satisfied that appropriate and proportionate arrangements are in place across all areas of responsibility.

I mean, when I look back on it now, and particularly in considering the reports in terms of the Leadership and Governance Review and the resettlement programme, they make for difficult reading and so they should. I think

that at an Executive Team level, at Trust Board level with the benefit of hindsight we should have been more alert to the, not necessarily the vulnerability of patients in those services because that was always known and understood, but actually the particular vulnerabilities in the transition arrangements where you had a service that was effectively moving into closing that service and relocating individuals into the community. And, as we all know, it's at those times of transition of the service model from one into the other that pose greatest risk. That was a time where it would have required greater organisational grip. I think from the point of view of, you know Commissioner and also from the departmental perspective, greater grip because increasingly as we move forward into the resettlement programme, the complexity of the individuals and their care needs became increasingly more challenging and difficult to meet. And looking back on it now and with the benefit of hindsight I wish that at all levels in the system that, you know, as the independent review indicated that there was a need for an overarching plan. There was a need for greater strategic leadership, better governance arrangements and better performance management arrangements. I think those are very astute observations. They were not matters that were immediately apparent to me at the time and certainly I regret that I wasn't more thoughtful in terms of the risks that that transition from one service, in-patient

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service model into working to provide a service in the community. But then again, and you know, we did not have an overarching strategy for that other than a commitment to that and, you know, I look forward to the completion of the service framework which I now know is being progressed. 15:06

So, I think there is much learning as to how the circumstances arose that contributed to that. I mean there is no excuse for what happened, absolutely none whatsoever but certainly I believe that there were contributory factors and causal factors, some of which could have been anticipated and perhaps some of which could have been prevented. 15:06

153 Q. Thank you. And I suppose one of those issues that the Inquiry has spent quite a considerable amount of time examining, the issues arising out of Ennis, the Ennis Ward. The Inquiry has heard that there was a prolonged existence of staffing difficulties, recurring difficulties around discharge and resettlement. I suppose if I can examine the issues that Ennis kind of crystallised and identified in that vain. In December '14 when you were appointed as acting Chief Executive of the Trust, were you briefed about the prosecution of two staff for alleged abuse on the ward? 15:06 15:07 15:07

A. No, I wasn't and, you know, looking at that it's difficult to understand why that wasn't escalated to Executive Team or the Trust Board. I mean certainly I had an awareness of the issue because it did, as Chief

Medical Officer, prior to taking up post, it came into the Department as an Early Alert. I was copied into correspondence which was sent to the Chief Executive, the then Chief Executive of the Belfast Trust and forwarded that to policy colleagues to take appropriate action, which I understand they did and I know that was covered in Sean Holland's evidence yesterday. But certainly, I had no reason to believe that there were any ongoing issues either in relation to Ennis or indeed that that was reflective of wider problems within Muckamore Abbey Hospital. And certainly I had no recollection whatsoever of receiving any briefing in relation to Ennis. 15:08 15:08

154 Q. So you had the view that it was quite an isolated or one off incident? 15:08

A. Well I don't think I had a view in that I hadn't been briefed on it and -- but then again I hadn't asked any questions about it either, so, you know, I accept that. But it was not something which was in my mind as a potential concern or something that I needed to actively question and certainly, no concerns of any nature were brought to my attention. 15:09

155 Q. I suppose then perhaps the fairer question then is reflecting back, does it surprise you that the Board wasn't focussing more closely on Muckamore in the aftermath of Ennis and the safeguarding investigation? 15:09

A. Well, you know, I did consider, as I say, the various reports and in particular the Leadership and Governance Review. I think it is surprising that a matter of that

significance was not escalated from Muckamore Abbey Hospital to the Executive Team, to myself and indeed to the Trust Board. I mean it's all the more surprising, given that there was interaction between the Belfast Trust at a certain level and the Health and Social Care 15:10
Board, but yet there doesn't seem to have been an awareness at director level within the Belfast Trust, no discussion with the Executive Team and the matter not elevated to Trust Board and that clearly was a failing. 15:10

CHAIRPERSON: And you didn't ask for any reassurance around it once you were appointed to the role?

A. No, you know, I didn't. I mean I suppose when I look back now, having been asked to take on the responsibility of the Belfast Trust and given the 15:10
previous difficulties and challenges, it perhaps would have been prudent to do a due diligence exercise across the totality of services. I didn't think to do that at the time and really got on with the task in hand. I did not seek nor had I any, as I recall I had no reason 15:11
at that time to have any concerns in relation to Ennis and didn't seek nor indeed was I offered any briefing in relation to it.

It's interesting that from my recollection, although it 15:11
was quite some considerable time ago now, I do remember receiving an update in relation to Iveagh which was the children's learning disability unit which had been subject to a critical inspection by RQIA and had been

subject to an Improvement Notice. That actually pre-dated my taking up post, as I recall, although I can't be now certain. And I recall visiting, because I asked to visit the facility after I took up post, basically to satisfy myself that the recommendations in relation to the RQIA inspection had been complied with. So, I use that as an example of action that I did take and, again, would have hoped I would have taken in relation to Ennis had I been briefed, had I been aware and had I been cognisant of the concerns that had been raised. 15:12 15:12

156 Q. MR. McEVOY: And just a moment or two ago, the issues of staffing difficulties and resettlement of patients as well at the hospital, the Inquiry has heard the Trust was missing resettlement targets, having repeated issues with staffing. Given that it was experiencing such issues does it surprise you that the hospital didn't feature more often on the Trust Board agenda, again thinking back? 15:12

A. Yeah, and again I haven't had the opportunity to look at Trust performance reports because, again, resettlement targets were present within the Programme for Government, were present within the commissioning plan direction, would have been present within Trust delivery plans and performance against those would have been considered at the internal performance meetings within the organisation with the various directorates and their teams and even beneath that within the various divisions, and similarly would have been 15:13 15:13

considered at Trust Board. I mean the reports themselves would have looked more generally at services as opposed to institutions. I can't now recall the level of granularity or detail that was considered. But, I mean I did look through documents that were provided to me by the Belfast Trust during my time. Muckamore, as I think I have said in my statement, was mentioned on 12 occasions, none of which were those particularly material, certainly none of those mentions flagged any particular concerns. I did have the opportunity to look through some of the adult safeguarding reports and delegated statutory functions reports which were tabled at Trust Board during my tenure and, again, there were no particular concerns or issues raised there. 15:14

But I agree, that given the increasingly challenging circumstance that were faced around resettlement programme, the repeated failure to meet those resettlement targets, notwithstanding the wider issues about whether or not there was sufficient community infrastructure or workforce to meet the needs of individuals in the community, looking back on it I agree that one would have expected a greater degree of prominence at Trust Board meeting. 15:15

157 Q. Maybe move on then to touch on the work of the Assurance Group and the Assurance Committee, which is something you have adverted to a little bit earlier. If we can look at page 125 and it's paragraph 306

please. It will come up on screen. You're talking here I think, for context, about one of your responsibilities on taking up the acting role as CEO of the Trust was to attend Assurance Committee meetings.

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"It was approved and established by the Trust Board of directors as a standing committee the purpose of which was to have oversight of all aspects of corporate governance excluding finance and to ensure robust Assurance Framework is maintained." 15:16

And then at 310, again just for a bit more context then you talk about the duties of the Assurance Group.

"The key duties of which were to provide advice to the 15:16
Assurance Committee while monitoring the Assurance Framework agenda for the Trust as follows:
Reviewing and approving the assurance updates from the steering groups.
Learning from the Experience Steering Group, Social 15:16
Care Steering Group, governance steering group..."

And so on. So, you say that the Assurance Group would have reported to the Assurance Committee through the Executive Team and that you then, as Chief Executive, 15:16
would have assured the Assurance Group, is that right?

A. Well, I mean I wouldn't have -- I think I wouldn't characterise it as I would have assured the Assurance Committee. I think I would have, as other directors

would have in the organisation, would have been held to account by the Assurance Committee in relation to our respective roles and responsibilities. The Assurance Group was there to support and advise and make sure that the appropriate reports were completed there and provided. I was acutely aware of my responsibility to ensure that the Trust Board and Chair were adequately informed so they could execute their responsibility. So it was as much as the Assurance Group was also, insofar as it was signing off on reports, it was also looking for gaps in information on matters which would rightly be escalated to the Assurance Committee if indeed there were gaps in assurance or controls, or where there was no assurance in some instances. 15:17 15:17

158 Q. I suppose the Inquiry is interested on the question of challenge here because at 309: 15:17

"The membership of the Assurance Group is comprised of the Chief Executive, all Directors of the Trust, the Co-Director of Risk and Governance and the Head of Office of the Chief Executive." 15:17

In your experience would the Assurance Group actively challenge the directors about the contents of the reports? 15:18

A. Well, I can assure you that I did and, you know, whilst I remained Chief Executive I also was Chief Medical Officer and I was acutely aware of my responsibilities as Chief Executive in terms of the wider requirements

of the Department and the policy commitments of the department. You know, I obviously cannot divorce my knowledge and awareness of that.

159 Q. Yes?

A. So and I was also acutely aware of my responsibilities, not just to the Trust Board of the organisation but ultimately through the Health and Social Care Board, to the Department, to the Per Sec in the department and ultimately to the Minister in relation to delivering on guidance and standards in relation to the governance of the organisation, in relation to quality and safety, in terms of the duty of quality, in terms of risk management, in terms of financial control. So the responsibilities were not just internal within the organisation as Chief Executive, but they were external to the Department. And for me to execute my role and responsibility as Chief Executive, I have acquired that challenge from the Trust Board of the organisation because that's a core element of the governance of any organisation. And, you know, there was challenge, it was appropriate, it was proportionate, it wasn't always comfortable, but nor again should it be. 15:18 15:18 15:19 15:19

I mean, you know, obviously it will be for the Inquiry to ultimately determine, but at the time I had no reason to believe that those arrangements were anything other than satisfactory. 15:19

160 Q. I suppose if we think about the perennial issue, for example, it is just an example of staffing at

Muckamore, you describe at the end of paragraph 310 one of the duties of the Assurance Group as being the identification of gaps and controls assurance processes and systems and ensure action and planning against these. 15:20

Looking back, do you think that the Assurance Group was a sufficiently robust mechanism for identifying those gaps? I suspect from your previous answer I know what the answer might be, but given the perennial problem of 15:20 something like staffing, you have any other reflections?

A. Well I think the problem with staffing in the health service and indeed in the entire NHS remains a perennial one and is an extremely difficult one to 15:20 address. You know, I can expand on that but certainly there were very significant resourcing challenges throughout that period. There were significant challenges in the organisation vis a vis financial savings. But equally, because of the wider system of 15:21 limited resources within health and social care and indeed within the Northern Ireland block, zooming back a little bit, we were not in a position to adequately perform workforce planning or indeed to resource the numbers of healthcare professionals, nurses, allied 15:21 health professionals, doctors that we required. So that was a problem across all services, all service areas and remains so to this day.

Certainly I would have expected and, you know, directors would have known that where there were significant issues, material issues of risk as a consequence to staffing levels, that those should have been escalated. They would have known and they would have taken the advice from the Director of Nursing, Medical Director, Direct of HR in terms of any mitigations or actions that could have been taken to address those and if they couldn't be addressed I would certainly fully have expected those to have been escalated to the Assurance Group and/or Assurance Committee or directly to the Trust Board. 15:22 15:22

So, you know, looking back I think that there could have been a greater prominence given to the potential implications of some of the staffing challenges that were faced particularly within Muckamore Abbey Hospital. 15:22

161 Q. Thank you.

CHAIRPERSON: Sorry, just in relation to that are you saying essentially because of the lack of finance you weren't able to perform the necessary function of workforce planning? 15:22

A. I'm zooming back, at a departmental level it has been an ongoing problem that we develop workforce plans across all of the service areas, across all of the disciplines, whether that's nursing or in medicine itself. And because of the recurrent long-term funding that you require to actually train a nurse or train a 15:23

doctor that when you're, as we were and have been and still remain, in Northern Ireland dependent on annual budgets which are non-recurrent, it is very difficult to make long-term strategic planning decisions in relation to workforce planning or development. So at a 15:23
Northern Ireland level, and it continues to be the case, that it was very difficult to realise the workforce plans that we knew were required to meet the service requirements and needs of the population, and that remains a problem today. Now that isn't, that 15:24
isn't a rationale for not seeking to deliver service in a way that is satisfactorily staffed but it is just a statement of fact of, I suppose, the macro picture. At an individual Trust level clearly it remains the responsibility of the Trust to ensure that it has 15:24
adequate staff in place to safely provide care. I mean, and I know you heard from Charlotte McArdle this morning, there have been particular challenges in Mental Health and Learning Disability Services for quite sometime both in terms of both specialist nursing 15:24
staff, but also in specialist medical staff in relation to the service and that remains a challenge today:

CHAIRPERSON: In terms of funding, are you saying the position is different in Great Britain in relation to a particular department that has to go to the Treasury? 15:25

A. No, I am afraid, Chair, it's a long standing widespread problem. I mean there has been commitment from various UK Governments over the recent years in relation to increasing staffing, but it is an enduring problem.

You know we have, and it's one of the successes of the NHS and health and social care, we have a growing and ageing population and that is a good thing, it is a sign of success, but more of us are ageing with more long-term conditions. The health needs become greater. 15:25
The complexity of those needs is greater and the workforce required to meet those needs obviously needs to be developed and there is a shortfall between the workforce that we have, the workforce that we need and the ability to realise that with the resources. 15:26
CHAIRPERSON: That is as it were a problem for Great Britain and Northern Ireland?

A. I think it's probably a global problem in fairness, Chair. I don't think there are easy fixes to it and I think it's one that we continue to struggle with. 15:26

162 Q. MR. MCEVOY: Now one of the key things that the Inquiry is centrally concerned with is the identification of fault lines in the healthcare system that resulted in the abuse of patients going unreported and undetected. The evidence the Inquiry has shows that from 2017, 15:26
certainly from what happened in 2017 is suggestive of abuse of patients in the hospital having occurred unchecked and unreported. Looking back from your own professional experience, do you have a view how a situation like that could have come about? 15:27

A. I think it's -- I struggle professionally to understand how a situation like that could come about where -- I suppose I really want to preface my comments by saying that the abuse that took place was reprehensible, it

should never have happened and it was fundamentally wrong. It was an abuse of power, it was an abuse of power relationships and, you know, it should never be acceptable, it should never be tolerated in any system. And there were many, because I have met them during visits to Muckamore Abbey Hospital when I was Chief Executive and indeed as Chief Medical Officer, there are many committed and dedicated staff working within that organisation. There are clearly others who were not. I think what I find particularly troubling about it is the fact, and again it goes back to the quote from the Leadership and Governance Review about the normalisation, that some staff could ever regard that as acceptable and normal, you know, the fact that this was normalised behaviour. 15:28 15:28 15:28

I think also what concerns me is there are clearly other staff who were not involved in abuse but yet somehow or other felt unable or disempowered in terms of raising those concerns, flagging those issues, and in themselves tolerated that behaviour and that equally is unacceptable. 15:29

And I think that's why the Governance Review, and certainly as it quotes the Way to Go Report, I find particularly troubling in terms of the institutional loyalties within the service which were not to the individual patient or service user, but were actually to others working within the service and I find that 15:29

very difficult to rationalise.

You know, I grew up with my first cousin who had a severe learning disability and who was a much loved member of the family and I just cannot countenance how such abuse was perpetrated and how such abuse was tolerated and how some appear to have turned a blind eye to that. 15:29

CHAIRPERSON: But I think the question was can you assist with identifying fault lines? 15:30

A. I think that I'm not certain I quite understand the reference to the fault lines and perhaps --

CHAIRPERSON: Well I suppose in terms of governance or lack of granularity of the information that the Board was perhaps receiving or previous red flags such as Ennis and the abuse at the other establishment. 15:30

A. I think certainly if we step back and consider Ennis again, and the Leadership and Governance Review has reflected on that and I absolutely accept the findings within that and vis a vis Ennis. Ennis was a missed opportunity, there is no doubt about it. There was a failure to join the dots and perhaps, you know, and again I am very conscious of the benefit of hindsight and hindsight bias looking back, but clearly given the vulnerabilities of the individuals in the service, the vulnerabilities of a service that was in significant transition, increasing complexity of the individuals within that service, those sources of information and intelligence about what happened in Ennis and a greater 15:31 15:31

curiosity about what were the underlying culture or systemic issues, while it appears and certainly on my understanding of the Ennis Report that while there were questions raised as to whether this constituted institutional abuse, that does not seem to have featured in consideration of the escalation of that in terms of asking further questions. 15:32

I know that the former Chief Social Work Officer did ask questions of the Health and Social Care Board on foot of what appeared to be the closure of the Ennis Report in correspondence in April 2014 to the Health and Social Care Board, as to other issues that had been identified and whether or not in the view of the Commissioner of the Services those were symptomatic of potentially wider issues. But it doesn't appear to have registered that, at any level on the system, either at the organisational level in the Belfast Trust or indeed within the Commissioner level or perhaps potentially also within the Department, that a further look and greater scrutiny was required. 15:32 15:32 15:33

I think also that, you know, and again I was asked this question and I don't want to get ahead of your questions, but when you put that in context of some of the historical abuse allegations, which again I was asked about in my evidence and others have been asked about this week, and in the context of what was known on previous service failures elsewhere in the UK, 15:33

Winterbourne, you know, and I know the action that I took at that time in terms of writing to our regulator, seeking assurances around the mechanisms and the processes that they had in place to assure themselves that something similar to Winterbourne wasn't occurring in Northern Ireland. I got a very detailed report back of the various arrangements that were in place which I then shared with our Health and Social Care Trusts asking them whether there were gaps or there were issues that they wished to flag. 15:33 15:34

I think that we were certainly, I think at various levels considering that. But with the benefit of hindsight and subsequent events I think we have to ask ourselves whether we were sufficiently probing or sufficiently exacting in the questions that we were asking or the challenge function that was being used to actually inquire. You know the balance perhaps you could argue was more on seeking assurance that everything was well as opposed to -- 15:34 15:34

CHAIRPERSON: Yes.

A. Problem sensing and, as I have said in my statement, actually turning over stones, looking where problems might potentially be. So I think, you know, I think the Ennis Report was certainly a missed opportunity. 15:35

CHAIRPERSON: Just having asked yourself that question, whether you were sufficiently probing or challenging, what did the answer come to?

A. I think the answer to that is quite a simple one, I

don't think any of us at any level were and I think we are all diminished by that, and I include myself in that. I think, you know, it is not possible to conclude otherwise. You know, I mean I have reflected on this and these things are always very, very clear when you look back. And, you know, I always remember the quote in the Clapham Junction rail disaster where I think it was Anthony Haydn QC indicated there is no human action or decision that with the inaccurate benefit of hindsight cannot be made to look sub-optimal, flawed or incorrect. I do think that it is with a clarity of hindsight now that I make those comments in terms of I think we should have been more anxious, more probing, allowed greater scrutiny and potentially -- and I think also particularly given the increasing vulnerabilities of this service and the challenges that the resettlement programme was facing.

15:35 15:36 15:36

CHAIRPERSON: Thank you.

163 Q. MR. MCEVOY: Now, I suppose turning to the role of Chief Medical Officer in the context of the provision of Learning Disability Services, the Inquiry, as you have indicated the Inquiry has heard extensively from the former Chief Social Work Officer and Former Chief Nursing Officer over the past couple of days. From your own perspective as Chief Medical Officer do you think the post ought to require more direct involvement in the oversight of Learning Disability Services?

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A. Well the, I mean the ultimate responsibility for the oversight of any service, including Learning Disability

Services, resides with the organisation providing those services, we have already discussed the role of the Executive Team, the Chief Executive and his or her accountabilities in that regard and the Trust Board of the organisation, those are clear. You know, the 15:38
Statutory Duty of Quality 2003 Order is very explicit in relation to the duties that it places on Trust Boards, Chief Executives and also on Commissioners of services. So I think there is, in such a delegated system of accountability, it is a delegated system of 15:38
accountability by both necessity and design. It would not be possible for the Department per se, individual policy colleagues from the Department or professional colleagues to be directly accountable for the delivery of service. Now that's not to obviate or obfuscate the 15:38
responsibility in such a delegated system of accountability to both scrutinise and seek assurances and there are arrangements in place in terms of sponsorship meetings, accountability review meetings at a departmental level. And there are within the Health 15:39
and Social Care Board, supported by the PHA, arrangements for performance management of services, service improvement of services and matters to be escalated to the Department. But again, you know, I think that given, and being more specific in terms of 15:39
my own span of responsibilities professionally and from a policy perspective, it would not be possible for me as Chief Medical Officer to have operational oversight of any particular service.

Certainly within my office up until September '22 I had a dedicated Senior Medical Officer who was providing professional medical support and advice to policy colleagues within the policy team within Social Services Policy Group who worked very closely with them. But again that would not have involved, nor indeed could it have involved operational oversight.

164 Q. Right?

CHAIRPERSON: Are you moving on to the next issue. 15:40

MR. MCEVOY: I am.

CHAIRPERSON: I think we ought to take a short break also for the stenographer so we'll just take a 10 minute break then we will continue, thank you.

15:40

THE INQUIRY RESUMED AFTER A SHORT BREAK AS FOLLOWS:

CHAIRPERSON: Thank you very much. Yes.

165 Q. MR. MCEVOY: Thank you, Chair. So, Professor, the next issue that I'd like to cover if we may, relates to the 15:55 question of whether an institution such as Muckamore Abbey and Learning Disability Services more generally are optimally served by being part of a structure of the scale and size of the Belfast Trust. The reason it comes up is because at two junctures in your statement 15:55 at 312 on page 128, I'll take you to the phrase, you can see there the fourth line down you talk about the scale, scope and complexity of health and social Services provided within the Trust. And then a similar

phrase at 319 on page 131, paragraph 319 on 131. Thank you. You can see there:

"The Trust Board and Executive Team seldom included individual facilities on their respective agendas..." 15:56

And we have touched on that a little bit earlier.

"Given the scale and complexity of the Trust to my recollection issues which were discussed at that level 15:56 generally focused on services and matters would have been raised to the Trust Board on an escalated issue or exceptionality basis."

We talked about this earlier in your evidence. I 15:56 suppose it is clear the Trust is a massive organisation responsible for delivering a diverse range of services over many facilities. In your experience was it too big to enable effective oversight of all services, and particularly the demands and complexities of the 15:57 learning disability service?

A. Yes, I have considered this and I have reviewed some of the evidence where, particularly that of Andrew McCormick who was former Perm Sec in the Department who I worked with and I came into the Department at the 15:57 time of the first part of the review of public administration, the establishment of the five or the health and social care trusts as they were then and then later the establishment of the Health and Social

Care Board merging the four previous organisations. I think that, I can speak bluntly, I think it's a cop out to say that an organisation is too big. I think that the span of control of an organisation is one of the many challenges that an organisation has to give consideration to in terms of how it manages its business, the system of controls that it has in place, the governance arrangements that it has in place and ensuring that the organisational structure is appropriate to manage the responsibilities of the organisation and that, in a large organisation when there are delegated systems of accountability, that there is appropriate challenge in that system of delegation and that the level of information that provides either assurance or demonstrates the need for additional scrutiny is appropriate and proportionate. So I think what's more important rather than organisational scale and complexity is the culture within the organisation, the leadership within the organisation. That said, there is no doubt large organisations are and can be more difficult to direct and to control. 15:58 15:58 15:58 15:59

I've also considered some of the reflections that other colleagues, former colleagues made in relation to a discrete mental health or learning disability organisation. Now ultimately that will be a policy decision for a minister. I think what has always troubled me and given my policy responsibility as Chief 15:59

Medical Officer with respect to addressing health inequalities, improving life expectancy, is the fact that if we look at the huge disparities in health and health and wellbeing, health outcomes that there are amongst individuals living with a learning disability, 16:00
my concern would be that there would be a potential greater even disconnect between addressing their general health needs while focusing on their mental health needs and/or learning disability needs. So I think I don't, I can absolutely see both sides of the 16:00
argument but I would be concerned that what is more appropriate is that we provide holistic care to people with a learning disability across the totality of their health and social care needs. But as I say, you know, there is undoubtedly potential advantages in a smaller 16:01
organisation dealing specifically with mental health and/or Learning Disability Services, as is the case in other parts of the United Kingdom.

CHAIRPERSON: I'm sorry, I just want to understand what you are saying about there being a greater disconnect. 16:01
Is it because they are learning disabled patients there was not the same focus on their general health needs? I'm not sure what you're saying.

A. Well, no, I think all of these issues can be managed so I think that there is no ideal model. I think that 16:01
there has to be a commitment to meeting the entirety of the needs of someone living with a learning disability, both their social care needs, their physical health needs and ensuring that those are met equally and

appropriately. I mean it is a statement of fact that, you know, if we look at individuals living with enduring severe mental health problem or we look at individuals with a severe learning disability, they die prematurely. In relation to long-term conditions there are questions to be asked about whether those conditions could be treated more effectively than they currently are. If you look at the uptake of, for instance, screening programmes, vaccination programmes, again individuals with a learning disability are at times disadvantaged. So I think there is an issue, in my view, around holistic care and ensuring that, as was outlined in Bamford Review around Equal Lives that people with a learning disability do have Equal Lives and equal access to and in many respects a different access to, because providing access to care in the way that we would provide for the general population will not necessarily meet the needs or the particular requirements of someone --

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PROFESSOR MURPHY: I understand what you're saying but the fact remains that in Muckamore Abbey they didn't even have annual health checks.

16:03

A. No absolutely, and I think I have again seen that in evidence. Now, I think the question has to be asked, and I think this is legitimate question, that it would be in my view premature to rush to conclusion that because of the particular failings in Muckamore Abbey Hospital, and whatever the contributing factors were, that the separation of Learning Disability Services

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into a separate trust would ensure that those needs are met more holistically. I think there were, and again obviously for the Inquiry to consider, but I think there were particular issues in Muckamore and I would caution against generalising or forming the conclusion that somehow or other separating out mental health and learning disabilities outwith other services is actually a solution. You know, it requires further consideration and discussion. I mean obviously the Panel will have experience of the benefits and disbenefits of such models and approaches in other jurisdictions and, I suppose, really from my perspective I think it is just important we keep an open mind on that.

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CHAIRPERSON: But however large the Trust, it is the duty presumably, or do you agree, it is the duty of the provider Trust to ensure that, whether there are mental health patients or learning disability patients, their holistic health needs are net.

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A. Unequivocally so, unequivocally so. Basically what I am saying, that is absolutely the case, and I am just hesitant of suggesting that there is a structural solution to that. I think that it is absolutely the case that there is a requirement and a duty on any provider organisation, irrespective of its complexity, irrespective of its design or make up to holistically meet the needs of the population that it serves. That's unequivocal. I am less convinced that there is a structural solution to how that is met. I think that

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what is important is that there is a recognition of that responsibility and there is a culture and a leadership within an organisation that is committed to delivering on that.

CHAIRPERSON: Thank you. 16:05

166 Q. MR. MCEVOY: So Professor, moving from I suppose the position of learning disability within the Trust to maybe the departmental outlook on learning disability, hopefully you were taken to the quote, the description from Professor Roy McConkey when he gave evidence to 16:06 the Inquiry back last March where he described the Department as being a department of hospitals. Do you think that at departmental level the field of learning disability is adequately prioritised and resourced?

A. Maybe if I could reflect firstly on the reference to 16:06 the department of hospitals. I think I understand the point that Professor McConkey was making and I think there is an important context to that which, you know, as Chief Medical Officer my policy responsibilities are significant in relation to the priority that the 16:07 Department, working with other departments across government, affords to our public health policy in relation to making life better. The underpinning strategies in relation to obesity, suicide prevention, what we are doing in relation to sexual health and 16:07 well-being, promotion of good mental health and wellbeing as opposed to treatment services. That in the area of health improvement, addressing health inequalities across government level and all of those

underpinning strategies, including health protection, vaccination, immunisation programmes, screening programmes, those are all key policy priorities for the Department, which are quite apart from the service priorities for the Department. While I understand the context of the comment and the point that is being made, it would be misleading to suggest the Department is solely focused on service delivery and health service policy, notwithstanding the wide area of social care policy, the work the Department is leading on autism and a whole raft of other areas in terms of children with special educational needs. 16:08 16:08

I think the point that Professor McConkey, who is a respected colleague, is making is the fact that there is perhaps an imbalance in the focus afforded to services and I think I would include in that social care, perhaps learning disability as opposed to the focus that is on acute services, elective services. Those tend to be the issues which dominate the headlines, I think disproportionately so. Because again, and that's not a commentary on the media at all, it is just a reflection of where the focus at times lies. And perhaps not a realisation that the reason that we have pressures on our acute service is the fact that we need to have greater focus on anticipatory care, greater focus on prevention and we need to change the direction of how health and social care is orientated, a greater focus on disease prevention, 16:08 16:09 16:09

keeping us all well so that we all live longer and healthier lives and reducing the demand on health and social care services. That is a fundamental change that is required.

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Now that challenge has been made greater as we've come through the pandemic and we are all aware of the consequences that that has had in terms of society more generally and on health and social care services. Something that I said recently, the challenges that we face in health and social care will take the same conviction and courage that it took to form the health service in 1948, that it now needs and is required to reorientate health and social care services and public health policy to meeting the needs of the next generation, because we are increasingly in a situation where because of the change in demography, the change in health needs of the population, new advances in treatment, that the previous model that we had will not be sufficient to, and isn't sufficient at present, nor will it be sufficient in the future to meet the future needs of the public.

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167 Q. And I suppose then to go back to the point about the departmental provision, do you think then that learning disability, as it currently stands, is adequately prioritised or could more always be done?

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A. I think, apologies if I didn't answer the question --

168 Q. No, you're okay. We certainly have your comment in relation to the observation of Professor McConkey.

A. I mean I think, I know that policy colleagues work extremely hard within the Department. I know that they are extremely committed to raising the profile and priority of learning disability and there has been a long standing commitment to that. I think it's always 16:11
difficult -- and indeed previous Ministers have prioritised learning disability. I think it's always difficult in what is a relatively small department to maintain the balance of the focus on the issues and, as I said earlier, to ensure that we're dealing with what 16:12
is often the medium and longer term but not immediately urgent as opposed to that which is immediately urgent and commanding all of the attention. That will always be a challenge, particularly in an environment where there is, you know, finite both departmental resource 16:12
in terms of people resource and an environment where there is finite financial resource. But again, so I think there is an opportunity to give and afford a higher priority. Obviously the Inquiry itself affords that opportunity to shine a light and provide a greater 16:12
profile to many of the issues which I know you have considered over the last significant period of time.

169 Q. So Professor, before the break we did touch on the interrelationship between your role as Chief Medical Officer and then those of the CNO and the CSWO. 16:13
Dipping back into the history of matters being looked at by the Inquiry, it might be helpful if you can assist us in gaining an understanding of how those relationships worked in the context of the Department's

response to the Trust's handling of the CCTV revelations back in 2017?

A. I mean certainly, I mean I think I have outlined in the statement some of the actions that I took in and around the end of April, start of May 2019 where I suggested a number of interventions which I think contributed to the ultimate establishment of the Muckamore Departmental Assurance Group, the regional group and further engagement. I think in terms of all of those structures that the policy colleagues had in place prior to that date, so the ongoing engagement that there was between policy teams, the Belfast Trust, the Health and Social Care Board, the Regulation Quality Improvement Authority, my SMO, Senior Medical Officer in Mental Health and Learning Disability was actively involved in and participated in and provided professional advice into that. He reported through to my Deputy Chief Medical Officer who reported to me and if there were material matters of concern those could have been raised with me. 16:13 16:14 16:14 16:15

Now I have to say from my own professional background I don't have any professional or technical expertise or experience in mental health or learning disability, but my Senior Medical Officer colleague, who has since retired within the Department had significant experience in that field and worked in a very integrated way with colleagues when those allegations were raised and provided professional advice to 16:15

colleagues along with Charlotte and her team and Sean and his team.

170 Q. The reason why the issue arises or the theme arises is because we opened the correspondence indeed this morning with Professor McArdle, there is a co-signed letter from the Chief Social Work Officer and the Chief Nursing Officer, October 2017, but there is no corresponding signature from you, the Chief Medical Officer. And I suppose a bystander following the work of the Inquiry might wonder, given the wide public interest in the issues to emerge from the hospital and those allegations, might there be an expectation that all three chief officers would become collectively involved in a departmental response, or is there a reason why not? 16:15 16:16 16:16

A. I wasn't asked to sign the letter. Had I been asked to sign the letter I would certainly have been happy to sign the letter. I have no issue with that. I was fully support of Sean as Chief Social Work Officer and policy lead and Charlotte as Chief Nursing Officer in the actions that they were taking, there is no question about that. Equally within the Department, you know, as chief professionals and policy leads we lead on our own respective areas and we support each other, provide input where that's requested or when it's required. I wouldn't take any inference from the fact that my signature wasn't on the letter. I personally and professionally take no inference that I wasn't asked to sign the letter. You know, this was consistent with 16:16 16:17

the departmental approach. And as I say, my Senior Medical Officer, who reported to me ultimately, was fully involved in those discussions and the challenge function to the Trust and the actions that were taken by the Department. So there was no disconnect if that's the basis of the question.

171 Q. And then turning to the question of policy and operational decisions around resettlement, would you or your office be in a position to provide advice, professional advice of assistance on questions of resettlement? 16:17

A. Well certainly my office did. I didn't personally. Again that wasn't due to any -- and again I have said this in the statement that was not, absolutely not a reflection of the importance of the issue. It again is a reflection of the many other demands that I had on my time and again that's not to diminish in any way the importance of this as a central issue and also to reaffirm that my office through my Senior Medical Officer was fully engaged in and working along with policy colleagues in that respect. I mean he sat on the Muckamore Departmental Assurance Group. He was a member of the Regional Oversight Group that was overseeing the resettlement programme which was chaired by the Health and Social Care Board, so through him my office was fully involved in that. You know, as I say, my reason for not being personally involved was that he had the requisite expertise within my team and certainly I had other significant commitments which 16:18 16:18 16:18

were no more or less important. But, as I say, he had the expertise and if there were matters which he required my input or my deputy's input, he certainly could have sought that and, you know, would have done so. I don't now recall him seeking such input but that's more of a reflection of his significant experience and competence in this area from a professional perspective.

172 Q. Okay. And then if I could turn up page 114, please. This is in relation to the question of utility and effectiveness of service framework models in the context of learning disability. The Inquiry, I suppose, is keen to explore and understand the decision not to commission the Health and Social Care Board or the PHA to develop a new service framework. 16:19 16:20

CHAIRPERSON: Sorry, do you want paragraph 279?

173 Q. MR. MCEVOY: Yes, there is a paragraph in relation to it. And in 2019 now, at 279 you see, you tell us that in 2018 the Service Framework Programme Board decided not to renew the Learning Disability Framework and you have attached the correspondence. Can you help us understand what the thinking or can you recollect what the thinking was around that decision? 16:20

A. Just before we do that, I think just in reflecting on your last question, I think that the Service Framework Programme was a programme of work that I initiated as Chief Medical Officer and I think the prominence that I afforded mental health and learning disability is reflected in the fact that in the process of 16:20

identifying those service frameworks I was fully committed to progressing learning disability as a service framework. And I was very actively involved in the development of that service framework. You know, it was, and I know you have perhaps had an opportunity to look at some elements of that, it was co-produced before co-produced was termed as a way do things, so it was a very active process engaging with service users, with carers. It involved the Department of justice, the Department of Communities, the Department for Social Development, it was a very joined up integrated cross-government, cross-sectoral approach. It was a privilege to be involved in it and I can share some of the reflections on it. I think it was of its time. It pre-dated for instance much of the work with NICE and NICE guidance which subsequently then produced evidence based guidance in relation to both technical appraisal in terms of drug treatments but also clinical guidance in terms of for services and commissioning of services and also more latterly then public health guidance. 16:21 16:21 16:22 16:22

So these sort of pre-dated certainly our relationship with NICE and our service level agreement with the National Institute of Clinical Excellence. I think that it's fair to say that when these discussions were proceeding the feeling of the Health and Social Care Board as the Commissioner was that things have moved on, the evidence base had moved on. The process by which we develop them had become extremely cumbersome. 16:22

The number of KPIs that had been developed had become increasingly cumbersome, there were more efficient and effective ways of ensuring that services that were commissioned and the performance management of those services was managed.

DR. MAXWELL: I was going to reflect that it was similar in England.

A. Yes.

DR. MAXWELL: England went through a process of having service framework for most specialities and around this time had moved away from that as well to more effective ways of looking at the evidence base and getting it into practice.

A. Yes, and I agree with you and similarly, you know, I did, I make no bones about the fact that I did steal the idea from colleagues in Wales and I did sit and join their service framework developments boards. I was hugely impressed by the level of engagement that there was, particularly with service users and carers. We emulated that here. I do think, I agree with you, we did move forward to much more efficient and effective ways of commissioning services using evidence and applying that. I do wonder however, if we lost something in the engagement piece, if I'm really honest, in that process, and you know, we have now subsequently augmented that in terms of commitment to patient public involvement and co-production and that's enshrined in how we develop services and comission services. But there was a bit in the middle where I

think we perhaps lost some of that engagement.
DR. MAXWELL: I think we had a previous witness who mentioned having a tsar, that was another thing we saw in England, if there was an area where service was looking to develop you had a tsar, like we have a diabetes tsar, he is very active. Did you have a champion or ambassador for any area of development?
A. Essentially during that process, I reflect on a number of the workshops, I thought the greatest ambassadors were those individuals living with a learning disability because it is hard not to go to a meeting where you're discussing the needs of individuals and those individuals and their carers are telling you very frankly that there is a huge gap between what you think you are providing and what you actually are providing and their experience of service. So in many respects I think as a professional, and other professional colleagues who were involved in that programme of work, that hearing from those with first hand lived experience of the service and the adequacy or otherwise were great advocates for it. I think it was Andrew McCormick in his evidence talked about the concept of czars and it was considered at a point in time from my recollection, although I don't now recall from the passage of time all the detail, we would have a learning disability tsar. We subsequently went on and have one for instance in mental health services in Professor Siobhan O'Neill. And there is no doubt in my view, I have to say, and apologies to Siobhan in

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advance but at the time I was concerned that saying there was a tsar mean that everyone else said it is not our responsibility now, we have got a tsar, it is over to he or she. But that hasn't proven to be the case. I think her role has worked extremely effectively. I Chair our Protect Life Tool which is our suicide prevention strategy at policy level across government. She provides a very effective challenge function, advocacy function, but also provides significant academic input and challenge into that and also including her input into the implementation of the mental health strategy. So I think that is obviously, ultimately it will be a policy decision for a Minister but I think there are potential advantages in that. 16:26 16:26

174 Q. MR. MCEVOY: The Inquiry would also welcome clarification of your position with regard to engagement with the Leadership and Governance Review Team. We touched on the report earlier and indeed in the body of your statement I think at paragraph 60 on page 35, you referenced the report. You say that you have fully considered the reports and their findings and recommendations which you believed to be informed and balanced and are generally consistent with your own experience of oversight arrangements. 16:27 16:27

"...although some aspects of these reports I have reviewed with the benefit of hindsight." 16:28

The review itself noted that some former Trust managers did not engage with the process and observed that the former Chief Executive of the Trust was also not available for interview within the timescale set for the review.

"The Review Team regrets that it conclusions were not informed by input from those individuals."

So, for the assistance of families of patients can you clarify if you are the former Chief Executive to which the report was referring? 16:28

A. I can only conclude that I am. I mean no-one regrets that more than I do. I mean I am fully aware of my professional duty to and input to all investigations and inquiries, whether they be of a statutory nature or otherwise. 16:28

I did speak directly to the Chair of the Leadership and Governance Review. I did commit to meeting with himself and the Panel during the course of that. The nature of that conversation was in the context of the pandemic. We were right in the middle of the response to the Covid 19 pandemic. In that conversation he outlined to me that he appreciated the demands on my time, which were considerable at that stage. And you know, it was just a matter of fact and it's not, just for information, myself and my team at that stage were working 16, 18 hours a day, seven days a week and had 16:29 16:29

been for the previous seven to eight months. And again, the volume of correspondence was -- so I gave a commitment that I would do and I wanted to, a verbal commitment to that.

16:30

I, in preparation for today's hearing, I did search through previous correspondence. And while I don't now recall receiving the correspondence, I did receive a note from the Chair of the Panel towards the, I believe the start of June asking, I think it was the 1st June 16:30
certainly from memory, asking that I would give evidence by 17th June. I don't recall receiving that but it wasn't any reluctance on my part to contribute or input. It was basically a sheer reflection of the other demands that were considerable and unprecedented 16:30
at that time in terms of supporting the Northern Ireland government in terms of its response to the pandemic and coordinating and leading the public health response and indeed at that stage ensuring that the health service were capable of responding to the 16:31
pandemic. So again, you know --

CHAIRPERSON: As previous CEO of the Trust that they were exploring, particularly around the time of your CEO --

A. Yes, yes. 16:31

CHAIRPERSON: Did you not want to offer your views.

A. Unequivocally, I think I have said that in the answer to the question, absolutely. I mean when I engaged directly with the Chair I gave him a personal

commitment that I would, Mr. Bingham, David Bingham, I gave a personal commitment that I would. I fully intended to. And I can only conclude that it was just as a consequence of other competing demands and pressures at that time. It wasn't any reluctance on my part to contribute, none whatsoever. And I subsequently communicated that, you know. I mean the wording is factually accurate but I was dismayed that it would be interpreted in any reluctance on my part to contribute because that was not factually correct. 16:31 16:32

CHAIRPERSON: So were you warned that that paragraph --

A. No.

CHAIRPERSON: That reference was going to be made?

A. At no stage was I advised that that reference was going to be made. So when I saw the reference I was concerned about the reference, potential implications of the reference, but it is not factually incorrect that I was not able to provide input within the timeframe of the Inquiry. I did make my concerns known within the Department but at that stage the report was in the public domain and I took no further action at that time. 16:32 16:32

175 Q. MR. MCEVOY: And I suppose you are positive in terms of your impressions of it and what it says but, looking back at it, do you think there are matters that you would have brought to the review's attention that you might have caused the Review Team to arrive at different conclusions? 16:32

A. No, I have to say when I read the report I do believe

that it was an honest and very thoughtful report. I have to say it raised matters which I wasn't conscious of or aware of at the time. But, you know, looking back through with the benefit of hindsight, it's quite abundantly clear that issues they were flagging were real issues. I mean it's a very difficult report to read and it's a very difficult report to read given my previous role of Chief Executive of the Belfast Trust, you know, that there was a lack of leadership within Muckamore Abbey Hospital, there was dysfunctional relationships within Muckamore Abbey Hospital, there was a lack of curiosity at Trust Board level, you know, concerns around the oversight and governance of the services that were provided, given the vulnerability. It's a difficult read. But I have no reason to believe it is not an accurate and honest reflection of what the Panel both observed and what they heard. So I take no issue with the report whatsoever and I think there is very significant and important learning within it. 16:33 16:33 16:34

176 Q. All right. Finally, Professor, if I can move to page 129 please and this is a paragraph we looked at at the outset of your oral evidence and it's down to 315. I appreciate you have touched on this already but just to revisit it if we might you say that: 16:34

"The abusive behaviour that occurred was a fundamental abuse of position and a breach of trust which diminishes all concerned. I have anxiously reflected on whether as CEO I was too accepting of the management

oversight and assurance arrangements then in place, especially given the vulnerability of the people with learning disabilities in Muckamore Abbey Hospital.

I have also considered and it will ultimately be for the Inquiry to decide to what extent any normal oversight arrangements would have detected what appears to have been such aberrant and criminally abusive behaviour perpetrated upon vulnerable patients largely unable to voice their concerns in circumstances where it was in the perpetrator's interest to conceal and cover up the abuse." 16:35 16:35

Now we discussed that earlier in your evidence but is there anything further you wish to add to those reflections? 16:35

A. Yeah, I think I mentioned this in my earlier comments and I refer to the word "normal". I think that given, and looking back now as I mentioned earlier, given the vulnerability of those individuals receiving treatment and care within Muckamore Abbey Hospital, given the nature of the service, given the fact that it was a service that was in transition, and that assuming and having in place the same oversight and governance arrangements that applied across other service areas, other business areas, other directorates was in and of itself, now looking back, insufficient. And one can only conclude that, given what clearly was occurring, had occurred and subsequently came to light. And 16:35 16:36

that's why it was, I think, important to mention the word normal, because I think that there has to be, you know, a much greater focus, a greater degree of rigor, a greater degree of scrutiny, a wider range and source of information and intelligence, both hard intelligence and data and soft intelligence and it should always have been so. So I think that, to my mind, is an important learning point. 16:37

And it doesn't just apply, I would suggest, to Learning Disability Services but other services and particularly where those are being provided to vulnerable clients and patients. And I suppose again, as I reflected on this, it's hard not to reflect on the level of scrutiny and data and hard facts that we have in relation to other intensive treatment areas. So, for instance, if we think of Intensive Care and if we think of acute care and if we think of coronary care and cardiac surgery and I think the same level, although it would be different and the metrics would be different and the oversight arrangements may be different, but that same level of governance, scrutiny and accountability should be applied given the nature of the service and the nature of the services, the nature of the individuals to whom the service is provided. That's why I deliberately use the word normal. 16:37 16:37 16:37 16:38

177 Q. Professor, before we finish are there any further observations you wish to make that may assist the Inquiry in its of Terms of Reference?

A. No, not in terms of assistance to the Inquiry. I would like to thank the Inquiry for listening attentively to my evidence. I want to take this opportunity to apologise unreservedly as Chief Medical Officer, as former Chief Executive in the Belfast Trust for the systematic failings that occurred, the abuse that occurred and the harm and distress that has caused to individuals, who had a right to expect better. It was a fundamental breach of Trust, it was an abuse of power. It was fundamentally wrong and it should never, ever have happened. And I think this is an opportunity to ensure that those lessons are learned and corrective action is taken so that, insofar as is possible, this never, ever happens again. 16:38 16:39

178 Q. Thank you Professor, nothing further Sir. 16:39

CHAIRPERSON: Professor, can I thank you for attending. As you know it was quite late notice for you to attend so I am grateful to you for giving us your time this afternoon. Thank you very much indeed.

A. Thank you Chair. 16:39

CHAIRPERSON: Right, tomorrow morning we've got round up of evidence. Before that I've considered the request to have an oral hearing and I'll give some reasons as to why I am afraid I am not going to have an oral hearing in relation to the issues 16:40 Ms. Anyadyke-Danes KC has raised but that will not take very long we will be into the round up and straight into the evidence of...

INQUIRY SECRETARY: [Inaudible].

MR. MCEVOY: The round up will take place on Zoom.
CHAIRPERSON: I am so sorry, I was told that twice earlier. The round up itself will not be publicly available because it will refer to some patient and staff evidence. So on that we will be reverting, so far as CPs are concerned who wish to watch, to the Zoom link and then of course when we get to the witness we'll move onto the public link. So anybody who is watching now and wishes to watch tomorrow who is a CP, please join the Zoom link. Thank you, thank you very much, 10 o'clock tomorrow. 16:40 16:40

THE INQUIRY ADJOURNED UNTIL WEDNESDAY, 23 OCTOBER 2024 AT 10.00

16:40