MUCKAMORE ABBEY HOSPITAL INQUIRY

SITTING AT CORN EXCHANGE, CATHEDRAL QUARTER, BELFAST

HEARD BEFORE THE INQUIRY PANEL

ON THURSDAY, 20TH APRIL 2023 - DAY 36

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WITNESS PAGE

MR. CHRIS HAGAN

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1 THE INQUIRY RESUMED, AS FOLLOWS, ON THURSDAY, 20TH
2 APRIL 2023
3
4 CHAIRPERSON: Apologies for the short delay this
5 morning. Ms. Kiley. 10:10
6 MS. KILEY: Yes, good morning, Chair, Panel. This
7 morning's witness is Mr. Chris Hagan, who is a Belfast
8 Trust witness who has come to address the Inquiry in
9 respect of Module 3. Can I, just before the witness is
10 brought out, deal with one administrative issue which 10:10
11 has arisen? This witness has furnished to the Inquiry
12 a second statement. It was by way of addendum, I
13 should say. It was only provided to the Inquiry on
14 Monday this week and, as such, it hasn't been possible
15 for the Inquiry to prepare that for upload and 10:11
16 disclosure in the usual way.
17 CHAIRPERSON: It is completely outside the time limits
18 to do so for CPs.
19 MS. KILEY: Yes.
20 CHAIRPERSON: There was also a letter, I think, prior 10:11
21 to that which was a correction letter --
22 MS. KILEY: There is, there's a --
23 CHAIRPERSON: That has been disclosed because that came
24 in, I think, last week.
25 MS. KILEY: That's exactly right. There's a letter 10:11
26 that identified that there's a correction to be made to
27 the first statement and I will deal with that with the
28 witness. But this is something separate and it's
29 provided an addendum second statement, including

1 exhibits, that run to just over 1,500 pages. That
2 statement provides information on three of the discrete
3 topics that the panel is looking at today.
4 CHAIRPERSON: Right.
5 MS. KILEY: That's Module 2 - A, C and D. A, "Policies 10:12
6 for Delivering Health and Social Care to Learning
7 Disability Patients" --
8 CHAIRPERSON: Can you just slow down a bit, I'm so
9 sorry? 2A, C and D, yeah?
10 MS. KILEY: That's right. So A, just for the record 10:12
11 and for the information of those listening, is
12 "Policies for Delivering Health and Social Care to
13 Learning Disabilities Patients 1999 to 2021". C is
14 "Policies Regarding Restraint and Seclusion" and G is
15 "Policies and Procedures Re Psychological Treatments, 10:12
16 Speech and Language Therapy, Occupational Therapy and
17 Physiotherapy".
18
19 So, the proposed way forward is this, in taking
20 Mr. Hagan through his evidence today, I intend to deal 10:12
21 with all of the remaining topics in Module 3, save for
22 those three that I have just identified. So, to be
23 clear, I will not be addressing what the witness says
24 about those topics in either his first or second
25 statement. So we're going to park those entirely for 10:13
26 today, Chair.
27 CHAIRPERSON: Does the witness know this?
28 MS. KILEY: He does. And there will be a second
29 evidence session to be arranged at a later date when a

1 Trust witness will return to address those topics.
2 CHAIRPERSON: And either Mr. Hagan or another?
3 MS. KILEY: We can take that up with the Trust and
4 identify an appropriate witness, Chair.
5 CHAIRPERSON: Okay. Right. 10:13
6 MS. KILEY: So, with that said, can we call Mr. Hagan,
7 please?
8 CHAIRPERSON: Certainly. Thank you.
9
10 MR. CHRIS HAGAN, HAVING BEEN SWORN, WAS EXAMINED 10:13
11 BY MS. KILEY, AS FOLLOWS
12
13 CHAIRPERSON: It's Mr. Hagan, isn't it - I think you're
14 a surgeon?
15 MR. HAGAN: Yes. 10:14
16 CHAIRPERSON: Can I just welcome you to the Inquiry.
17 We met very briefly in the little room. Obviously
18 you're going to be here for some time today because
19 you're statement is of some length, even though, as you
20 know, we are parking, I think, three particular topics 10:14
21 for another date. But if you do need a break at any
22 time, please just say so and obviously we'll stop. We
23 normally take a break after about an hour and a bit of
24 evidence, and then obviously we'll stop at lunchtime.
25 MR. HAGAN: Okay. 10:14
26 CHAIRPERSON: Thank you.
27 Q. MS. KILEY: Good morning, Mr. Hagan. As you know, I am
28 Denise Kiley, Inquiry Counsel, and we met briefly this
29 morning when I explained the procedure for taking you

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1 through your evidence this morning and this afternoon.
2 You have provided a statement dated the 20th of March
3 2023 and you will see - I know you have a copy in front
4 of you - you will also see a screen in front of you
5 there, Mr. Hagan. Throughout the course of your 10:15
6 evidence, I'm going to be calling up various numbers of
7 documents and they will appear on the screen in front
8 of you. So portions of your statement and exhibits
9 that I want to refer you to will appear on the screen.
10 So, for the record, your statement, which is dated the 10:15
11 20th of March, has a reference STM101. Your statement,
12 Mr. Hagan, is 168 pages long, with a large number of
13 exhibits running to a total of 20,966 pages. You will
14 be pleased, no doubt, to hear that I'm not going to
15 take you to every page - the Panel has the detail of 10:15
16 that. But in my questions I intend to focus on some
17 specific matters that I want to ask you a little bit
18 more about to assist the Inquiry.
19
20 Now, before I proceed in respect of your first 10:16
21 statement, the Inquiry understands that you wish to
22 make an amendment to that statement, is that right?
23 A. That's correct.
24 1 Q. And the Inquiry received a letter from the Trust dated
25 the 18th of April 2023 setting out a correction that 10:16
26 needs to be made. That letter could be brought up on
27 the screen, please. Just scroll down a little bit to
28 the second paragraph, please. That's it, if you just
29 pause there. You can scroll up just slightly to the

1 top, unfortunately - that's it, thank you. So,
2 Mr. Hagan, as you can see, the Inquiry was informed
3 that there had been an administrative error in respect
4 of paragraph 287A of your statement. Now, a pause just
5 to note for the record that paragraph 287 falls within 10:17
6 the area of your statement where you address risk
7 assessments and planning regarding changes of policies.
8 And I just want to read out what the correct text
9 should be for the record, first of all. So it said:
10 10:17
11 "At present, paragraph 287A is unfortunately an
12 erroneous duplication of paragraph 290A, which is
13 correct. Paragraph 287A should, in fact, read:
14
15 'An operational risk is a risk of any consequence grade 10:17
16 but which is evaluated as having a likelihood of below
17 25% and deemed by the director to be appropriately
18 managed at operational level and, therefore, not
19 required for inclusion on the corporate register. Such
20 risks may be managed at ward, facility, speciality, 10:18
21 service area or directorate level, with those risks
22 evaluated as extreme or high, warranting close
23 monitoring and more frequent supervision. More
24 detailed guidance on the practical steps involved in
25 completing the risk register is available to Trust 10:18
26 staff on Datex. The director, co-director and/or the
27 quality and governance manager must be notified if a
28 previously medium or low risk is amended upon
29 re-scoring to become high or extreme. Further, the

1 director's approval must be sought for the inclusion of
2 a risk on the corporate register.'"
3
4 So, Mr. Hagan, I just want to clarify for the record
5 are you content that the text that I have just read out 10:18
6 accurately represents what ought to be contained at
7 paragraph 287A of your statement?
8 A. Yes, that's correct.
9 2 Q. Thank you.
10 DR. MAXWELL: Can I just ask a question about that? So 10:18
11 it's an operational risk and therefore managed below
12 Trust Board if the likelihood of it occurring is less
13 than 25%, regardless of the consequence of it
14 happening?
15 A. Sorry, I don't quite follow what... 10:19
16 DR. MAXWELL: So risk assessments use a 5x5 matrix,
17 don't they, and one is the consequence --
18 A. Yes.
19 DR. MAXWELL: -- and one is the likelihood. And this
20 seems to suggest that even if the consequence would be 10:19
21 death, if the likelihood is less than 25% it would be
22 managed operationally and not escalated to the Board,
23 is that correct?
24 A. That's correct.
25 DR. MAXWELL: Thank you. 10:19
26 3 Q. MS. KILEY: Okay. So with that amendment noted then,
27 Mr. Hagan, can I ask you formally do you wish to adopt
28 this statement of the 20th of March as your evidence to
29 the Inquiry?

1 A. Yes, I do.
2 4 Q. Can I ask you then, first of all, to explain with
3 reference to paragraph 6 of your statement what your
4 qualifications are to the Inquiry, please, Mr. Hagan?
5 A. So I am a doctor by profession. I was appointed as a 10:20
6 Consultant Urologist and Transplant Surgeon in Belfast
7 Trust in 2004, having trained in Manchester, Glasgow
8 and Dublin and Belfast prior to that. I was then the
9 Clinical Lead for Urology between 2006 to 2008, and
10 then a Clinical Director in Urology - and transplant, 10:20
11 actually, as well from 2008 to 2015. And then I was
12 appointed as Associate Medical Director in 2015.
13
14 We then restructured our medical management within the
15 Trust and I became the Chair of Division in the 10:20
16 Children's Hospital as part of our collective
17 leadership. And then between 2018 and 2020, I was the
18 Deputy Medical Director For Risk and Governance. And
19 since 2020, I have been the Medical Director for the
20 Trust and I am the responsible officer for a large 10:21
21 number of doctors.
22 5 Q. MS. KILEY: Okay. And in that role as Medical
23 Director, Mr. Hagan, can you explain how Muckamore
24 Abbey Hospital falls into your remit in that role?
25 A. So I have a responsibility, a professional 10:21
26 responsibility to medical staff -- so there's a small
27 number of medical staff that work in Muckamore, but I
28 also lead on risk and governance within the Trust. So
29 I have a responsibility around management of

1 complaints, adverse incidents, coronial affairs et
2 cetera.
3 6 Q. Okay. And your statement addresses topics in respect
4 of Module 3 of the evidence modules the Inquiry is
5 looking at. They are a large and diverse number of 10:21
6 topics, so I think it's useful at the outset just to
7 set those out and to provide a bit of context.
8
9 You provide, in fact, the list of topics in an exhibit
10 to your statement, so if it could be called up, please, 10:22
11 000198. That's it, thank you. And if you could scroll
12 down to Module 3, please? So you can see there,
13 Mr. Hagan, and I just want to read them for the record,
14 the topics that are being dealt with in Module 3 are:
15 10:22
16 A. Policies for delivering health and social care to
17 learning disability patients 1999 to 2021;
18 B. Nursing care delivery model;
19 C. Policies regarding restraint and seclusion;
20 D. Safeguarding policies; 10:23
21 E. Policies and procedures re medication/auditing of
22 medication;
23 F. Policies and procedures concerning patients'
24 property and finance;
25 G. Policies and procedures re psychological 10:23
26 treatments, speech and language therapy, occupational
27 therapy and physiotherapy;
28 H. Re-settlement policies and provision for monitoring
29 of re-settlement;

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1 I. Complaints and whistle blowing, policies and
2 procedures;
3 J. Overview of mechanisms for identifying and
4 responding to concerns;
5 K. Risk assessments and planning regarding changes of 10:23
6 policy;
7 L. Procedures to provide assurance regarding adherence
8 to policies;
9 M. Policies and procedures for further training for
10 staff continuing professional development. 10:24
11
12 And, Mr. Hagan, we discussed this when we met briefly
13 this morning - you have provided a second statement
14 that provides some further information in respect of
15 topics A, C and G, isn't that right? 10:24
16 A. That's correct.
17 7 Q. And I explained to you that my intention today is to
18 park those and the Chair has referenced that too, so I
19 am not going to ask you questions about those topics,
20 but I am going to ask you then about all the other 10:24
21 topics, okay?
22 A. Okay.
23 8 Q. And just before turning to the topics themselves, in
24 your statement you helpfully give, from paragraph 8
25 onwards, some contextual information about policies 10:24
26 within the Belfast Trust and I just want to explore
27 that with you a little. At paragraph 8, which is page
28 000168, please --
29 CHAIRPERSON: It might - I think it's probably easier

1 if you just give the last three - we don't need all the
2 zeros.
3 MS. KILEY: That's fine. 168, please, then. We might
4 get to the stage where there are no zeros at the front!
5 CHAIRPERSON: Yes! 10:25
6 MS. KILEY: Page 6, please, sorry, could we have page 6
7 up, please?
8 CHAIRPERSON: Page 6?
9 MS. KILEY: Yes.
10 CHAIRPERSON: Which starts with paragraph 7? 10:25
11 9 Q. MS. KILEY: That's right... That's it, thank you. So
12 you say at paragraph 8:
13
14 "There are almost 700 operative policies in the Belfast
15 Trust. This is a reflection of the size and complexity 10:26
16 of what is a very large health and social care
17 organisation. Those policies, and efforts to ensure
18 compliance with them, are part of a system of
19 governance and assurance designed to see that the care
20 provided by the staff of the Belfast Trust is to a high 10:26
21 standard and is as safe as possible."
22
23 Can I ask, Mr. Hagan, do you know - that's a large
24 number of policies, as you pointed out - does the
25 Belfast Trust keep a central database of all its own 10:26
26 policies?
27 A. Yes.
28 10 Q. It does. And is that searchable? I'm wondering, for
29 example, is it easy to identify amongst those policies

1 and using that database those policies which apply
2 directly in the learning disability field?
3 A. So they are all searchable on the hub.
4 11 Q. Okay.
5 A. The Trust hub, that is. 10:27
6 12 Q. And then related to that, given that number of policies
7 and the number of divisions within the Trust, how are
8 staff made aware which ones are relevant to them and
9 the field that they're working in?
10 A. So the expectation would be, you know, as part of 10:27
11 induction, for instance, that staff would be made aware
12 of relevant policies through mandatory training and
13 what have you, and also when new policies are
14 introduced, those will be shared with staff that work
15 in that area to make sure that they are aware of them. 10:28
16 13 Q. What about when policies are updated, how is that
17 communicated?
18 A. So, it's the duty of the people that update the policy
19 to ensure that that's then shared with the relevant
20 staff to make sure that they are aware there has been a 10:28
21 change in policy.
22 14 Q. Okay. And we might come to look at that when we look
23 at specific policies later then. So turning to the
24 first substantive topic then, topic B, which is your
25 topic you refer to as Topic 2, the Nursing Care 10:28
26 Delivery Model, and you commence addressing that at
27 paragraph 19 of your statement - page 15, please.
28 Thank you. So, at paragraph 20, Mr. Hagan, you refer
29 to a departmental policy framework for nursing and

1 midwifery workforce planning called the "Delivering
2 Care Project" and I just wanted to ask you, first of
3 all, can you tell the Panel a bit more about that
4 project?
5 A. Well, I think it's important to say, first of all, that 10:29
6 I am not a subject matter expert on nursing, but I will
7 try and help you as much as possible around this, okay.
8 15 Q. Yes.
9 A. So "Delivering Care" was a project started in 2014 by
10 the Department and it was basically to look at safe 10:29
11 staffing models for nursing. That's fundamentally what
12 it was about, and it's led by the Chief Nursing Officer
13 and they have focused on various areas of - where
14 nurses work and make recommendations about staffing
15 models. But I think the bottom line is that the 10:29
16 optimum staffing models are significantly greater than
17 what was there previously with it.
18 16 Q. Yes. And in terms of the breadth of the initiative, to
19 be clear then, it's not learning disability specific;
20 it's about all nursing areas, is that right? 10:30
21 A. Yes, that's correct, it's about all nursing areas.
22 17 Q. And you provide some summary of the purpose of the
23 framework at paragraph 22 and 23 of your statement, so
24 I am just going to read that out. You say:
25 10:30
26 "More specifically, the Delivering Care Framework is
27 intended to support the provision of safe, effective
28 and high quality care in both hospital and community
29 settings through the development of safe staffing

1 models and ranges for the nursing and midwifery
2 workforce across the range of specialities, and to
3 identify and implement sufficient staffing levels in
4 the various settings.
5 10:31
6 The Delivering Care Framework has been commissioned in
7 phases, with each addressing a different clinical care
8 setting. Each phase is commissioned by the Chief
9 Nursing Officer within the Department of health, the
10 CNO. Implementation is overseen by a central steering 10:31
11 group supported by a working group and expert reference
12 group for each phase, and is led by the Public Health
13 Agency."
14
15 So is it right to describe the framework, the 10:31
16 Delivering Care Project, Mr. Hagan, as a high level
17 framework and then it's intended that some specific
18 documents flow from that in respect of specific
19 clinical care settings?
20 A. That's correct. 10:31
21 18 Q. And just returning to paragraph 20 then, you identify
22 what you describe as core publications and they're set
23 out there at 20A and 20B. So A is a document entitled
24 "Delivering Care: Nurse Staffing in Northern Ireland.
25 Section 1: Strategic Direction and Rationale for 10:31
26 general and specialist medical and surgical adult
27 in-hospital care settings", and B, "Delivering Care:
28 Nurse staffing in Northern Ireland. Section 2: Using
29 the framework for general and specialist medical and

1 surgical adult in-hospital care settings." Can I just
2 ask you why you describe those as core publications in
3 this context?
4 A. Well, I think that's what they have used as their
5 standard to then develop where the, you know, where 10:32
6 they would then make the recommendations in terms of
7 the staffing levels, if I follow you correctly.
8 19 Q. So those are the documents that were the first in a
9 series, is that right?
10 A. Yes. Yes. 10:32
11 20 Q. And are you saying that they were used as a standard to
12 then inform a series of other documents?
13 A. Well, yes, but, as I say, I am not the subject matter
14 expert on this.
15 21 Q. No, that's understood. I just wanted to ask you, 10:33
16 though, to be clear, as the title of those documents
17 suggest, they are directed at general and specialist
18 medical and surgical adult in-hospital care settings -
19 A. Yes.
20 22 Q. So I just wanted to be clear about how they are core 10:33
21 documents in the learning disability sector. Are you
22 saying that they contain also more widely applicable
23 principles?
24 A. I genuinely don't know the answer to that. I think
25 that's, you know, that would be a question perhaps 10:33
26 better directed to the CNO, because she's the person
27 that's led on this piece of work.
28 23 Q. Well, can I ask you a more general question about the
29 learning disability component of this? At paragraph

1 25, you refer to Phase 9 of this project and you say:
2
3 "Phase 9 concerns learning disability nursing,
4 in-patient and community care settings and is currently
5 underway but is not complete." 10:34
6
7 Are you able to assist the Panel with any other
8 information about what stage the learning disability
9 component is at?
10 A. I'm sorry, at the moment I can't, but will come back to 10:34
11 you with that.
12 CHAIRPERSON: Can we just get a time frame on this,
13 because paragraph 21 tells us that the Delivering Care
14 Policy Framework was introduced regionally in March
15 2014. So is that the first time a framework of that 10:34
16 nature was introduced?
17 A. Ehm, I'm - I don't know the answer to that, I'm sorry.
18 CHAIRPERSON: Right.
19 24 Q. MS. KILEY: At paragraph 26, Mr. Hagan, you do refer to
20 the more wider implementation of the programme and you 10:35
21 say that:
22
23 "The ongoing implementation and progression of the
24 Delivering Care Framework has highlighted a significant
25 disparity between actual staffing levels across care 10:35
26 settings and staffing models identified for the optimum
27 delivery of safe and effective care."
28
29 Can you tell the Panel a bit more about that? Whenever

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1 you answered my question earlier, you referred to some
2 of those discrepancies. Can you explain a little more
3 about the issues that have been encountered?
4 A. I mean, I think what I can say is that this process of
5 delivering care has identified that the staffing levels 10:36
6 in various care settings were not optimum and that more
7 nursing staff were required, and that's been then
8 backed up with investment of around £50 million to
9 date. The investment was in three key areas around
10 workforce stabilisation, workforce development, and 10:36
11 service development and reform, and that was addressed
12 in the March 2020 Nursing and Midwifery Task Group
13 Report and Recommendations, which is included in the
14 bundle.
15 25 Q. Yes, and that investment in workforce stabilisation, 10:36
16 workforce development, and service development and
17 reform, has that been across sectors?
18 A. I'm not certain how that's been distributed across the
19 entire HSC, I don't know.
20 26 Q. Are you able to say whether there has been specific 10:37
21 investment in learning disability as a result of that?
22 A. Well, there is an indicative investment for learning
23 disability, as you can see in paragraph 28.
24 27 Q. Yes, I wanted to ask you about that. What does that
25 phrase mean, "indicative investment"? 10:37
26 A. Well, I think that's what the recommended investment
27 would be. But, as you know, there's been difficulties
28 around recruitment and retention in Muckamore.
29 28 Q. And you refer to a recommended investment - where does

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1 that recommendation come from? We can see at paragraph
2 28 that there are quite specific roles for investment:
3 One Band 8B consultant nurse, one Band 8A advanced
4 nurse practitioner, and two Band 7 nurses. So how is
5 it calculated that that is the indicative investment 10:37
6 for learning disability?
7 A. I'm not certain how that was worked out, but we can
8 come back to you with the detail on that.
9 CHAIRPERSON: Can I just ask this, in terms of
10 indicative investment, does that mean that those posts 10:38
11 are funded and available but you say there's a problem
12 filling them, or are you saying that that was the
13 indication but you don't know whether, in fact, that
14 funding was ever provided?
15 A. I am going to have to come back and clarify that to 10:38
16 you.
17 CHAIRPERSON: Right. Thank you.
18 29 Q. MS. KILEY: When you're doing that and thinking about
19 that, Mr. Hagan, I have another question about it -
20 can you say where it's intended those posts will be? 10:38
21 Paragraph 28 refers to investment in learning
22 disability services, but could you also check, please,
23 whether it's intended that those posts are based at
24 Muckamore Abbey Hospital?
25 A. Yes. 10:38
26 30 Q. Okay, thank you. I want to just finish this topic then
27 with a more general question, which hopefully you can
28 assist with, Mr. Hagan. At paragraph 29, you do refer
29 to the purpose of the investment and I want to read

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1 that for the record.
2
3 "The purpose of the investment is:
4
5 (a) to provide a safe and effective learning disability 10:39
6 in-patient nursing service that delivers evidence-based
7 care and nurse-led therapeutic interventions with
8 in-patient environments over a seven-day period;
9 (b) to develop processes to address the health
10 inequality outlined in the needs assessment for 10:39
11 learning disability patients;
12 (c) to ensure that there are sufficient senior nurses
13 to provide safe and effective care across the life span
14 within both hospital and community settings who will
15 provide clinical and care leadership; 10:39
16 (d) to ensure safe effective user experience with
17 better outcomes."
18
19 So it appears that this indicative investment has
20 identified roles that are needed to fulfil that 10:40
21 purpose. And the question that follows, Mr. Hagan, is
22 this: Is the out working of that that without staff in
23 those roles, the learning disability service is not,
24 for example, to take point (d), safe and effective user
25 experience? 10:40
26 A. So, again, I'm going to have to come back to you with
27 more information around that, but you know that the aim
28 is to close Muckamore and to focus more on community
29 with the availability of rapid assessment and treatment

1 as required, and that's the new community model which
2 has been, you know, set out by Bamford et al. So I'd
3 need to come back to you and tell you exactly how that
4 fits in with that.
5 CHAIRPERSON: I think we've got to be a bit careful 10:40
6 about language as well. You say the aim is to close
7 Muckamore - I don't think the results of the
8 consultation have yet been promulgated, have they?
9 MS. KILEY: Not yet.
10 CHAIRPERSON: No. So that may be the aim, but we don't 10:41
11 know at the moment, or do we?
12 A. Okay.
13 CHAIRPERSON: Do you know if that's the aim?
14 A. Well, in Bamford, that has been, you know - what was
15 set out was to have a community model for learning 10:41
16 disability.
17 CHAIRPERSON: Right. So that's the context in which
18 you meant that?
19 A. Yes.
20 31 Q. MS. KILEY: But obviously while the hospital exists, 10:41
21 there has been identified this indicative investment?
22 A. Yes.
23 32 Q. And I know that you're now going to take away some of
24 those issues - you can see that this is an issue that
25 the Panel and the Inquiry is interested in and would be 10:41
26 grateful for the Trust's assistance with?
27 DR. MAXWELL: Can you confirm those posts then are at
28 Muckamore, or are they for the wider LD service and
29 may, in fact, be community based?

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1 A. Well, I need to confirm that with you, but my hope
2 would be that they crossed the hospital and community
3 because that has to be model going forward.
4 DR. MAXWELL: Can I just ask you about nurse staffing
5 at Muckamore? So I accept that Delivering Care hasn't 10:42
6 produced the framework guidance for in-patient staffing
7 for LD, but as a trust board, as a unitary trust board,
8 you will be making decisions about the staffing
9 establishment in all your in-patient settings. What
10 evidence is the board using to set budgets and 10:42
11 establishments for the in-patient care at Muckamore at
12 the moment?
13 A. So the director that's responsible for that area, along
14 with the director of nursing, will bring information to
15 Trust Board about staffing levels. And, as you know, 10:42
16 we have had difficulty with recruitment and retention,
17 relying on agency, so there is that awareness around
18 the difficulties around staffing --
19 DR. MAXWELL: I'm asking about the establishment,
20 rather than the fulfilment. So the number of posts 10:43
21 that are funded in the budget, how do you decide, as a
22 board - I accept that directors will bring
23 recommendations, but as a board you collectively
24 decide. What evidence do you use to set the budget for
25 the posts, regardless of whether you can fill them? 10:43
26 A. So the budget is set in line with the commissioning
27 model for Muckamore in terms of what Commissioner has
28 commissioned.
29 DR. MAXWELL: The Commissioner sets the numbers of

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1 posts?
2 A. No, but it's a commissioned service in terms of the
3 numbers of beds et cetera.
4 DR. MAXWELL: So how do you decide how many posts you
5 need per bed? 10:43
6 A. So, again, that is not within my level of expertise in
7 terms of how that is determined. That would sit very
8 much with the Director of Nursing and the director
9 who's responsible for the service.
10 DR. MAXWELL: I certainly think that's something that I 10:43
11 would be interested to know more about.
12 MS. KILEY: And, Mr. Hagan, as you can see, it is an
13 issue that the Panel are interested in and have asked
14 the Trust to address, so I am going to leave these
15 issues with you and move on from that topic now. And 10:44
16 it may be, Chair, that we can also liaise with the
17 Trust to ensure that answers to those questions are
18 provided.
19 CHAIRPERSON: And obviously this needs to have some
20 historical relevance. We need to understand how this 10:44
21 has been approached through the terms of - periods of
22 the terms of reference, rather than simply now, which
23 is to some extent outside our terms of reference.
24 MS. KILEY: Yes, we will certainly take that up with
25 the Trust. 10:44
26 CHAIRPERSON: Thank you.
27 33 Q. MS. KILEY: So, Mr. Hagan, for the purposes of your
28 evidence, I am going to move onto the next topic, topic
29 D, which is safeguarding. You commenced this at

1 paragraph 64 of your statement - page 33, please. And
2 I know, in fairness to you, Mr. Hagan, you say there,
3 you make it clear that you're not an expert in the
4 background to and development of the subject of adult
5 safeguarding policies, but there are some general 10:45
6 questions that I want to ask you with reference to some
7 of the exhibits that you have provided. So we'll try
8 our best to deal with those.
9
10 At paragraph 65 of your statement, you refer to a 10:45
11 description of safeguarding that was given in December
12 2020 by the Minister For Health, the then Minister For
13 Health and he described the concept of adult
14 safeguarding as being about:
15 10:46
16 "...about protecting an adult's right to life in
17 safety, free from abuse, exploitation and neglect."
18
19 And you then say:
20 10:46
21 "Perhaps an even simpler way of describing adult
22 safeguarding might be to say that it is about keeping
23 adults safe from harm."
24
25 You go on then in paragraph 66 and 67 to explain some 10:46
26 of the complexities and challenges in giving effect to
27 the principle, and I'll just read those:
28
29 "Notwithstanding that the concept might be simply

1 stated, the material set out below and to be considered
2 by the MAH Inquiry will demonstrate that the regional
3 system has struggled to find a settled way of giving
4 meaningful effect to the principle.
5 10:46
6 When jointly introducing the present regional policy in
7 2015, the then Minister for Justice and the then
8 Minister for Health, Social Services and Public Safety
9 acknowledged that 'safeguarding adults is complex and
10 challenging'. 10:47
11
12 Over time, the written policies and procedures and the
13 systems they describe have become increasingly
14 detailed, but these in themselves have not been
15 sufficient to prevent cases of abuse, used in the 10:47
16 broadest sense, in social care institutions such as
17 care homes for the elderly, or in learning disability
18 facilities such as MAH."
19
20 I just wondered, Mr. Hagan, are you able to describe 10:47
21 some of the complexities and challenges that the Trust
22 has encountered in giving effect to the safeguarding
23 principle in the learning disability service?
24 A. Well, you will be aware the abuse that was uncovered
25 with the CCTV footage and that that hadn't been 10:47
26 reported as safeguarding by staff at the time. And I
27 think that it's fair to say there was a culture
28 developed in Muckamore where these things seemed to
29 have been tolerated. And I think that the - and I

1 think therein is the challenge in an institution that
2 is isolated from - you know, it's in a stand-alone
3 facility and there's a lot been written about what can
4 happen in stand-alone institutions like that, and it is
5 - and how we keep patients safe. 10:48
6 34 Q. You referred there to the culture that developed at
7 Muckamore, and if safeguarding is about providing a
8 good culture how does the Board ensure that good
9 culture does exist in those services, even when there
10 are challenges such as the geographical challenge that 10:49
11 you have mentioned?
12 A. I mean, I think that it's clear that when the
13 safeguarding concerns became aware to us in 2017 that
14 the approach was very different from that of - when
15 that awareness was there with weekly sit-reps, for 10:49
16 instance, reporting incidents of seclusion, use of
17 chemical restraints et cetera, and there was a much
18 greater oversight of what was happening day in/day out.
19 I think, prior to that, there wasn't that same
20 oversight as to what was happening on the Muckamore 10:49
21 site in that respect. I think that safeguarding is all
22 our responsibility. It may be that social work has led
23 that, but it's the responsibility of all professional
24 and managerial groups to ensure that adults and
25 children are safe in our care. 10:50
26 35 Q. You refer --
27 CHAIRPERSON: Can I - I'm so sorry to interrupt,
28 Ms. Kiley, but your point on a stand-alone facility, I
29 understand something, you know, about that, and one of

1 the problems about stand-alone facilities, and it's
2 happened also, for what it's worth, in Great Britain,
3 is that you don't get a free throughput of staff and a
4 culture can develop within an isolated facility. But
5 is that true to say the same of Muckamore which had, it 10:50
6 seems even then, a number of agency staff going through
7 it, and it wasn't exactly isolated in geographical
8 terms, was it?
9 A. Well, it is, it's a small facility in the countryside.
10 But, I mean, when I was preparing for this, I did a lot 10:51
11 of reading around the subject and I found from
12 Winterbourne a quote from a physician called Samuel
13 Gridley Howe, who said that - he wrote about the evils
14 of institutional care and he wrote that:
15 10:51
16 "All such institutions are unnatural, undesirable and
17 very liable to abuse, and we should have as few as
18 possible and those few should be kept as small as
19 possible."
20 10:51
21 And:
22
23 "The human family is the unit of society."
24
25 I found that very profound. 10:51
26 CHAIRPERSON: Yes, it may be, but I am just wondering
27 about your point about Muckamore being isolated. And
28 we haven't explored this yet, but one of the things, I
29 suppose, we may want to look at is how, if a culture

1 did develop, did it develop despite the fact that there
2 was throughput of students, other staff, agency staff,
3 as opposed to a truly isolated hospital which sometimes
4 had almost no throughput at all. Do you understand the
5 point I'm sort of making to you? 10:52
6 A. Yes, I think there was long-term staff that had been
7 there for many years that contributed to the culture
8 that existed there. I think, new staff, it can be
9 difficult to challenge.
10 CHAIRPERSON: Yes. Okay, well, thank you -- 10:52
11 A. Particularly agency staff, I think, you know, it can be
12 more difficult for them to challenge and I think we
13 have - I mean, I'm straying a little bit off topic
14 here, perhaps.
15 DR. MAXWELL: Can I add to that? So you recognise that 10:52
16 small isolated units are at a higher risk, and
17 certainly that came up in the CQC report. But Belfast
18 Trust was aware that there were problems - there was
19 the 2013 Ennis Ward report. 2017 wasn't the first time
20 that Belfast Trust was aware that there were issues. 10:53
21 And so my question is, having been aware of problems in
22 2013, did Belfast Trust Board not want to have more
23 intense monitoring of the culture? Why did it wait
24 until 2017 to do this, knowing that there had been a
25 problem at least four years before? 10:53
26 A. So I think the issues in respect of the Ennis Ward
27 related primarily to the --
28 MR. AIKEN: Sir, I am concerned because this witness
29 has been asked to give information/evidence about

1 policies and procedures across a very broad range of
2 topics and --
3 CHAIRPERSON: Well, we haven't asked him to give
4 evidence about a very broad range of topics, first of
5 all. We wrote a letter to the Trust to cover a broad 10:54
6 range of topics. It's a matter for the Trust to choose
7 who they put up as a witness, not us.
8 MR. AIKEN: But the central point I'm coming to you is
9 the question that was just asked - I'm going to have to
10 come back to you on that, Sir, because it was one 10:54
11 witness that was sought and, consequently, this witness
12 is doing his best to answer on the information topics
13 that he's been asked about. But the question that's
14 just been posed is of a very different order - it's a
15 perfectly legitimate line of enquiry for the Inquiry to 10:54
16 examine, but the issue I'm raising is whether that's
17 for this witness in this context to grapple with that
18 type of question.
19 CHAIRPERSON: All right, well, I mean, this arose
20 really because of his answer about Muckamore being an 10:54
21 isolated facility, so that's how this arose. I agree
22 that in general terms this area is meant to be about
23 policy, procedure and for the Panel to understand. If
24 the witnesses comfortable - he is, after all, the
25 Medical Director - if he is comfortable answering this 10:55
26 question, then I think he should be allowed to do so,
27 but I take your point that we will, as far as we can,
28 subject to his answers, stick to the policy and
29 procedure module. But are you saying he shouldn't

1 answer the question he's just been asked?
2 MR. AIKEN: I'm inviting the Panel to reflect on what
3 this evidence session was to be about and then the
4 nature of that question and whether, in the context of
5 what Mr. Hagan has prepared to address, whether that - 10:55
6 getting into questions and answers of that sort would
7 be appropriate today --
8 CHAIRPERSON: All right --
9 MR. AIKEN: And perhaps you consider, notwithstanding
10 what I've said, that it is, but I am raising that 10:56
11 issue, rather than just let it all happen.
12 CHAIRPERSON: No, I understand, I understand your
13 concern. Mr. Hagan, I am going to leave it with you.
14 If you are content to answer that question and you feel
15 knowledgeable to answer it, then I can't see any reason 10:56
16 why you can't. But, you've heard what's been said. Do
17 you wish to answer the question or not?
18 A. Well, that topic is covered in Module 6. I do think
19 that the issues around Ennis, I think it should have
20 come to Trust Board what happened. But having read how 10:56
21 it was managed, you know, and it was a multi-agency
22 response to the issues that arose, including PSNI and
23 RQIA, there was good oversight of the management of it.
24 But I do think it should have come to Trust Board and I
25 think if something similar were to happen today, I know 10:57
26 that we would bring such an issue to Trust Board.
27 CHAIRPERSON: All right. Can you just give us a
28 moment...
29 Can I just say I think Dr. Maxwell's question is, as it

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1 were, very relevant --
2 MS. KILEY: Yes, Chair, and, inevitably, I think there
3 will be this sort of discussion whenever we are dealing
4 even with safeguarding policies because we need to
5 discuss, as we will soon see when we look at them, the 10:57
6 implementation and oversight of those policies. But,
7 we are going to turn to look at the policies
8 themselves.
9
10 I do want to pick up on one issue that was raised by 10:58
11 the Trust representative about the Trust being asked to
12 provide one witness --
13 CHAIRPERSON: That was my understanding.
14 36 Q. MS. KILEY: That wasn't the case, Chair, and the Trust
15 have provided this witness. So we will continue to 10:58
16 deal with the topic of safeguarding.
17
18 Mr. Hagan, I asked you initially and this discussion
19 arose from me asking you to describe some of the
20 complexities and challenges that you had explained in 10:58
21 your statement. And I want to move then to look at
22 another area that you refer to in terms of recent
23 development in your statement, and that is a
24 significant change in legislation which is to be
25 introduced in respect of safeguarding. You refer to 10:58
26 this at paragraph 68. You say that the Department of
27 Health intends to have the Northern Ireland Assembly
28 enact a new adult protection bill and statutory
29 guidance to accompany it, and that statutory guidance

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1 will replace the regional adult safeguarding policy.
2 You have provided in your exhibits the consultation
3 document in respect of the proposed legislation and I
4 want to just look at that with you now, Mr. Hagan. So
5 it appears at page 8172, if that could come up, please, 10:59
6 8172? You can see - it should be on your screen,
7 Mr. Hagan, entitled - it's a consultation document.
8 It's dated the 17th of December 2020. If we scroll
9 down to page 8174, we'll see the foreword by the
10 Minister for Health, who at that stage was Robin Swann, 10:59
11 and, again, there are some comments there about the
12 purpose of adult safeguarding. But if we scroll down
13 to page 8180, the purpose of this legislation is
14 explained and I want to look at that with you. So
15 8180, if you could just scroll out so we can see the 11:00
16 whole page, please. Now, can you see halfway down
17 there the text "Purpose of the new legislation"?
18 A. Yes.
19 37 Q. And you see that that appears commencing at paragraphs
20 1.22, and I just want to read some of these paragraphs. 11:00
21
22 "The regional policy..."
23
24 - this is paragraph 1.22 -
25 11:00
26 "...will for the moment continue to provide the broader
27 framework for adult safeguarding. The purpose of the
28 new legislation is to introduce additional protections
29 to strengthen and underpin the adult safeguarding

1 process."
2
3 And can you scroll down, please, to 1.25? It says
4 there:
5 11:01
6 "Fives years on and following serious care failings at
7 Dunmurry Manor care home and Muckamore Abbey Hospital,
8 there are, once again, clear recommendations for
9 legislative reform in this area.
10 11:01
11 An announcement from the Health Minister followed on
12 the 10th of September 2020 to confirm that a bill would
13 be brought forward to make lasting improvements in
14 adult safeguarding and bring Northern Ireland in line
15 with other parts of the UK." 11:01
16
17 So it appears, Mr. Hagan, that at least part of the
18 reason for this new departmental bill arose from
19 concerns about the safeguarding failings at Muckamore
20 Abbey Hospital, would you agree with that? 11:02
21 A. Yes.
22 38 Q. And this document that we are looking at is a
23 consultation document. Later on in the document there
24 are a number of consultation questions in the usual way
25 - I don't intend to turn to them. But I wonder can you 11:02
26 tell the panel did the Belfast Trust submit a response
27 to this consultation document?
28 A. I will need to come back and check that for you.
29 39 Q. Is it something that you would expect the Belfast Trust

1 to be interested in, legislative change of this kind?
2 A. Absolutely. I mean, I'm sure we did, but I'll need to
3 come back and confirm that with you.
4 40 Q. You also exhibit another document in respect of the
5 proposed legislation, and that is the Draft Final 11:02
6 Policy Proposals for Ministerial Consideration. They
7 appear at 8220, if we could turn that up, please? And
8 you'll see again this is another Department of Health
9 document, entitled "Adult Protection Bill - Draft Final
10 Policy Proposals For Ministerial Consideration July 11:03
11 2021". I am not going to go through all those
12 provisions and details. It's noted that these are in
13 draft. I just want to scroll down to give some
14 examples. Can we look at further down, please, at
15 paragraph 4 and 5 on the next page? Yes, "Duty to 11:03
16 report and duty to make enquiries". So there is a
17 series of draft final proposals and they include this
18 at paragraph 4, a duty to report, and it says:
19
20 "The draft bill will place a statutory duty on the HSC 11:04
21 trusts..."
22
23 - and other bodies that are listed there -
24
25 "...and independent providers commissioned or 11:04
26 contracted to provide health and social care services
27 to report to the relevant HSC trust any cases where
28 they believe there is a reasonable cause to suspect
29 that an adult meets the criteria of an adult at risk

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1 and in need of protection."
2
3 And there are other duties that these final proposals
4 intend to place on the Board - and again, Mr Hagan,
5 appreciating that these are draft proposals, I just 11:04
6 wanted to understand from the Board's perspective, has
7 the Board of the Belfast Trust made any preparations
8 for the intended implementation of those duties?
9 A. That's something that I would need come back to you
10 with with the Director of Social Work. 11:04
11 41 Q. So it's the Director of Social Work that you would
12 expect to be dealing with those sorts of issues?
13 A. Yes.
14 42 Q. But what about at Board level because this is a
15 significant introduction and new piece of legislation - 11:05
16 and I caveat all of this with an acknowledgment that
17 these are in draft, but given this advanced stage of
18 these final proposal documents, is that not something
19 that the Board would be looking at even at that final
20 draft stage? 11:05
21 A. So the Director of Social Work would bring documents
22 like this to Trust Board and also in her role as lead
23 for social work.
24 43 Q. And having seen that now and being aware that they are
25 final proposals, would you expect that this is the type 11:05
26 of document that the Director of Social Work would
27 bring to the board?
28 A. Yes, absolutely.
29 44 Q. And, if that's the case, there will then be a record of

1 that that you can check for us?
2 A. Yes.
3 45 Q. Okay. Returning then to your statement, at paragraph
4 69 you provide a list of what you describe as the main
5 policy documents which chart how adult safeguarding has 11:05
6 developed in Northern Ireland. It is a broad topic and
7 a significant topic and that's reflected by the number
8 of policies - I think they run to 57 in the list that
9 you have provided. But, just for context, I want to be
10 clear it's correct, isn't it, that there are regional 11:06
11 policies in respect of safeguarding and they operate at
12 a high level, and then the Trust has its own local
13 policies, if you like, in respect of safeguarding, is
14 that right?
15 A. Yes, that's correct. 11:06
16 46 Q. And I asked you this question earlier about all Trust
17 policies, but thinking just about safeguarding
18 policies, does the Trust keep a database of all the
19 safeguarding policies that are relevant in Northern
20 Ireland - so regional and Trust? 11:06
21 A. So we have a database of our own policies on our own
22 hub. I will need to come back to you on how - in terms
23 of regional policy, where that's kept.
24 47 Q. Okay, but on your own hub, all the Trust's safeguarding
25 policies will be there? 11:07
26 A. Yes.
27 48 Q. And you refer to it as a "hub" - is that something that
28 is accessible by staff?
29 A. Yes.

1 49 Q. So staff members can access - is it an online hub?
2 A. Yes.
3 50 Q. And they can access safeguarding policies there?
4 A. Yes.
5 51 Q. How do they know which ones are relevant to them? 11:07
6 A. Well, it is their responsibility in the area that they
7 work to be familiar with the policies that are relevant
8 to that area. But, as part of induction and training,
9 mandatory training, there will be that expectation also
10 that that's covered in that training so there's that 11:07
11 awareness.
12 52 Q. I want to ask you a little more about how the Board
13 assures itself that that is done, but I'm going to park
14 that for now because I want to look at the specific
15 policies -- 11:08
16 CHAIRPERSON: Before you do, sorry, just so we can put
17 a timing on this, when did the hub become operational?
18 A. Well, there has been a hub in place for a long - I
19 can't tell you exactly when that started, but the
20 policies have all, have been available online for as 11:08
21 long as I can remember.
22 CHAIRPERSON: Right.
23 A. And we restructured our hub a couple of years ago to
24 actually make it easier to find policies.
25 CHAIRPERSON: Thank you. 11:08
26 53 Q. MS. KILEY: Just a final question about the hub - do
27 agency staff have access to it?
28 A. Yes, they should do, I think. I will need to check
29 that.

1 DR. MAXWELL: Can I just check then - so agency staff
2 have access to the intranet? Because I presume you're
3 saying that the hub is on the intranet?
4 A. Yes.
5 DR. MAXWELL: And so agency staff are given access to 11:08
6 the intranet, are they?
7 A. I'll need to double check that for you.
8 54 Q. MS. KILEY: I want to turn to the safeguarding policies
9 that were in place in and around 2017 at the time that
10 allegations of abuse at Muckamore Abbey Hospital arose. 11:09
11 And you set these out and identify them, in fact, at
12 paragraph 70 of your statement. It's at page 42. So,
13 the Trust had - well, if I start at paragraph 70, you
14 set out the regional policy at that time was the 2015
15 policy, and that was authored by the Department of 11:09
16 Health, then the DHSSPS, and the DOJ, the Department of
17 Justice. It was entitled "Adult Safeguarding:
18 Prevention and Protection in Partnership". And then at
19 paragraph 71, you refer to The Trust's own individual
20 policy and it was the April 2013 adult safeguarding 11:09
21 policy entitled "Adult Protection Policy and Procedures
22 2013" and I just want to turn to that document, please.
23 It appears at page 6743, if we could call that up,
24 please? Do you see that on your screen, Mr. Hagan?
25 A. Yes. 11:10
26 55 Q. So this is the April 2013 Trust local policy. And if
27 we can scroll down - this is the covering page, but if
28 we scroll down, please, to page 6749, I want to look at
29 the various roles and responsibilities of persons set

1 out in the policy. You'll see there that topic 3/
2 Section 3 deals with roles and responsibilities. If
3 you could just zoom out so we can see the entire page,
4 please? Yeah, so Section 3 there deals with roles and
5 responsibilities. And at 3.1, the roles of the Trust 11:11
6 Board are set out, so I want to look at that first.
7 So 3.11:
8
9 "The Trust board (1) has a role to ensure that relevant
10 policies and procedures are in place in relation to 11:11
11 adult protection work; (2) to commit appropriate
12 resources to ensure that staff working in the field of
13 adult protection are adequately trained."
14
15 And then if you look down to 3.2, the roles of service 11:11
16 group, directors, co-directors and service managers are
17 set out. And if you can just keep scrolling down so we
18 can see 3.3 as well, please, and the roles of employees
19 are set out then - for example, to adhere to adult
20 protection policy and procedure. But my question is 11:12
21 this, how does the Trust monitor that those various
22 persons are carrying out those roles and
23 responsibilities in line with their policy?
24 A. So the staff will have annual appraisal or SDRs where
25 it's - review what their work is and whether they were 11:12
26 up-to-date with the requirements to work in that area.
27 And it's the responsibility of those that are managing
28 those areas to ensure that the people that work in it
29 are familiar with policies and procedures in that area.

1 56 Q. But how does the Board ensure that those managers are
2 doing that job?
3 A. So we have a system now called "Equality Management
4 System", so individual directors come to their
5 accountability review, essentially, with the Chief 11:13
6 Executive where the statutory mandatory training is
7 covered within that dataset. And then that comes to
8 Assurance Committee, which is de facto a representation
9 of Trust Board. So that's how we get assurance around
10 those types of matters. 11:13
11 57 Q. Is that, present day, that's how you get assurance now?
12 A. Yes.
13 58 Q. And are you able to assist with thinking back to 2017
14 and whenever the allegations in respect of CCTV emerged
15 in respect of Muckamore Abbey Hospital - how did the 11:13
16 Trust get assurance around that time?
17 A. So following the emergence of the issues around abuse,
18 the Trust put in place a weekly sit-rep, so that
19 recorded all issues of - or it captured seclusion,
20 restraint, use of medication, any safeguarding 11:14
21 concerns, staff who were suspended et cetera, and that
22 was - there was an oversight group that reviewed that
23 on a weekly basis and then reported that up and then
24 that came as a report to Trust Board. So the Trust
25 Board were fully cited on that. 11:14
26 59 Q. Okay --
27 A. And there is really good documentation demonstrating
28 that in Trust Board minutes.
29 60 Q. Yes, and I just want to be clear about the timing of

1 when that came in. That came in after the 2017 CCTV
2 allegations emerged, is that right?
3 A. Yes, that's right. So we got, as part of my - when I
4 was Deputy Medical Director in Risk and Governance, we
5 adopted a new process around - it's called live 11:15
6 governance, which is basically - which we spread across
7 the whole Trust, and that's where senior teams come
8 together on a weekly basis and review incidents,
9 complaints, mortality, any serious issues affecting
10 that service area. 11:15
11 61 Q. Sorry, on a weekly basis did you say?
12 A. Yeah, that's across the Trust, the senior teams. And
13 we then further expanded that using a model called the
14 "Charles Vincent Monitoring and Measurement of Safety"
15 to really put a focus on safety across the whole Trust, 11:15
16 and we used that to sort of underpin what we were doing
17 in terms of sit-rep reporting.
18 62 Q. And does that process continue now?
19 A. Yes.
20 63 Q. Okay, so there is still the period, though, before 11:15
21 2017, so I want to turn to that now. So before that
22 process that you've just described was put in place,
23 how did the Board assure itself that those people whose
24 roles are identified there in the safeguarding policy
25 were actually carrying out those roles? 11:16
26 A. So I'll need to come back to you on exactly what the
27 mechanism was prior to that. But, I mean, there was a
28 clear management structure at that time - we have a
29 collective leadership structure now, which is slightly

1 different - but where the director of the service was
2 responsible for ensuring the delivery and safe care
3 within that area, and the director would have had their
4 own accountability review within their teams and then
5 their accountability review with the Chief Executive. 11:16
6 64 Q. And would you expect safeguarding to be part of that
7 accountability review - so is that how you would expect
8 that the evidence would be demonstrated by the Board of
9 looking at that?
10 A. So it certainly is now, and safeguarding, for me, is 11:16
11 safeguarding across the whole Trust. And that's why I
12 said earlier on it's not just the responsibility of
13 social work, although they lead the policy. It's the
14 responsibility of all of us. So one of the things that
15 we're bringing in is on our safety thermometers on 11:17
16 wards, is have there been a safeguarding incident, you
17 know, the previous week or what have you. In terms of
18 the arrangements pre 2017, I'll need to come back to
19 you exactly how that worked.
20 MS. KILEY: Okay. And returning to the policy, Chair, 11:17
21 I am conscious of the time, but I just have a couple
22 more questions about this policy and then I think it
23 would be appropriate time to break.
24 CHAIRPERSON: All right, sure.
25 DR. MAXWELL: Can I just clarify - safeguarding is 11:17
26 included in the safety thermometer in your Trust, is
27 it?
28 A. No, it's something that - so at ward level, the
29 Band 7 nurse who has responsibility for that area, we

1 brought in NHS safety thermometers and one of the
2 things that we're doing through our risk and governance
3 is ensuring that safeguarding incidents are captured
4 also now within that so that - and I think it would be
5 expressed as "time since last safeguarding incident", 11:18
6 rather than - if you get where I'm coming from on this?
7 DR. MAXWELL: Yes, yeah --
8 A. So as there's an awareness --
9 DR. MAXWELL: So it's a specific criteria on the safety
10 thermometer, is it? 11:18
11 A. Well, we want to bring it in on that, because we
12 brought in safety thermometer a couple of years ago and
13 we report - those come up through --
14 DR. MAXWELL: So you're intending to put safeguarding.
15 It isn't actually on it at the moment? 11:18
16 A. Yes, so we're collecting - I mean, we're trying to work
17 out the mechanism exactly how to do it, but that is the
18 intention --
19 DR. MAXWELL: So it's the intention rather than
20 something that's actually happened historically? 11:18
21 A. No, well, so safeguarding incidents will, if there is a
22 significant safeguarding incident, it will be reported
23 up through this live governance process that I have
24 described to you. But I wanted to create more
25 awareness and ownership of it at ward level because I 11:18
26 think that's - it is everybody's responsibility and I
27 think that, traditionally, it sat - there has been a
28 lack of awareness, I think, in some professional groups
29 around it.

1 DR. MAXWELL: Yeah.
2 A. And Outpatients is the other area because you'll know
3 the RQIA reviewed our outpatients following Urology
4 Inquiry, or as part of that, and safeguarding in
5 Outpatients was also highlighted as an issue. 11:19
6 65 Q. MS. KILEY: Can I take you back to the policy itself,
7 please, and if we could scroll down to point 3.4, I
8 just want to understand a little bit about the roles of
9 specific staff that are mentioned in this policy. Now,
10 again to reiterate, I appreciate it is not the policy 11:19
11 that's in place now, but this is the one that is the
12 2013 policy.
13
14 The first - the heading of paragraph 3.4 refers to
15 "Staff trained in adult safeguarding". The first staff 11:19
16 referred to is a designated officer. Could you just
17 explain what sort of staff member carries out the role
18 of a "Designated Officer"? For example, is it
19 typically a member of ward staff or somebody else?
20 A. All I can tell you is it's a professional member of 11:20
21 Trust staff who does that. I'll need to come back to
22 you and tell you exactly who would do that.
23 66 Q. Do you know what their discipline is? Are they a
24 nursing discipline/a social worker?
25 A. Again, I will need to clarify. Traditionally, it would 11:20
26 be social worker or nurse.
27 67 Q. And are you able to say what their area of
28 responsibility would be? So, by that, I mean would a
29 designated officer - would one designated officer be

1 responsible for a ward or a hospital or a service?
2 A. I'm not sure of the answer to that, I'm going to have
3 to come back to you.
4 68 Q. The same question then for the "Investigating Officer".
5 And, again, I am not going to read all this out, but 11:21
6 their role in the policy at that point of time is set
7 out there, but I just wanted to understand about the
8 investigating officer - what sort of person would have
9 carried out that role, can you say?
10 A. Again, I'll need to come back to you to confirm that. 11:21
11 69 Q. Okay. And there are other members of staff named there
12 also - the "Achieving Best Evidence Specialist
13 Interviewer" and, further down, "Staff Trained in the
14 Protocol for Joint Investigation", and I wanted to ask
15 you the same question about those - is your answer the 11:21
16 same?
17 A. Can we come back to you with that so as I can help you
18 on that?
19 70 Q. Okay. Those are the matters that I wanted to raise
20 with you about that policy. I still have other 11:21
21 questions about the safeguarding topic, but I think it
22 is an appropriate time now for a break, Chair.
23 CHAIRPERSON: Sure. All right, well, we'll take a
24 short break. You'll be looked after - somebody will
25 get you a cup of tea or coffee or whatever it is that 11:22
26 you need. If you do discuss your evidence, then we
27 would expect to hear about it. But you probably
28 haven't got much time in the next 15 minutes, in any
29 event. So somebody will look after you and we will

1 reconvene just before a quarter to. Thank you.
2
3 THE INQUIRY ADJOURNED FOR A SHORT PERIOD AND THEN
4 RESUMED, AS FOLLOWS
5
6 71 Q. MS. KILEY: Mr. Hagan, we were looking just before the
7 break at the 2013 Trust safeguarding policy and you
8 explain in your statement that that was replaced in
9 October 2019. And I want to look briefly at the
10 replacement policy. It appears at page 7662?
11 CHAIRPERSON: So this is 2019?
12 72 Q. MS. KILEY: This is 2019. So we can see there
13 "Operational Date" in the fourth box down, October
14 2019, "Due next for review in October 2014". Can you
15 tell the Panel why the decision was made at that time
16 to replace the safeguarding policy that we've just
17 looked at?
18 A. I'm assuming it's because it was due for renewal, but I
19 would need to come back to you specifically why. And,
20 as you know and as you've said already, the landscape
21 for safeguarding has changed and it's a very iterative
22 thing and I think it's been hard to define and hard to
23 understand. So it's a constantly evolving process and
24 I think you can't stand still in that respect. I also
25 think that there was an assurance group that reviewed
26 policies in Muckamore following the 2017 issues around
27 the CCTV and that highlighted some of the policies were
28 out of date as well.
29 73 Q. Well, that's what I am wondering really, is this new

1 policy, at least in part, a response to some of the
2 issues that arose in respect of Muckamore in and around
3 2017?
4 A. Well, you will be aware of the assurance report from
5 2018 and that demonstrated that some of the policies
6 were out of date. And I think that some of them were
7 out of date by some time and so it was important that
8 they were brought up-to-date.
9 74 Q. So just sticking with this 2019 policy, I want to just
10 look down at the stated purpose of the policy. It's at
11 page 7663. If you could just scroll down, please, to
12 1.2? Yes. And you'll see the first substantive
13 paragraph under "Purpose" gives some background about
14 the purpose of the policy. If you could scroll down a
15 little bit more, please, and just pause there. The
16 text I want to draw your attention to is that which
17 starts "The primary purpose...". So you will see it
18 says:
19
20 "The primary purpose of this policy is to make clear to
21 all Trust staff that the Belfast Trust has accepted,
22 adopted and implemented the regional policies..."
23
24 - and they are then listed, the "Adult Safeguarding
25 Policy: Prevention and Protection in Partnership"
26 dated DHSSPS 2015, and the "Adult Safeguarding
27 Operational Procedures: Adults At Risk of Harm and
28 Adults in Need of Protection", and that is dated 2016.
29 Both those policies are then appended to this Trust

1 policy. I wanted to ask you, though, about that
2 regional policy first, so the first one authored by the
3 Department. Are you aware is this policy the first
4 time that the Belfast Trust formally adopted that
5 regional policy?
6 A. Again, I'm going to have to come back to you to assist
7 you with that. We would need to go back to the Trust.
8 75 Q. I just want to explore timing a little bit with you
9 because, as you have said, safeguarding is ever
10 evolving and we can see that there are a number of
11 policies in that respect. The regional policy is dated
12 2015 and, in fact, if we can just look back at the 2013
13 policy for a moment, please, if you bring up page 6743?
14 So here we're looking back at the 2013 policy - this is
15 the Trust policy. We know the next Trust policy is
16 2019, okay. And, in between, we have the Departmental
17 policy in 2015. If you look at the box halfway down
18 that page, you'll see the version history of the 2013
19 policy and you'll see the date of amendments goes up to
20 2014, but, as we've just seen, the Departmental
21 regional policy came in in 2015 and it doesn't appear
22 that the 2013 policy was amended in light of the 2015
23 policy. Can you see that from the version --
24 A. Yes.
25 76 Q. Is that something that is unusual in your experience?
26 A. It's a good question. I mean, I think that because of
27 the number of policies, at times it can be difficult to
28 ensure that all of them are up-to-date. But there is a
29 process whereby policy authors are reminded in good

1 time before the policy comes up-to-date whether it
2 stands as extant or it needs revised or it could be
3 stood down. So the question is probably best directed
4 to the author of that, you know, why it wasn't updated
5 when it was due to be updated in April 2015.
6 77 Q. But I think the question is a little bit more than
7 that. So the 2015 period that I'm interested in is the
8 date that the Department issued regional guidance --
9 A. Sure.
10 78 Q. And, as a trust, would you expect that the Trust policy
11 would usually be amended if new regional guidance came
12 in?
13 A. Absolutely, and I think you will see through some of
14 our documentation around, for instance, restraint where
15 we actually put it in the policy that we were aware
16 that there was new guidance coming from the Department
17 in March 23 and that we would update the policy within
18 that calendar year because we knew the guidance was
19 coming. So I do think we have got better in that
20 respect. But you'll be aware of the - I think it's the
21 Owen Barr et. al report from 2018 which looked at the
22 policies affecting Muckamore and they were out of date,
23 out of that assurance paper. It also looked at the
24 safeguarding and how it had been managed.
25 79 Q. But you'd accept that looking at this, it appears that
26 departmental policy - regional policy was introduced in
27 2015 and that didn't make it's way into Trust policy
28 locally formally until 2019, is that right?
29 A. Yes.

1 DR. MAXWELL: Can I just ask about the process for
2 updating because it does very clearly say "Next review
3 is April 2015". And you've talked about the database
4 of policies - is there a separate management database?
5 So you've talked about the database on the hub, on the
6 intranet - within risk and governance and I think you
7 were Deputy Chief Medical Officer for Risk and
8 Governance at one point - in the risk and governance
9 process, is there a separate database which is
10 highlighting policies that are coming up to review so
11 you can assure yourself that they are being reviewed?
12 A. So within Risk and Governance, there's a team that
13 managed policies and they will write to the author of
14 the policy and make them aware that the policy is due
15 for renewal three months beforehand and they have three
16 options - either renew it, say that it's unchanged, or
17 say that it can be stood down.
18 DR. MAXWELL: So would you not then produce another
19 version that says, you know, "Version 3 unchanged"?
20 A. Absolutely. I can't explain to you today why that
21 didn't happen so --
22 DR. MAXWELL: But there is a process for doing that.
23 And if somebody didn't update it, didn't respond to
24 this letter, who would it be escalated to by the policy
25 team within Risk and Governance? 12:00
26 A. Well, it should be escalated to the director of that
27 service.
28 DR. MAXWELL: But who within the Risk and Governance
29 team would it be escalated to?

1 A. Oh, more than likely the co-director in risk and
2 governance would do that.
3 DR. MAXWELL: And can I just ask what your role as
4 Deputy CMO for Risk and Governance was in relation to
5 the Co-Director for Risk and Governance? 12:01
6 A. So we restructured in Belfast in terms of our medical
7 leadership because we wanted to bring in more medical
8 leadership because we believed that a clinically-led
9 managerial supported organisation - but also we wanted
10 to distribute leadership down to the bottom in a 12:01
11 collective leadership approach. So we created 13
12 divisions across the organisation and, within each
13 division, there would be a chair of division, who's a
14 doctor, a senior manager as a co-director, and a
15 divisional nurse. And in areas where there was - like, 12:01
16 children's community, for instance, there'd be a social
17 worker sitting in that group as well. But in the
18 medical directorate, we tried to replicate that. So
19 there was a co-director for Risk and Governance and I
20 sat beside her as the Deputy Medical Director for Risk 12:02
21 and Governance. My main responsibilities were around
22 incidents, SAIs, coroners, litigation, but also had a
23 role in standards and guidelines and things like that.
24 But there was aspect another deputy in the team that
25 also did some of that work as well because the remit is 12:02
26 actually enormous and it's a part-time role because
27 it's balanced with clinical work.
28 DR. MAXWELL: Thank you.
29 CHAIRPERSON: And just so I understand, we've referred

1 to you as CMO - you weren't the Chief or the Deputy
2 Chief Medical Officer - you were the Deputy Director?
3 A. There's different terminology in Northern Ireland.
4 The CMO is Sir Michael McBride. But, in England, they
5 have split medical director roles because the span of 12:02
6 control is so enormous. So you would have a medical
7 director for regulation, who's the responsible officer,
8 and then you would have a medical director who would
9 cover patient safety, essentially, and that could be
10 your - and then they use terminology like Chief Medical 12:03
11 Officer within trusts but we don't use that --
12 CHAIRPERSON: Oh, within trusts, do you?
13 A. Yes.
14 CHAIRPERSON: Right, sorry, I didn't understand.
15 A. We don't use that in Northern Ireland because it would 12:03
16 cause real confusion because we're relatively small.
17 CHAIRPERSON: But you were - what was your formal
18 title?
19 A. So 2018 to 2020, I was the Deputy Medical Director for
20 Risk and Governance and I would have also stood in for 12:03
21 the Medical Director at various things like Trust Board
22 or what have you if she was not available.
23 CHAIRPERSON: Thank you.
24 80 Q. MS. KILEY: So, Mr. Hagan, we looked at the 2019 policy
25 and we know that it specifically adopted the regional 12:03
26 policy. It appears as an appendix to the 2019 policy
27 and I want to look at that briefly now. That's page
28 7673, please. So you'll see there at the top right
29 Appendix 1. So that's the appendix to the Trust's 2019

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1 policy but this that we're looking at is the regional
2 policy dated July '15. Does that remain regional
3 policy on safeguarding?
4 A. I assume so. I don't know if there has been an update.
5 81 Q. In fairness, you don't exhibit an updated policy. So 12:04
6 my assumption in reading your exhibits and statement
7 was that this is the most up-to-date regional policy?
8 A. As far as I know. But, I mean, I think we've got to
9 remember I was being asked to cover until 2019/2020 and
10 we've tried to keep up-to-date with stuff, but I don't 12:05
11 know if it's been updated, I'm sorry.
12 82 Q. That's understood, okay. I want to just refer to some
13 of the infrastructure, the safeguarding infrastructure
14 that's referred to here and ask you a little bit about
15 that. So if we could scroll down, please, to page 12:05
16 7689, there are two particular bodies that are referred
17 to in this document, Mr. Hagan, that I want to ask you
18 about - the Northern Ireland Adult Safeguarding
19 Partnership, and then the what are described as Local
20 Adult Safeguarding Partners. So you'll see that on the 12:05
21 screen now, the first body, under the heading "Adult
22 Safeguarding Infrastructure", and bearing in mind this
23 is regional infrastructure is the Northern Ireland
24 Adult Safeguarding Partnership, NIASP. And it also
25 refers to five Local Adult Safeguarding Partnerships, 12:05
26 LASPs. The document says:
27
28 "They were established under the Adult Safeguarding in
29 Northern Ireland Regional and Local Partnership

1 Arrangement 2010. They are collective partnerships
2 with a responsibility for adult safeguarding in
3 Northern Ireland. The partnership are tasked by DHSSPS
4 with the support of DOJ with the delivery of...Adult
5 Safeguarding Outcomes by Way of Strategic Plan 12:06
6 Operational Policies and Procedures and Effective
7 Practice, which will be developed and implemented in
8 accordance with this policy."
9
10 And if you scroll down to 6.1, it tells you a little 12:06
11 bit more about the Northern Ireland Adult Safeguarding
12 Partnership. The Panel has that and can read it, but I
13 wanted to ask you, Mr. Hagan, if you could assist a
14 little more about the role of the Northern Ireland
15 Adult Safeguarding Partnership and how that interacts 12:06
16 with the Belfast Trust. Are you able to speak to that?
17 A. Unfortunately, I'm not. I am not familiar with how
18 that works. We'd need to come back to you with a
19 specific answer, I'm sorry.
20 CHAIRPERSON: When you were in the role of Co-Director 12:07
21 of Risk and Governance, did this not come into your
22 radar?
23 A. No, because this policy sits within - it's essentially
24 social work led on adult safeguarding. It didn't come
25 in in terms of - I wasn't the author or co-author of 12:07
26 this.
27 CHAIRPERSON: Okay.
28 83 Q. MS. KILEY: I do want to ask you still, though, about
29 that second partnership, the Local Adult Safeguarding

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1 Partnerships, because it may have been more on your
2 radar. If we could scroll down to the next page,
3 please, 'til we see what's said about those - at 6.2,
4 if you just pause there. So it explains that the five
5 Local Adult Safeguarding Partnerships are located 12:07
6 within and accountable to their respective HSC trusts.
7 So without going through all that information, it
8 appears then, is it right, that there is a Belfast
9 specific, a Belfast Trust specific LASP, is that right?
10 A. Yes, but you can see in the second paragraph it was 12:08
11 chaired by the Trust Executive Director of Social Work.
12 84 Q. Yes?
13 A. And safeguarding, both children and adult safeguarding
14 is led within the Trust by the Director of Social Work.
15 85 Q. Yes, but is that something that you would expect the 12:08
16 Director of Social Work to be reporting at Board level?
17 Is that not the point?
18 A. So there's the delegated statutory functions and what
19 have you, and the Director of Social Work will report
20 on that to Trust Board and there's a whole mechanism 12:08
21 around that. And, again, it's not within my - well, it
22 has never been within my span of control. There is an
23 awareness, obviously, but I have never led on that
24 within the Trust. I come back to the point - and I've
25 conjoined with the Director of Social Work on this that 12:09
26 adult safeguarding is everybody's responsibility but,
27 it is not something that I have led on within the
28 organisation or reported on to Trust Board.
29 86 Q. And just taking that, it's not something you've led on

1 or reported on to Trust Board, but sitting as you do as
2 a medical director on the Trust Board, are you not
3 familiar with having been reported to on LASPs, and
4 particularly the Belfast Trust LASP?
5 A. I'm not familiar with that terminology but I know that 12:09
6 the Director of Social Work will bring concerns to
7 Trust Board, you know, for instance, around
8 safeguarding or other issues in respect of social work.
9 87 Q. Just for completeness then, I want to turn to the
10 second document that is appended to the 2019 policy, 12:09
11 and that's the NIASP Operational Procedures. They
12 appear at page 7734. So you see there, Mr. Hagan, this
13 appears to be a product of that first body that we
14 discussed, the NIASP, and they have produced
15 operational procedures and, in the 2019 Belfast Trust 12:10
16 policy, the Belfast Trust adopt these operational
17 procedures. So to be clear about what that means in
18 practice, if the trust are adopting procedures they are
19 agreeing to be bound by those or to apply those
20 throughout the organisation, is that right? 12:10
21 A. Yes.
22 88 Q. And if we scroll down, there is just one matter that I
23 wanted to ask you about and a particular role in this
24 at page 7747. You'll see at the top of the page it
25 refers to an adult safeguarding champion and Section 3 12:11
26 provides some more information about what the adult
27 safeguarding champion does and which organisations need
28 them. And at paragraph 3.1, it says that - it refers
29 to:

1
2 "'Adult safeguarding. Prevention and Protection in
3 Partnership 2015' sets out the requirement for
4 organisations to have an adult safeguarding champion,
5 ASC. If the organisation or group does not have staff 12:11
6 or volunteers who require to be vetted, then it's not
7 required to have an ASC. However, having an ASC is
8 identified as good practice for every group or
9 organisation."
10 12:11
11 And I wanted to ask you about whether the Belfast Trust
12 has an adult safeguarding champion?
13 A. Yes.
14 89 Q. Could you tell the Panel a bit more about that role and
15 what the role provides to the Belfast Trust? 12:12
16 A. Well, I think the main role is to raise awareness of
17 adult safeguarding. Adult safeguarding is everybody's
18 responsibility. And, again, I'm going to repeat myself
19 here - it was about not seeing it as just belonging in
20 the realms of social work, but belonging in the realms 12:12
21 of nursing, medical, AHPs et cetera and it's
22 to lead on that throughout the organisation. Now it's
23 an enormous role for one ASC for an organisation of
24 22,000 people, but I think it was an important
25 function. 12:12
26 90 Q. And what level of seniority does the ASC hold within
27 the Trust?
28 A. I'm not sure what grades, I'm sorry. We would need to
29 come back - I'm not sure what grade this had. I mean,

1 it's not a director.
2 91 Q. It's not a director, so it's below that, okay.
3 CHAIRPERSON: And what's their background or what's
4 their training? Are they a social worker, are they a
5 doctor, are they a nurse? 12:13
6 A. My understanding is that it was a social worker.
7 CHAIRPERSON: Currently? Does it have to be held by a
8 social worker or --
9 A. Traditionally, yes, it would be - I don't think it has
10 to be but, traditionally, it would be - social workers 12:13
11 tend to have the expertise around the legislation and
12 the knowledge.
13 CHAIRPERSON: Right.
14 92 Q. MS. KILEY: We can see from the portion of the
15 operational procedures we've just looked at that there 12:13
16 is reference to a date in 2015 that set the requirement
17 for the organisation to have an adult safeguarding
18 champion. Do you know even roughly when the Belfast
19 Trust first had an adult safeguarding champion?
20 A. I'd need to come back to you on that. 12:13
21 93 Q. Okay. Now, the final specific policy that I want to
22 pick up on within this safeguarding topic is one which
23 you have referred to in respect of CCTV. That's the
24 June 2017 policy entitled "Implementation of CCTV
25 within MAH to assist with investigations related to 12:14
26 safeguarding issues". If we could bring that up,
27 please, it's at page 7365... That should be on your
28 screen now, Mr. Hagan. And that's the front cover of
29 the policy, but if we could scroll down to 7368,

1 please, we will see the background. Can you just zoom
2 out a little, please, so I can see some more of that?
3 Thank you. So the background to the introduction of
4 this policy is said to be that:
5 12:15
6 "Muckamore Abbey Hospital provides an assessment and
7 treatment service for adults with learning disability
8 on a regional basis, which includes a regional low
9 secure learning disability forensic service. Due to
10 complex needs, challenging behaviours and associated 12:15
11 mental health issues, there is a high proportion of
12 adult safeguarding referrals.
13
14 During the investigation process regarding adult
15 safeguarding allegations, it has proven difficult to 12:15
16 establish clear and concise witness reports taken from
17 the client group, many of whom have communication
18 difficulties and lack capacity. In many cases, staff
19 witness reports have helped, but the process has been
20 slow and in conclusive. All incidents which meet the 12:15
21 appropriate criteria are referred to the PSNI..."
22
23 - and there is some further information about how, in
24 practice, those referrals work. But just bearing in
25 mind particularly that second paragraph, is it fair 12:15
26 enough to say that part of the reason for the
27 introduction of this policy was to assist with
28 safeguarding investigations in the particular
29 circumstances of Muckamore, given the complexities

1 particularly in respect of communication that some of
2 those service users had?
3 A. Yes, that's right.
4 94 Q. And if we can just scroll back up then to page 7365, I
5 just want to look at the dates of this policy. So if 12:16
6 you just stop there, thank you. So just looking at
7 that box again in the bottom half of the page, we can
8 see that on the left-hand side there is a date the 24th
9 of September '15, Version 0.1. So it appears that
10 Version 1 of this policy is drafted in September '15, 12:16
11 but if you look up then to the box entitled
12 "Operational date", it's noted as June 2017. And I
13 wondered if you could assist the Panel with why it took
14 nearly two years to approve this policy and implement
15 it? 12:17
16 A. I'm not able to answer that, I'm really sorry, I'll
17 need to come back to you with the answer.
18 CHAIRPERSON: If we look in the box above, it shows how
19 many people it's got to be approved by, or seems to, or
20 I may just be misreading it. You've got Clinical and 12:17
21 Social Care Governance - is that a committee,
22 effectively?
23 A. Yeah, I mean, that's just the steps through the
24 organisation that the policy will have come.
25 CHAIRPERSON: Yeah, exactly. 12:17
26 A. But I can't explain why it's taken two years to - it
27 shouldn't take - I don't understand why it's taken two
28 years to go from draft to final version.
29 CHAIRPERSON: No. And, I suppose, I just wanted to ask

1 the paragraph we've just been looking at which was
2 specific to Muckamore, would this have been before the
3 revelations from the CCTV? Because if you look at
4 these dates, the first approval was given back in
5 August '16; then in March of '17, which I think was 12:18
6 still before revelations - I can't immediately remember
7 when the revelations were, but they were around --
8 MS. KILEY: March '17.
9 CHAIRPERSON: They were around Autumn of '17, I
10 thought. 12:18
11 MS. KILEY: June!
12 CHAIRPERSON: Was it June? So this doesn't look as if
13 this would have been created in the knowledge of the
14 revelations, or can you assist us with that?
15 A. No, I'm going to have to come back to you on that, I'm 12:18
16 really sorry.
17 DR. MAXWELL: We have heard other evidence that the
18 CCTV was in stalled in 2015 --
19 CHAIRPERSON: We know that, yeah. No, we know that it
20 was installed, yes, but I don't think it was 12:18
21 operationalised until '17.
22 DR. MAXWELL: The way I read this is it took a year of
23 drafting and consultation before it was taken to the
24 first committee, and it had to pass all the committees
25 before it could be approved as the Trust policy, is 12:19
26 that correct?
27 A. That's certainly what it looks like there, yes.
28 CHAIRPERSON: Yeah, okay.
29 DR. MAXWELL: And it went to the Policy Committee in

1 June '17, and then finally approved by the Executive
2 team in June '17. And I think the CCTV revelations
3 were in August '17, weren't they?
4 95 Q. MS. KILEY: I know you're going to come back on some of
5 the questions I've asked, but I just wonder generally 12:19
6 is that sort of time period usual within the Trust from
7 a draft policy to an approved policy, in and around two
8 years?
9 A. I don't think so. I think that that seems long but
10 I'll need to come back to you on that again. 12:19
11 96 Q. Okay. Sticking with the issue of CCTV but returning
12 then to your statement, I want to look at paragraph 73
13 and 74.
14 CHAIRPERSON: Page number?
15 MS. KILEY: Sorry, 42... 12:20
16 CHAIRPERSON: Can I suggest you carry on? We can't get
17 it on the screen, but everybody has got access to it --
18 97 Q. MS. KILEY: Yes, well, I want to read some portions
19 into the record, so perhaps you can follow that way.
20 And you have a hard copy, do you, anyway, Mr Hagan? 12:20
21 A. Yes.
22 98 Q. So paragraph 73, you say:
23
24 "I am informed by colleagues and therefore draw to the
25 attention of the MAH Inquiry that as the investigation 12:20
26 at MAH developed, it became impractical to operate the
27 standard adult safeguarding procedures in respect of
28 matters discovered on the March to September 2017 CCTV,
29 often referred to as the historical CCTV."

1
2 And then moving forward you say:
3
4 "Instead, a responsive adult safeguarding approach was
5 developed, fully communicated to key stakeholders, 12:21
6 including DOH, RQIA and PSNI, and utilised. It
7 complied with the spirit and purpose of adult
8 safeguarding, but did not involve the formal completion
9 of all the various forms and steps that formed part of
10 the then policy. 12:21
11
12 In short, matters of concern from the CCTV were
13 referred to the Police in the first instance for
14 criminal investigation. In addition, due to the volume
15 of interim protection plans, part of the adult 12:21
16 safeguarding process for keeping a patient safe, were
17 applied to the relevant staff members, along with other
18 protective system measures, rather than to the
19 individual patients, but by these means each individual
20 patient was thereby provided with protection." 12:22
21
22 Just pausing there, I just wanted to ask you to explain
23 a little bit more about some of the terminology you
24 use. So at paragraph 73, you refer to or you describe
25 this different approach that emerged after the CCTV 12:22
26 allegations as a responsive adult safeguarding
27 approach. Can you just explain what you mean by that?
28 A. Well, I think this is in response to the volume. This
29 wasn't an ordinary safeguarding issue. This was

Gwen Malone Stenography Services Ltd.

1 multiple issues of safeguarding and abuse, and I think
2 that we had to be flexible and pragmatic about how we
3 managed that in a multi-agency approach. And, as you
4 know, some of the - well, the police largely led in
5 terms of the investigations to determine whether there 12:23
6 was a criminal investigation required. So that's why
7 the process was adapted to fit that. And that's why
8 interim protection plans were put in in terms of staff
9 rather than around patients because it would have been
10 impractical in that respect. 12:23
11 99 Q. Because of the volume?
12 A. Yes.
13 CHAIRPERSON: Can I just - I'm so sorry, can I just ask
14 this - that we've heard this frequently, it's PSNI-led,
15 but fundamentally the question of safeguarding patients 12:23
16 is always down to the Trust?
17 A. Yes.
18 CHAIRPERSON: It's never devolved to any other agency,
19 is it?
20 A. No, absolutely. I meant, sorry, in terms of leading 12:23
21 the investigation.
22 CHAIRPERSON: I appreciate that.
23 A. But, absolutely, the prime aim was to keep patients
24 safe.
25 CHAIRPERSON: Quite. 12:23
26 100 Q. MS. KILEY: And just taking that a step further, you
27 said that that responsive approach was communicated to
28 stakeholders, including DOH, and while safeguarding is
29 obviously a Trust responsibility, DOH have an oversight

1 of that, isn't that right?
2 A. Yes.
3 101 Q. And just you refer to communicating the approach to key
4 stakeholders - are you able to say do you know if the
5 Department of Health approved the Trust's approach at 12:24
6 that time?
7 A. I wasn't part of those meetings but I know that there
8 was extensive meetings and, as you know, there is the
9 MDAG oversight group, which is Department led. So the
10 Department are fully informed on this. 12:24
11 102 Q. Okay. And one final matter I just wanted you to
12 clarify then arising out of paragraph 74 that we've
13 looked at was that you referred to interim protection
14 plans applying to staff members and then, over the
15 page, you say "along with other protective system 12:24
16 measures." Can you explain what you mean by that
17 phrase, "other protective system measures"?
18 A. Sorry, where is that?
19 103 Q. Paragraph 74, the very last line on page 42 and moving
20 to page 43. I'll just read it again. You say: 12:25
21
22 "In addition, due to the volume of incidents, interim
23 protection plans was applied to relevant staff
24 measures, along with other protective system measures."
25 12:25
26 So my question is just what that phrase "protective
27 system measures" means?
28 A. So I've talked about that already - that's the weekly
29 sit-rep in terms of --

1 104 Q. Okay.
2 A. -- and the oversight group, the weekly reporting to
3 Exec team and the Trust Board reporting, so that's what
4 that "system protection measures" mean without really
5 good oversight of what's happening on that - this is 12:25
6 the Muckamore site - every week.
7 105 Q. Okay, thank you. And finally then in respect of this
8 topic of policies, I just want to refer you to
9 paragraph 78 because you make a statement about the
10 Trust wishing to recognise the staff role in dealing 12:25
11 with challenges in respect of safeguarding. So I want
12 to just let you address that and say something more
13 about it, if you wish, paragraph 78, to finish off this
14 topic. Having carried out your review of policies, you
15 say: 12:26
16
17 "The Belfast Trust recognises that the adequacy of
18 adult safeguarding and other measures and processes
19 implemented by the Belfast Trust and others in the wake
20 of matters arising from the MAH 2017 CCTV viewing are 12:26
21 not a matter for this statement. The Belfast Trust
22 does, however, wish to recognise that many of its staff
23 have had to respond to and have had to work under very
24 considerable pressure to deal with an unprecedented
25 challenge emerging from the viewing of CCTV at MAH. 12:26
26
27 The Belfast Trust considers that how various processes
28 worked in the context of what occurred at MAH, both
29 internal, including adult safeguarding, and external is

1 an important matter for examination. This is so that
2 maximum learning can be achieved by all."
3
4 I just want to pause there because you specifically
5 refer to the Trust position about recognising the 12:27
6 challenges faced by staff in dealing with this. I
7 wanted to acknowledge that and to give you an
8 opportunity to say anything more about it, if you wish?
9 A. I mean, I think I've articulated it quite clearly here
10 but, I mean, it was an unprecedented challenge that 12:27
11 staff faced trying to manage an exceptionally difficult
12 situation. You will also know from family feed-back
13 that some of the experiences that patients have had in
14 Muckamore is excellent, so not all staff in Muckamore
15 were carrying out abuse. There were very good staff 12:27
16 there as well. And I think it's about recognising how
17 that was managed and the difficult and the complexity
18 of it.
19 106 Q. Yes, indeed. And the Inquiry has made it clear it
20 wishes to hear from all staff in due course. 12:27
21 A. Yes.
22 107 Q. Thank you, Mr. Hagan. Moving on then to the next
23 topic, which is your Topic 5, our Topic E, "Policies
24 and procedures in respect of medication, the auditing
25 of medication". You commence dealing with this at 12:28
26 paragraph 79 of your statement and you really, in
27 introducing this, note that there is a very broad range
28 of policies which the Belfast Trust has in respect of
29 medication - perhaps, understandably so. And you have

1 said that your statement in this regard intends to
2 focus on the policies which appear to be of greatest
3 relevance to Muckamore. And so you've identified some,
4 in particular, and I just want to ask you some
5 questions about some of those. 12:28
6
7 So you start at paragraph 83 by referring to what you
8 describe as the "Central medications related Belfast
9 Trust document", and that is the Hospital Medicines
10 Code. Can I just ask you to explain why that is the 12:29
11 central document? What does that speak to?
12 A. So, basically, that's the code that, if you like, it's
13 the generic code for the whole Trust around
14 prescribing, okay, and it is in secondary care settings
15 and it includes all medical, dental, nursing staff, 12:29
16 operating department staff, AHPs, pharmacy staff, and
17 it includes the policies and procedures to be followed
18 for the prescribing, administration, dispensing,
19 monitoring, ordering, storage and transport of
20 medicines, so it's a sort of all encompassing document. 12:29
21 108 Q. And would you expect those various professionals that
22 you've just outlined, does the Trust expect that all of
23 those professionals would have a familiarity with that
24 document?
25 A. They would certainly have an awareness of it. 12:29
26 109 Q. And you then describe at paragraph 84 something that
27 you say is another particularly important document and
28 that is the "NICE guideline 5: Medicines optimisation:
29 the safe and effective use of medicines to enable the

1 best possible outcomes." I think it would be useful
2 just to look at this one just to aid our discussion.
3 It's at page 8483. While that's being turned up,
4 Mr. Hagan, are you able to say again why this is a
5 particularly important document in the context of 12:30
6 Muckamore Abbey Hospital?
7 A. Well, it's important across all fields, to be honest
8 with you, to ensure that what patients are prescribed
9 is optimal for them, that there's not polypharmacy with
10 lots of different drugs that may interact with each 12:31
11 other adversely. So it's about that recognition that
12 what patients are being prescribed is safe for them and
13 appropriate for them and that that monitoring of that -
14 so that could happen in primary care or in secondary
15 care. 12:31
16 110 Q. The document is now up on the screen. We can see it's
17 a NICE document authored by the National Institute of
18 Health and Care Excellence. I just wanted to ask you
19 about the status of that document. Does it apply
20 directly in Northern Ireland? 12:31
21 A. So we do adopt NICE guidance. We are asked to by the
22 Department.
23 111 Q. And it is a guidance document - that's its status?
24 A. Yes.
25 112 Q. Which type of staff would be expected to follow this 12:31
26 particular document?
27 A. So, primarily doctors and nurses.
28 CHAIRPERSON: Sorry, just to understand the context of
29 that last answer, do you accept all NICE guidance?

1 A. So, we're asked to by the Department. So it comes to
2 the Department and then they will distribute NICE
3 guidance that they wish us to adopt.
4 113 Q. MS. KILEY: And just arising from that, does the NICE
5 guidance make it's way then onto the hub that you 12:32
6 talked about earlier that has that compilation of
7 policies?
8 A. I don't think so but I would need to double-check that.
9 114 Q. Okay. There was a particular part of this that I
10 wanted to ask you about and that's the Yellow Card 12:32
11 scheme under this guidance. So it appears there is
12 reference to that at page 8484. You may not need to
13 see that particular reference but, while it's being
14 brought up, are you able to explain to the Panel a bit
15 more about the Yellow Card scheme? 12:32
16 A. So this is about reporting adverse --
17 115 Q. Yes.
18 A. So, I mean, it's a mechanism for reporting adverse drug
19 reactions.
20 116 Q. I'll wait for it to be brought up so I can ask you a 12:33
21 little more. 8484. If you could just scroll down a
22 little bit, please, and if you just pause? And that is
23 - you've referred to there, it says:
24
25 "All problems (adverse incidents related to a medicine 12:33
26 or medical devise used for treatment or in a procedure)
27 should be reported to the Medicines and Healthcare
28 Products Regulatory Agency using the Yellow Card
29 scheme."

1
2 Are you able to explain how - what constitutes an
3 adverse incident - an adverse event, sorry?
4 A. So it could be a whole range of - you know, it could be
5 from an unexpected complication relating to a medicine 12:33
6 to potentially even allergic reaction, although, you
7 know, if the patient has a known allergy, then it's
8 unlikely to be Yellow Card. But it's an unexpected
9 reaction to a drug.
10 CHAIRPERSON: Sorry, because I've got the - I can click 12:34
11 on the link, whereas I expect we can't. This is really
12 about where the medicines themselves either cause
13 unintended side effects or someone's injured or someone
14 gets the wrong diagnosis - it's not really about the
15 misuse of drugs, is it? 12:34
16 A. No, no, not at all.
17 117 Q. MS. KILEY: Well, that was my next question --
18 CHAIRPERSON: Sorry, Ms. Kiley!
19 118 Q. MS. KILEY: Using the example, for example, if someone
20 suspected that PRN had been misused or overused, is 12:34
21 that the sort of thing that would be reported under the
22 Yellow Card scheme?
23 A. No. No.
24 119 Q. Okay, thank you. At paragraph 88 of your statement,
25 you then refer to an additional framework that governs 12:34
26 just nurses and midwives, specialist community public
27 health nurses, pharmacists, and other allied health
28 care professionals and you set that out. And that's in
29 respect of non-medical prescribing, essentially. Does

1 that set out how suitably trained nurses and
2 pharmacists and allied health professionals are able to
3 prescribe drugs on ward, essentially, is that right?
4 A. So, we have increasing number of non-medical
5 prescribers from a variety of non-medical backgrounds 12:35
6 and it's an important innovation, I think, that more
7 non-medics are able to prescribe because they're able
8 then to have more autonomous practice and, you know, I
9 think it's about distributing responsibility for health
10 care as well. So that's tightly regulated within the 12:35
11 Trust about non-medical prescribing.
12 120 Q. And those three documents that you have set out there
13 at paragraph 88 A, B and C, represent that, as you've
14 described, regulation. Is there any other regulation?
15 A. Not to my knowledge. 12:36
16 121 Q. Those are the policies --
17 DR. MAXWELL: They have to be approved by their
18 regulator. They have to pass a qualification and be
19 registered with their regulator before they can be
20 non-medical prescribers. 12:36
21 122 Q. MS. KILEY: Yes, and I think you later come to the role
22 of regulators in respect of staff as well and we can
23 see that later on in your statement?
24 DR. MAXWELL: Can I just ask are there any non-medical
25 prescribers at Muckamore? 12:36
26 A. I don't know, I'm sorry.
27 DR. MAXWELL: That might be interesting to know.
28 123 Q. MS. KILEY: And, again, just for clarification, I want
29 to ask you about the status of another document that

1 you refer to at paragraph 95. You refer to NHS, an NHS
2 England document dated July 2017 entitled "Stopping
3 overmedication of people with a learning disability,
4 autism or both" and it's given the acronym "STOMP". I
5 wanted to ask you again whether that applies in 12:37
6 Northern Ireland, given it's an NHS England document?
7 A. Well, it fits very much with medicine reconciliation or
8 medicine optimisation, you know, so each patient's
9 medication is reviewed to make sure they're on
10 appropriate medication for them and as little for them, 12:37
11 so it feeds in with that. And my expectation is that
12 the learning disability mental health teams would be
13 aware of STOMP.
14 124 Q. But in terms of a trust position, is it the case that
15 the Trust is committed itself to applying that NHS 12:38
16 England document?
17 A. Well, absolutely. You know, it's best practice.
18 125 Q. And if that's the case, thinking again about the hub
19 and the status of this document, how are practitioners
20 in Northern Ireland made aware of that sort of 12:38
21 document?
22 A. So the way teams work is that you - the expectation is
23 that managers or clinical leads within those teams will
24 ensure that latest guidance is shared with their teams.
25 So we have safety patient clinical governance meetings 12:38
26 where teams come together, depending on the area,
27 either weekly, biweekly or monthly, and they will share
28 best practice. The patient safety clinical governance
29 meeting is the unit block of governance within the

1 organisation. There's about 54 clinical teams and that
2 is where that type of information will be shared,
3 distributed, and that's also where you can do clinical
4 audit. So clinical audit is a vehicle for determining
5 whether you're compliant with that type of thing. So 12:39
6 that's how that works at a very sort of - at the
7 frontline, if you like, and then you have reporting
8 systems up that capture that. And I've talked about
9 live governance earlier on, about how divisional teams
10 assure themselves that patient safety clinical 12:39
11 governance meetings are functioning appropriately. So
12 the patient safety clinical governance meeting will
13 also have mortality and morbidity, so that's deaths and
14 adverse outcomes would be discussed as well. So that's
15 the unitary block of how we manage this type of thing. 12:39
16 126 Q. So you referred there to clinical audits and I want to
17 ask you a little bit about that because you refer to
18 that in your statement at paragraph 97 and 98. They
19 should be up on the screen for you, Mr. Hagan. And you
20 say at 97 that you are not personally aware:- 12:40
21
22 "...of any specific regional Belfast Trust or MAH
23 policy in relation to the auditing of medication. Nor
24 are the colleagues I have asked about this topic."
25 12:40
26 And you then say:
27
28 "I am also unaware of any specific fixed program of
29 auditing of medication in place at MAH before 2018

1 other than for controlled drugs, for which it is
2 mandatory pursuant to the policies and procedures in
3 that area addressed above."
4
5 And you then go on to explain by way of example that 12:40
6 you provided audits undertaken in 2011 across MAH wards
7 and you say - and that's in respect of controlled drugs
8 - but you then say:
9
10 "I am advised by Ms. Murray that an audit of drug 12:40
11 Kardexes was undertaken in 2019 on the MAH population
12 at that time. Around the same time, a separate
13 clozapine audit was also undertaken."
14
15 I just want to pick up on some of those issues and ask 12:41
16 you for clarification. So you say that you were
17 unaware of a specific fixed program of auditing of
18 medication in place at MAH before 2018. Does that mean
19 that there has been such a program since 2018?
20 A. I've talked to you already about the weekly sit-rep -- 12:41
21 127 Q. Yeah.
22 A. So that was a mechanism for capturing where medication
23 was used for rapid tranquillisation or sedation. So
24 that was how that information started to be captured.
25 Going forward, so we now have that data and we know 12:41
26 when drugs have been used in that manner.
27 128 Q. So the weekly sit-reps are continuing, is that right?
28 A. They don't come in the same way as they used to because
29 we have much more assurance about what's happening

1 there, but it comes up now in what's called the Quality
2 Management System. So there's accountability review
3 with the Chief Executive on a regular basis where these
4 things are scrutinised. But, you know, the expectation
5 is that the director of the service will have good 12:42
6 oversight of that and, if there are any emerging
7 issues, that they would be escalated in real-time.
8 CHAIRPERSON: Can I just ask - you were Associate
9 Medical Director in '15 - would that put you on the
10 Board? 12:42
11 A. No.
12 CHAIRPERSON: And as Deputy Medical Director of Risk
13 and Governance, would you have sat on the Board?
14 A. Not routinely. Only very occasionally if the Medical
15 Director wasn't - if she was away, for instance, or 12:42
16 other reasons.
17 CHAIRPERSON: Right. Obviously, the Medical Director,
18 herself or himself, would always be on the Board?
19 A. Yes.
20 CHAIRPERSON: Do you know if there was a board director 12:42
21 responsible for patient safety?
22 A. So I think a lot of that falls to the medical director.
23 CHAIRPERSON: Yeah.
24 A. -- in terms of patient safety because of the Medical
25 Director's role in clinical governance and risk and 12:43
26 governance. But it is the responsibility of all
27 executive directors --
28 CHAIRPERSON: I know, you keep saying that and, you're
29 absolutely right, there are a number of reports that

1 say when it's the responsibility of everybody, it's the
2 responsibility of nobody! So one has to be careful
3 about that.
4 A. Sure.
5 CHAIRPERSON: So, specifically, patient safety would be 12:43
6 within the Medical Director's role?
7 A. I see that as one of my main functions, is to ensure
8 patients are safe in our organisation, and that
9 includes all aspects of patient safety.
10 CHAIRPERSON: It arose only because we were looking at 12:44
11 the medicines policy, but, of course, it covers a broad
12 range - sorry, Dr. Maxwell?
13 DR. MAXWELL: So is it formally assigned to the Medical
14 Director, because in some organisations it isn't the
15 medical director - and has the Board formally noted 12:44
16 that you are the director responsible for patient
17 safety?
18 A. Well, I think if you read my job description, you know,
19 patient safety is one of the main functions of that.
20 But I think that the Director of Nursing would also 12:44
21 argue that she --
22 DR. MAXWELL: Well, that's what I was thinking!
23 A. -- you know, that she has a role in that. And the
24 Director of Social Work would also argue that as well.
25 But I think that, particularly in the hospital setting, 12:44
26 the medical director often leads on patient safety
27 issues.
28 DR. MAXWELL: But to answer Mr. Kark's question, there
29 isn't a single designated patient safety director at

1 Board level --
2 A. No, we don't have --
3 DR. MAXWELL: It's shared - there are a number of
4 overlapping directors.
5 CHAIRPERSON: And is that - well, we have to ask about 12:45
6 your Trust - is that right in your Trust, it was
7 shared?
8 A. Well, the organisation is so massive and it is an
9 integrated health and care organisation, including
10 community, I think that one person being responsible 12:45
11 for all patient safety, whenever it's - I mean, I know
12 you'll not like the answer, but it's everybody's
13 responsibility as well. But, ultimately, most of it
14 does come to me and to the other executive directors if
15 it's more relevant to their field. But I would tend to 12:45
16 be involved in most serious patient safety issues.
17 CHAIRPERSON: Thank you.
18 129 Q. MS. KILEY: I just want to return, Mr. Hagan, to the
19 auditing of medication, you describe the position post
20 2018 with reference to the sit-reps, but I just want to 12:45
21 be clear at the point of time. Prior then to 2018, and
22 in the absence of any formal auditing of medication at
23 Muckamore Abbey Hospital, how was the Board assured
24 that medicines were appropriately administered and
25 managed at Muckamore? 12:46
26 A. So, I'll take you back to the structure that existed
27 before that. So you have the clinical director, who
28 would have been responsible for day-to-day operations
29 with the service manager on the Muckamore site. And

1 their duty would have been to escalate concerns around
2 prescribing either up through the director route - to
3 their director or to the medical director. I'm not
4 aware of concerns being raised about prescribing prior
5 to 2017/'18. 12:46
6 130 Q. Well, the Inquiry has heard about the use of PRN
7 medication at Muckamore. So using that to think of as
8 a particular example, how would the Trust Board monitor
9 that PRN was appropriately used at Muckamore?
10 A. So we know that now because that comes in - we have run 12:47
11 charts that demonstrate the use of PRN medication --
12 131 Q. But just keeping with this prior to 2018 period, those
13 procedures weren't in place. Was there anything akin
14 to those that were feeding that information to the
15 Trust Board? 12:47
16 A. I'm not aware of that level of data coming through.
17 132 Q. Okay. Just in terms of roles, can I check does the
18 Belfast Trust have ward-based pharmacists?
19 A. So, we do have in some areas.
20 133 Q. Was there one in Muckamore? 12:47
21 A. I'll need to come back to you, I'm not 100% certain.
22 We do know, though, that a ward-based pharmacist makes
23 - really contributes to patient safety.
24 134 Q. And is that because part of the role of a ward-based
25 pharmacist is to check that the prescriptions are safe 12:47
26 and being administered?
27 A. Absolutely.
28 135 Q. But did you say that they are not in all areas?
29 A. We don't have ward-based pharmacists in all areas and

1 that is primarily due to resource, the funding.
2 136 Q. But you will check to see if there is one?
3 A. Yes.
4 137 Q. -- and was one at Muckamore for the various periods
5 that we're looking at? 12:48
6 A. Yes.
7 138 Q. Thank you. Chair, I'm going to move on to my next
8 topic. I'm in your hands as to whether you wish me to
9 continue. It's a short topic on F, Policies and
10 Procedures Concerning Property Finance, and I think we 12:48
11 can get that done, perhaps, in 10 or 15 minutes -
12 CHAIRPERSON: Yes.
13 MS. KILEY: Mr. Hagan, as I say, I want to move on then
14 to next topic, which is policies and procedures --
15 CHAIRPERSON: Sorry, Mr. Hagan, are you okay to do 12:48
16 that, I beg your pardon?
17 A. Yes.
18 139 Q. MS. KILEY: -- in respect of property and patient
19 finances. You deal with this at paragraph 19 or 99, I
20 beg your pardon, onwards of your statement. 12:48
21 And in this section, you provide a policy which you say
22 is the one most likely to be of interest to the
23 Inquiry. It appears at page 10031. And this is the
24 April 2015 Belfast Trust Patient Finances and Private
25 Property Policy for In-Patients Within Mental Health 12:49
26 and Learning Disability Hospitals. So it should come
27 up on your screen. Just while we wait for that to come
28 up, I have a general question for you. In your
29 statement, you referred to earlier Trust wide documents

1 about the management of patient property and finances -
2 for example, the 2018 Belfast Trust Patient Property
3 Policy. But, the policy that we're about to look at
4 now is specific to mental health and learning
5 disability hospitals. Are you able to say was 2015 the 12:49
6 first point in time that Belfast Trust had a specific
7 property policy that was designed for the learning
8 disability hospital sector?
9 A. I'm sorry, I'm going to have to come back to you on
10 that. 12:50
11 140 Q. And just if you are taking that away to consider, there
12 would have been some provision for managing patient
13 finances in the learning disability hospital context
14 prior to 2015, isn't that right?
15 A. I assume so, yes. 12:50
16 141 Q. Would you expect that to be a policy style document?
17 A. I'm going to come back to you on that. I'm not an
18 expert on patient property and finance.
19 142 Q. Okay, you may or may not then be able to assist with my
20 next questions but I want to look at the 2015 policy 12:50
21 and there's just some terminology that I want to check
22 with you, Mr. Hagan, and if, you can assist, that would
23 be great. The 2015 policy appears at page 10033,
24 please, and if we could just scroll down, please - and
25 a little further so we can see the bottom of that page 12:51
26 please. Pause there. Just under that section, "Key
27 Policy Principles", there is a reference to a number of
28 a number of matters and one of the terms used is
29 "therapeutic earnings" - can you see that at the

1 bottom:
2
3 "Therapeutic earnings. Muckamore Abbey only. Not
4 applicable to mental health in-patient units."
5 12:51
6 And the policy then goes on to discuss the handling and
7 management of therapeutic earnings. Are you able to
8 assist the Panel with what that refers to?
9 A. No, I'll need to come back to you on that.
10 143 Q. And then just looking at the monitoring of this policy 12:52
11 just before we leave it, if you scroll down to page
12 10048, please, and if you just scroll down towards the
13 bottom of that page, please, and pause there, you see
14 just at the very final paragraph on the screen there
15 there's reference to the "cash office" and "patient 12:52
16 bank" and it says:
17
18 "The cash office/patient bank staff will produce
19 monthly fluctuation reports for each of the wards,
20 which will be sent to senior nurse managers, 12:53
21 operational managers..."
22
23 - et cetera, et cetera and I just wanted to ask you
24 about that particular body. Can you explain anything
25 more about what the cash office/patient bank is within 12:53
26 the Belfast Trust?
27 A. Well, I know there is a cash office, but I don't know
28 anything about the fluctuations reports, I'm sorry.
29 144 Q. The cash office, can you tell the Panel where that

1 sits? This policy really explains how property
2 finances are dealt with at ward level, but there is a
3 role here for the cash office and I just wonder if you
4 can assist with what that is?
5 A. I will need to come back to you on that, I'm really 12:53
6 sorry.
7 145 Q. Okay. I have no further questions on that topic, in
8 any event, Chair, so it may be an appropriate time...
9 CHAIRPERSON: Okay, thank you very much. Could I ask
10 -- 12:54
11 MS. ANYADIKE-DANES: I beg your pardon, I didn't want
12 to interrupt you --
13 CHAIRPERSON: Did you want to address me?
14 MS. ANYADIKE-DANES: Yes.
15 CHAIRPERSON: Could you go - I mean, really, I would 12:54
16 say this, that it is part of the protocol it's only if
17 it's an urgent matter immediately affecting the Inquiry
18 that can't be dealt via counsel --
19 MS. ANYADIKE-DANES: Sorry, it relates to a part of the
20 transcript and my -- 12:54
21 CHAIRPERSON: I think that can just be dealt with with
22 counsel and the transcriber, can't it?
23 MS. ANYADIKE-DANES: Well, it may be --
24 CHAIRPERSON: And this isn't the corrected transcript.
25 MS. ANYADIKE-DANES: No, it isn't that. It's not an 12:54
26 error in the transcript --
27 CHAIRPERSON: Oh, sorry, okay.
28 MS. ANYADIKE-DANES: No, it's me, I introduced it
29 incorrectly but I just wanted to refer you, Sir, to the

1 fact that it arises out of what was said in the
2 transcript. It arises from, in the current transcript
3 as it is now, in lines 10 to 13 at page 54, and that
4 related to when the CCTV was operationalised in
5 Muckamore. That's actually dealt with in the Review of 12:55
6 Leadership and Governance, that report of the 31st of
7 July 2022, I think it is. And what that says is - and
8 this is the significance for my clients, CP clients, is
9 that it went in in 2015, but they say that when they
10 conducted a review of all the material - this is the 12:55
11 Review Team - that, so far as they were concerned, that
12 it actually switched on and stayed on from 2015. It's
13 just it wasn't - they weren't aware that it was on
14 until 2017.
15 CHAIRPERSON: Sorry, this really doesn't affect the 12:55
16 operation of this Inquiry now. You can deal with this
17 through correspondence or with counsel.
18 MS. ANYADIKE-DANES: Well, I apologise for that.
19 CHAIRPERSON: Thank you. Could I ask everybody to
20 remain in the room just for five minutes because I'm 12:56
21 afraid there will be some information about whether we
22 can sit at all this afternoon. Okay, I'm going to
23 rise.
24
25 THE INQUIRY WAS SUBSEQUENTLY ADJOURNED UNTIL WEDNESDAY, 12:56
26 26TH APRIL 23 AT 10:00A.M.
27
28
29