MUCKAMORE ABBEY HOSPITAL INQUIRY

SITTING AT CORN EXCHANGE, CATHEDRAL QUARTER, BELFAST

HEARD BEFORE THE INQUIRY PANEL

ON THURSDAY 25TH MAY 2023 - DAY 44

44

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THE INQUIRY RESUMED AS FOLLOWS ON THURSDAY, 25TH MAY 2023:

CHAIRPERSON: Good morning. Thank you very much. Yes, Ms. Briggs? 09:30

MS. BRIGGS: Good morning, chair, members of the panel. Today's witness is Dr. Margaret Flynn. As you are aware, Dr. Flynn was chair of the independent team commissioned by the Trust to undertake a serious adverse incident review to examine the safeguarding 09:30 practices at the hospital.

CHAIRPERSON: Yes.

MS. BRIGGS: The resulting report is titled "a review of safeguarding at Muckamore Abbey Hospital, a way to go", and it was submitted to the Trust in November 09:31 2018.

Dr. Flynn will be giving evidence to assist the panel with an overview of the report and an analysis of its recommendations for the purpose of evidence module 6C. 09:31

Chair, you flagged up yesterday that there may be an application for a restriction order in respect of part of the witness' evidence. There will in fact be such an application, but it will relate only to a limited 09:31 part of the witness' evidence, which I intend to deal with at the end of today's evidence session.

CHAIRPERSON: Yes.

MS. BRIGGS: I am therefore not going to deal with that

application now, but at an appropriate time later today.

I should add that Inquiry counsel have made PPS and PSNI aware of our view that the application should be made only in respect of part of the witness' evidence, and they are agreeable that this is the appropriate way to proceed. 09:31

CHAIRPERSON: Okay, that's fine, thank you very much indeed. 09:31

MS. BRIGGS: Thank you very much. Perhaps if we call the witness then at this stage.

DR. MARGARET FLYNN, HAVING AFFIRMED, WAS DIRECTLY EXAMINED BY MS. BRIGGS AS FOLLOWS: 09:32

1 Q. MS. BRIGGS: Dr. Flynn, good morning. My name is Sophie Briggs, I am one of the counsel team to the Inquiry, and we have met this morning. You have provided two statements to the Inquiry, isn't that right? 09:32

A. That's correct.

2 Q. The first of those is dated 24th April 2023. Its reference is STM - 108. Do you have a copy of that statement in front of you? 09:33

A. I have.

3 Q. It's less than two pages with one exhibit, which is the report with which the Inquiry is concerned today. Its shorthand is often referred to as the "Way to Go

Report", is that right?

A. That's correct.

4 Q. And are you content to adopt the contents of that statement and its exhibit, being the report, as the basis of your evidence to the Inquiry? 09:33

A. Yes, indeed.

5 Q. Okay. And in respect of your second statement, that deals with your attendance at a Belfast Trust board meeting on 5th September 2019. The reference is STM - 117. It's dated 24th May 2023. Do you also have a 09:33 copy of that statement --

A. I have.

6 Q. -- and its exhibit in front of you? And are you content to adopt that as your evidence to the Inquiry?

A. Yes, indeed. 09:33

7 Q. Okay. If we can go to your main statement then, the first one, and pull that up on the screen, please. You tell us at paragraph three there that you were the chair of the review team whose work culminated in the report. Is that right? 09:34

A. That's correct.

8 Q. And the report itself was published in November 2018, is that right?

A. That's correct.

9 Q. And you tell us at paragraph 1 there your 09:34 qualifications and your position. At the time of carrying out the review and chairing the review team, did you have any formal or informal role in relation to Muckamore prior to that?

A. No, I was aware of it because of work that I had undertaken in England concerning the closure of other long-stay hospitals, but no formal relationship. At the time of this work, as well, I was the chair of the National Independent Safeguarding Board in Wales. I'm sorry, I omitted to say that earlier. 09:34

10 Q. Thank you very much, Dr. Flynn. If we turn, then, to the report itself, it's the Inquiry's pages six I'm looking for. The review team is set out there and their various positions and roles. From an overview - and please correct me if this isn't right - it would seem that none of them had roles at Muckamore, is that fair to say? 09:35

A. That's correct, yes.

11 Q. So it would be fair to say that this is an external review? 09:35

A. Yes, indeed. I didn't know my colleagues before the review commenced, they were identified by the commissioning body.

12 Q. Okay, thank you very much. The bold writing then at the bottom of that page, it starts "one of the themes the reader can see weaved through the report". There is a reference there to creating high quality community services and the movement away from patients living at Muckamore. 09:35

That obviously mirrors the recommendations of Bamford and departmental policy at the time of the report. Was the closure of the hospital and the movement towards

quality community services a clear consensus from the review team before it started its report from the outset, or did that become clear as the review process was undertaken?

A. It was a clear consensus at the outset. It was something of a relief to know that we were like minded, and we didn't believe that the hospital had a role in peoples' lives. 09:36

13 Q. If we can go to internal page nine at paragraph 1, please. It says there that during January 2018, the Belfast Health and Social Care Trust set out the Terms of Reference for a review of safeguarding activities at the hospital. Is January 2018 the date that the review team's work started then? 09:36

A. Yes, as a team. I think I'd had some preliminary telephone exchanges, conversations with members of the trust and -- 09:37

14 Q. What did those relate to?

A. It was pretty mundane. It was really start times and ease of accessing, getting over to Belfast. 09:37

15 Q. Okay. Thank you very much. So, the Belfast Trust then, could you describe them as the commissioners of the report?

A. Yes, indeed.

16 Q. Okay. You go on there to say that the Trust -- sorry, the report goes on to say that the Trust asked the review team to identify the principal factors responsible for historic and recent safeguarding incidents at the hospital. Could you assist the 09:37

Inquiry by further outlining the context to the review, without giving detail on any individual case, and in very broad terms, what prompted the Belfast Trust to having the report commissioned?

A. Growing disquiet and uncomfortable publicity that the hospital did not live up to the promise of its name. 09:38

17 Q. Was there any discussion at the time of the report, the review being commenced, about who would be looking at the report itself, for example, whether it would be made public or not? 09:38

A. No, and that is an omission on my part. Perhaps naively, I assumed it would be a public document, but I didn't check that out.

18 Q. Okay. Did that understanding on your part that it would be a public document, did that continue throughout the course of the review team's work? 09:38

A. Yes, it did. And to that end, I think there was a necessary caution about identifying individuals within the document, although necessarily some families would know the circumstances of either their own relatives or people that they were close to. 09:39

19 Q. Is what you are saying then that the reason why, for example, individuals aren't named in the report, was that because of your understanding that the report would be made public, is that right? 09:39

A. Yes, indeed, yes.

20 Q. Was that an understanding shared by your review team?

A. I couldn't say hand on heart, but I believe it was. I believe it was.

21 Q. At what point then did it come to your knowledge that the report wouldn't be made public?

A. It was a drip feed, because I delivered the report with a member of the senior team at Muckamore Abbey to families who had shared their experience with myself and my colleagues, they were delivered copies of the paper report. And I thought it was -- and then I gathered that sections of this report featured in the local press. 09:39

22 Q. Okay. I'm going to come to the time after the report towards the end of this section of your evidence, but for this point we'll focus on the Terms of Reference, okay? 09:40

A. Mm-hmm.

23 Q. We can see the Terms of Reference there listed on the screen. Did the review team have any input into the Terms of Reference -- 09:40

A. No, they --

24 Q. -- or were they --

A. They were set out for it. 09:40

25 Q. And they were set out by the Belfast Trust?

A. Yes.

26 Q. Was there any attempt at any stage by the review team to have any input into those?

A. No. I recall, however, explaining that if anything caused us, individually or as a team, any disquiet about practices we observed, or heard about, we would not hold back and have people in a position of waiting for a report. 09:40

27 Q. Thank you very much. The reader can see there from the Terms of Reference, if we scroll down just a little bit, that's perfect, that a number of the items in the Terms of Reference relate to the period 2012 to 2017. We can see some of them on screen now. 09:41

A. Hmm.

28 Q. Could you assist the Inquiry as to whether you have any understanding as to why that time period was chosen by the Trust?

A. No. 09:41

29 Q. Okay. And the first term of reference then, if we just scroll back up a little bit, it relates to the PICU and Six Mile, specifically in August 2017 and October 2017. Do you have any understanding as to why those specific months were chosen? 09:41

A. I didn't at the time, no.

30 Q. You didn't at the time?

A. No.

31 Q. Did you gather that understanding as the review went on? 09:42

A. I recall that we did, yes.

32 Q. Okay. And why was that then, to the best of your knowledge?

A. Because of significant events in those wards.

33 Q. Significant events -- 09:42

A. Adverse events.

34 Q. The adverse events, they specifically occurred in August and October 2017, is that right?

A. Within that timeframe, yes, thereabouts, yes.

35 Q. Within -- between August 2017 and October 2017?
A. Sorry, I can't be that specific, I don't recall.
36 Q. Thank you very much. If we can go to the Inquiry's page ten then. In paragraph 5, this deals with the methodology of the review, it says there that the Trust provided safeguarding files spanning 2012 to 2017, concerning 69 hospital patients. 09:42
A. Mm-hmm.
37 Q. Were 69 patients selected?
A. Oh, yes. We were directed to a filing cabinet of files, and that was our principal source of information. 09:43
38 Q. And did that filing cabinet solely contain the files of 69 patients and no other?
A. That's right. That's right. 09:43
39 Q. So were you aware as to whether, for example, there were other safeguarding files that weren't in that cabinet that were presented to you?
A. We assumed that there were.
40 Q. What made you assume that? 09:43
A. Because some of the incidents involved more than a single patient and other people were identified in the files. And we assumed that there were parallel files, and it was perhaps because more information concerning an incident resided in one file. 09:43
41 Q. Okay.
A. There was, however, a great deal of repetition within the files.
42 Q. Okay. Did the review team have any view as to whether

the files themselves, i.e. the 69 patients' files, were complete?

A. We did have a view. Although there was a great deal of paper, it was sometimes very difficult to discern what had happened. 09:44

43 Q. Okay. For example, did the review team have any view that there might have been pages or extracts missing from individual patient files?

A. That would be speculation. There was a great deal of paperwork, and yet sometimes handwritten material was 09:44 extraordinarily difficult to -- it was illegible.

44 Q. Okay. I have a very similar question in respect of the next item on that list there, the 61 RQIA reports of inspections of hospital wards?

A. They were given us to us as well in box files. 09:45

45 Q. They were given to you?

A. In box files, yes.

46 Q. And does the review team know whether that represented the full RQIA reports for a certain period or whether file reports were selected for presentation to the 09:45 review team?

A. I don't know that we had a shared view about this. What we did have, from our reading of the reports, was a sense of repetition of recommendations. For example, I know that the RQIA were unhappy with our treatment of 09:45 their inspection reports within this document.

47 Q. I think you're referring there to the feedback that the RQIA received, and we will come to that later in your evidence, Dr. Flynn.

A. Yes, fine. Yes, indeed.
48 Q. I had asked you as to whether the 61 RQIA reports were, for example, selected to the review team's knowledge for presentation, or whether, in the review team's knowledge, they represented the full set of files. And you said, "I don't know if we had a shared view of this." 09:46
A. (Witness Nods).
49 Q. Can I ask what was your view of that?
A. I assumed that the hospital had given me the information that we required to do -- to faithfully undertake this work. 09:46
50 Q. Okay, thank you very much. And then the 12 patient experience interviews, I'll ask you about those, finally. Did they relate to any specific period? 09:46
A. I'm afraid I don't recall.
51 Q. Okay. Do you know whether similarly those may have been selected or they represented the full set of patient experience interviews that were in the possession of the Trust? 09:46
A. I don't recall. They were very limited. They had a template and I thought it was -- they were less than helpful in conveying anything of peoples' day-to-day experience of life at the hospital.
52 Q. Who compiles those patient experience interviews, is that the RQIA or the Trust? 09:47
A. The inspectors, I presume.
53 Q. Inspectors from the RQIA?
A. Yes. Yes.

54 Q. Towards the end of that paragraph, there's a reference there about information that the review team requested concerning staff sickness absence rates, and it goes on with a number of other things.

A. Mm-hmm. 09:47

55 Q. Can I ask, first of all, what data did the review team receive concerning staff sickness absence rates?

A. We received information that my colleague, Bryce McMurray, was able to draw upon in his section of the report. He wrote the briefing concerning workforce 09:48 matters. We received information concerning the seclusion reports. The governance structure, we were given information about that. We met the advocate who facilitated patient self-advocacy.

56 Q. Dr. Flynn, if I stop you there. 09:48

A. Sorry, yes.

57 Q. In terms of, say, the information, the data that was received in terms of the governance structure, was that written down --

A. Yes, it was. 09:48

58 Q. -- and provided?

A. Yes, it was names and an organisational chart.

59 Q. And would that still be in your possession, Dr. Flynn, that type of information --

A. I -- 09:48

60 Q. -- those records?

A. I would have sent it to you, I'm afraid, I do not recall.

61 Q. Okay. And would it similarly have been written down

records in relation to the patient mortality rates and the other things that we can see there, was that written down information that was provided?

A. Yes, it was. But I think I recall going on-line to read a coroner's report. 09:49

62 Q. Okay. At paragraph 6 then, I'll not read it, but it lists, to some length, the individuals that the review team met with.

A. Hmm.

63 Q. And when one looks at that paragraph, it's clear that the review team met with a range of senior staff. 09:49

A. Mm-hmm.

64 Q. Did the review team meet with more junior staff who conducted the direct face-to-face care?

A. Oh, yes, yes, that was as important. We didn't want to be associated with sitting in a remote office. 09:49

65 Q. Okay.

A. So, certainly lunch breaks were opportunities for making appointments to visit wards. That was necessary, because some of the wards are locked -- 09:50

CHAIRPERSON: Just to pause you for a moment, Dr. Flynn. Could I ask you to move that microphone slightly more centrally? It's not your fault, but it's quite a directional microphone, and I think there may be difficulties with the public hearing. Is that better? 09:50

DR. FLYNN: Is that any better?

CHAIRPERSON: I'm not sure it is, because if the witness is looking at Ms. Briggs, it needs to be the

other side. Yes, that may be it. Thank you. Let's see if that works.

DR. FLYNN: Is that any better?

MS. BRIGGS: I think it is a little better. Perhaps we could bring it just a little bit closer again. 09:50

CHAIRPERSON: All right, thank you.

DR. FLYNN: Okay?

MS. BRIGGS: Yes.

CHAIRPERSON: Sorry to interrupt.

66 Q. MS. BRIGGS: No problem, chair. You were mentioning 09:50 there that those types of meetings with more junior staff might have been conducted in the likes of lunch breaks, making appointments with those staff. So --

A. Well, talking with them as we visited wards and met people in the cafe on the hospital site. And people 09:51 did take the opportunity to seek us out as well.

67 Q. Okay, thank you very much. If we can go down to paragraph 10, please. It describes there how three review team members watched 20 minutes of the CCTV footage, which resulted in the suspension of six staff 09:51 members during November 2017. Was there any particular reason, Dr. Flynn, as to why 20 minutes was viewed?

A. I should say it was nosiness on my part, I was told that there was CCTV, and I said, well, what's the quality of it like? I was interested to know what the 09:51 quality was like. And so we were invited to have a look. We watched about 20 minutes - this is myself, Bryce McMurray and Michael Browne.

CHAIRPERSON: I think that's enough that we can hear

about the quality of the CCTV.

MS. BRIGGS: Thank you very much, chair. If we can go, then, to paragraph 11.

A. Sorry, it also implies, that paragraph, that our viewing resulted in the suspension. I do apologise, that was not the case. 09:52

CHAIRPERSON: No.

68 Q. MS. BRIGGS: Thank you, Dr. Flynn. If we can go to paragraph 11, and go to the last sentence there:

09:52

"Finally, the review team offered to facilitate multi-agency events, including senior hospital managers and trust members to discuss the findings and test out potential recommendations."

09:52

Can you assist the Inquiry by answering simply what is meant by testing out potential recommendations?

A. Yes, there's no point in a review team making recommendations that have no resonance whatsoever with individuals who may be called upon to enact these recommendations. So, we asked could we meet with people to discuss the prospective recommendations. 09:53

69 Q. Were some recommendations, for example, changed or shaped by those sessions?

A. No, if anything, we were encouraged that we should be as forthright as we were. And we were also encouraged not to write many recommendations. 09:53

70 Q. So the testing process was successful, insofar as it confirmed the recommendations that were in the mind of

the review team?

A. Yes, indeed. And in addition, staff, managers and those in commissioning roles nominated their own recommendations.

71 Q. Okay. 09:54

A. Which we've identified in the report.

72 Q. Thank you very much, Dr. Flynn. The Inquiry has heard evidence about a 2005 report completed by the Eastern Board and North and West Belfast Trust in relation to safeguarding at Muckamore Abbey Hospital. Did the 09:54 review team have any prior awareness of, or access to, that report in carrying out its own review?

A. I became aware of it during the course of the work and I shared it with my colleagues.

73 Q. Were there any other similar reviews or reports looked 09:54 at?

A. No. No, we did contribute to the work of other reviewers, a review in parallel with our own concerning governance.

74 Q. Okay. At paragraph 16 then, it's the Inquiry's page 09:54 12, the history of the hospital is discussed there, and there's reference to appendix 2. Specifically in bold it says there:

"From its early expansion providing quasi permanent 09:55 living and training placements in a self contained village community, the hospital's decline was associated with becoming rundown, understaffed, over populated and obsolete as a model of service provision.

However, the hospital survived closure head winds."

And it goes on to say:

"With familiar claims." 09:55

And it lists what familiar claims were. Was that the review team's own views, that the hospital decline was associated with it becoming rundown, understaffed, over populated and obsolete as a model of service provision? 09:55

A. Yes. Yes, we talked about that. Although I think the historians who wrote the document also believed that it was diminishing physically. And I think I recall that they believed it was going to close.

75 Q. Okay. And you had said that, yes, the review team had talked about the hospital's decline being associated with those things. 09:56

A. Mm-hmm.

76 Q. Was that based on the review team's own look back at the historical development of the hospital? 09:56

A. I encouraged everybody to read the report. And there was a film as well that I encouraged my colleagues to read. So we did our homework. And this resulted from our discussion.

77 Q. And did the review team take any view as to at what time the hospital became those things? 09:56

A. It was a steady decline.

78 Q. And there's mention there of closure head winds. Did the review team become aware of times when there were

calls for closure?

A. Yes, indeed, yes.

79 Q. When were they?

A. I had worked in Northern Ireland as a Barnardos' research fellow, obviously working with young people with learning disabilities. And one of the young people in the service that I was based at was to be placed at Muckamore. And I knew from discussion with colleagues then - and I am going back 30 plus years - but the hospital will close soon, that was the sense then. 09:57 09:57

80 Q. And when was that?

A. 30 plus years ago.

81 Q. I'd like to jump back at this stage to the executive summary, it starts at the Inquiry's page seven. At paragraph 4, the review team's findings are listed there. I want to ask you about some of these. They do touch upon topics that we will deal with in more depth later on. Have you got the page, Dr. Flynn? It's page seven of the Inquiry's page numbering? 09:58 09:58

A. I do apologise, I've got the context of the findings... I'll use this. It's okay.

82 Q. Can you see the screen okay, Dr. Flynn?

A. Yes, I can.

83 Q. Okay. The first one, there's reference to the chronic boredom of patients. Is this something that the review team saw and witnessed for itself? 09:58

A. Yes, indeed. Yes, indeed, we did.

84 Q. Okay.

A. And in fact people didn't hold back, they told us how bored they were and how things had changed and how they had once enjoyed activities that were no longer available, visits, holidays, interesting things to do.

85 Q. Okay. And did the review team see for itself a lack of activities on the ground? 09:59

A. Oh, yes. We saw very limited activities. Those which were available tended to be offered to patients who were mobile and were able to communicate readily.

86 Q. And you mentioned there being told about it by patients. Was the review team told about it by anyone else, such as staff? 09:59

A. Families.

87 Q. Okay.

A. And some staff certainly wanted people to be more engaged and more active than they were. For example, there is a swimming pool on the hospital site, and on the only occasions I've visited, it's been empty. I mean, not the water, that is, but there's nobody swimming. 09:59 10:00

88 Q. Thank you, Dr. Flynn. We can see another reference to the failure at that bullet point: The failure to create and offer them high quality community services. Did the review team look to the adequacy and availability of community services? 10:00

A. We were told a great deal about them. And it seemed that, to us, that the transfer from Muckamore Abbey Hospital was associated with placements in existing facilities, care homes and nursing homes. We were --

there didn't seem to be an enormous amount of creativity in terms of developing services around individuals. And it was really helpful having Mary Bell as a member of the review team, who described her own family's experience. And indeed I was able to 10:01
contribute my own brother's experience - he has a learning disability.

89 Q. Okay. And that's from your brother's own experience elsewhere in these services?

A. In England, but Mary's in Northern Ireland, yes. 10:01

90 Q. The sixth one down there says that there was a culture of tolerating harmful and disproportionately restrictive interventions. What kind of interventions is the review team referring to there?

A. The use of seclusion, which seemed extraordinary. And 10:01
because it was excessive and it was associated -- it was used principally for three people, with implausible explanations, such as, he likes to be in there. We couldn't see that the seclusion room would do anything other than wait until someone's distress diminished and 10:02
they became tired and then perhaps more manageable.

91 Q. Okay.

A. Certainly more placid.

92 Q. Did the review team see the use of the seclusion room in action, or was this conclusion based on, for 10:02
example, the reporting --

A. It was based on the reports, but also the distress of some families.

93 Q. And when you say based on the reports, is that based on

the safeguarding files, or other reports?

A. The safeguarding files did make reference to the use of seclusion and people being taken to seclusion. But in fact it was the data that was more significant, because then we were able to associate it with the same three individuals. 10:03

94 Q. Dr. Flynn, if we move down to the ninth one then, the second one from the bottom: "There is confusion about safeguarding concerns and complaints".

10:03

Can you tell the Inquiry a little bit more about that?

A. Yes. Personally I struggle with concerns, to say you have a concern isn't quite the same as saying, I have a very particular complaint that I want to be -- I want -- and I want it to be dealt with. 10:03

It also captures, I think, the ways in which the safeguarding response became clumsy. So, do you want to take this concern any further? Was a question that was sometimes asked of individuals, or indeed their relatives. And given that the relatives were not present when certain events occurred, it just seemed an astonishing sideways drift into very ambiguous territory. 10:04

10:04

So, do you want to take this complaint further? So does it go to the police? Does it remain in the hospital? Does the hospital scrutinise practice? And we couldn't determine from the documents that were

available to us what happened to concerns and what happened to complaints, for example.

95 Q. Were the two being dealt with separately?

A. No, there was -- because they became interchangeable in some records. 10:04

96 Q. Okay. Over the page then, the third one, third bullet point from the bottom, it says there: "Leadership is distributed and not being used to benefit hospital patients". 10:05

I will come back to the topic of leadership in more detail later --

A. Yes, indeed.

97 Q. -- but what was the leadership structure in the hospital, and what was meant by it being distributed? 10:05

A. Well, we took the view that the self advocates we met were leaders in their own right. And similarly some of the relatives and former relatives, who were part of the friends of Muckamore Abbey, they had assumed roles to encourage others to either become involved or put 10:05 their shoulders behind particular initiatives.

However, we could not identify benefits for hospital patients. Leaderships in terms of advocacy, this is not a criticism of individuals, but we found that 10:06 individuals who were assisting people to become advocates and were providing advocacy services at the hospital, they were focused on, for example, a shelter for smokers.

And it seemed to us that there was so much wrong at the hospital that it was almost a distraction to focus on a shelter for people who smoked.

98 Q. And that deals with leadership in the sense of advocates or external advocates? 10:06

A. Yes.

99 Q. What about leadership structure within the hospital itself?

A. We understood that it was not as visible as it became. So, certainly the director with whom I had most contact 10:07 was very visible and had wanted to be so, but we understood from staff, and most particularly that the senior managers at the hospital were, remained in the administrative, in the administration block.

100 Q. Sorry, I didn't quite catch that, remained? 10:07

A. Sorry, in the administration block and didn't do walk-arounds or meet staff very regularly.

101 Q. Okay. At paragraph 5, lessons are identified. The first one is that safeguarding practice at the hospital involves negotiating too many obstacles. What were 10:07 those obstacles, Dr. Flynn?

A. There was an uncomfortable phrase in, I think it was either a third, maybe two-thirds, I'm so sorry, I'll just have to check, of the safeguarding files, where people were described as - excuse me, I'm looking at 10:08 the...a history of making allegations. It seems to me that that is a formidable obstacle, because it becomes too easy to assert that because they've done this before, we can't really, you know, why should we

believe him or her on this occasion?

So that's a very substantial obstacle. We couldn't make sense, either, of when referrals were screened in or out. It seemed to us that some referrals that were so-called screened in, that, well, the rationale for that didn't make sense when compared with those that were screened out. 10:08

102 Q. So does the reference - sorry, Dr. Flynn - to obstacles, is that obstacles faced by the patients themselves? 10:09

A. Well, indirectly, yes. Indirectly.

103 Q. Mm-hmm.

A. And another, a very typical outcome of the safeguarding practice, most particularly in relation to people who were believed to lie - they've done this before, they'll do it again - was that the solution was, well, make sure that there are two members of staff with them at all times. That was not a good outcome for those individuals. 10:09 10:09

104 Q. And that's something that's dealt with in the report. But in your own words, why is that not a good outcome for the individuals?

A. It was people who were under occupied, patients who were under occupied being observed by two members of staff. Days must have been excruciatingly long for them. So they weren't engaged in activities with the patients, they were simply observing them. And that put pressures on the ward, because staff weren't 10:10

available to do other things.

105 Q. Thank you very much. At paragraph 7, the report details the feedback sessions which endorse the review's findings, and you've given evidence about that already. 10:10

A. Yes.

106 Q. Earlier on in the report, it says that the feedback sessions occurred on specific dates, this is at paragraph 3, we don't need to go there at this stage --

A. Yeah. 10:10

107 Q. -- but they happened on 24th and 25th September 2018.

A. Yeah.

108 Q. Is it fair to say then that the findings were received well?

A. I think the findings were something -- were uncomfortable for staff, for nursing staff who were engaged in day-to-day work. They were positively received, broadly positively received by others. 10:11

109 Q. And did all of those groups endorse the findings of the review? 10:11

A. I don't recall anyone resisting them vocally, but perhaps privately they were less than comfortable with them.

110 Q. And if we can go down to page 15, please. And if we go down towards the findings section, if we put that at the top of the page. The reader of the report can see, at the start of each of these sections, which go through the Terms of Reference, each start with a box of quotations. And it's explained there at the top 10:11

that the following sections begin with quotations from RQIA reports, the freestanding quotations were gathered during interviews and meetings, they are mostly unattributed.

10:12

So in this specific example, then, are the first four quotes that have the ward name followed by the date, are they then quotes from RQIA reports?

A. They're inspection reports, yes.

111 Q. And the last quote, which is unattributed, then that is -- 10:12

A. A family.

112 Q. A family?

A. Yeah.

113 Q. I'm going to ask the technical team to go down one page and just show paragraph 28, and nothing else on that page, please. Sorry, down to the next page. 10:12

A. 13.

114 Q. And just show paragraph 28.

CHAIRPERSON: 108 - 16. 10:13

115 Q. MS. BRIGGS: Thank you very much. The instances of abuse are highlighted there. To the review team's mind, was equal attention paid by the hospital to the different types of abuse, be it physical, non physical, sexual, psychological - and they're detailed there? 10:13

A. Well, they certainly filled in forms concerning each. I don't know whether that signals equal attention. But there were so many different kinds of forms, I truly don't know whether some of these forms represented -

this will be completed prior to contact with the PSNI, for example.

116 Q. You have mentioned there contact with the PSNI. Was there a particular staff member, without naming names, or individual, responsible for liaison with the PSNI within Muckamore? 10:14

A. I don't believe so, because there was a period when the police had a physical presence at the hospital, enabling patients to make direct contact with them. It seemed bizarre to us that people, patients might report being pushed by a peer to the police and there being no further action, for example, when in fact the grouping of patients was clearly unhelpful for some patients. 10:14

117 Q. If we can scroll a bit further --

CHAIRPERSON: Just before we move on from that, can I just ask this: Did you get the sense that the PSNI's presence was the result of action by the management of the Trust of the hospital, as opposed to their own volition, saying well, we'd better come in here and... 10:15

A. I think it must have been the surfeit of referrals to the police, because at one stage they were referring everything to the police -- 10:15

CHAIRPERSON: Yes.

A. -- and it just seemed a complete nonsense. There was no weighting given. So, for example, psychological abuse, I think most of us have some understanding of what that is. But actually, to describe that, to expect somebody with limited cognitive and perhaps communication skills to describe that is really very 10:15

challenging and the police had no idea what to do with it.

CHAIRPERSON: Yes.

A. It's likely to accompany being thumped, however, and feeling terrible about that experience and being targeted perhaps.

CHAIRPERSON: Yes, okay. Understood, thank you.

118 Q. MS. BRIGGS: If we can scroll down a little bit so that the page shows paragraph 30 and no further, please. And if it speeds it up for the technical team, we can show 30 and 32 - 30, 31 and 32. Not to show anything after paragraph 32, please. Thank you very much.

Paragraph 30 there deals with the difficulties with safeguarding files. There's reference to incomplete pages and illegible writing.

A. Mm-hmm.

119 Q. Do you recall whether senior management at the hospital, at the time of the review, were aware of the poor standard of the documentation?

A. I think their sense was of being overwhelmed by the documentation, bewildered by the very different number of files -- sorry, forms. So, for example, you've got decision to close adult protection investigation, you've got pre interview assessments, procedures for the protection, witness statements. Not all of those featured in a single file, they were dispersed across the 60/61 files or whatever. So I think the new people with whom we engaged were as bewildered as we were,

because we had conversations about, you know, this is the material we're looking at.

120 Q. What about the established people?

A. The?

121 Q. You mentioned there the new people were bewildered. What about the more established members of staff, how did they feel about the documentation? Did the review team become aware of any views or awareness? 10:18

A. I think there was just this, there was a weariness about it. You know, it was about more laborious form filling. We did hear a lot about form filling and how tedious the practice was and how you had to write down everything: He says she pushed me, she says she didn't, that variety. And I think that was an enormous frustration for staff. 10:19 10:19

122 Q. Okay. If we can go - it's on the screen now actually, paragraph 32. That deals, or addresses the fact that there are, the review team was advised as to staff who are related to each other at the hospital, including families who have worked there for generations. If we could scroll down - that's enough. Just so I can see the last sentence on paragraph 32: 10:19

"This is a relevant backdrop since the primary loyalties of people who are related or in intimate relationships are unlikely to be to the patients. There was no reference to conflict of interest declarations in any file." 10:20

And we can scroll back up a little bit there. Were there instances that the review team found of one family member investigating or reviewing allegations made by patients or staff against another one of their family members? 10:20

A. We wouldn't know. We did not know. But it was sufficiently uncomfortable. And the observation was made more than once, which is why it merited its own paragraph, that people were in relationships or whatever. I wasn't going to question people about that really. But we wouldn't know. And yet it seems to me incredibly important that people should declare the conflict of working alongside their partner or husbands, wives, whatever. 10:20

123 Q. Would a declaration of interest be enough in those circumstances, or should family members just not be working together in a hospital such as this? 10:21

A. That would be my view, yes.

124 Q. Which would be your view?

A. That family members, partners should not be working alongside each other. 10:21

125 Q. And you said earlier in your evidence that you wouldn't know if there was one staff member investigating a member of their own family; would the files not reveal who the allegation was made against and who was investigating the allegation? 10:21

A. We wouldn't have known if that was the case. That would not have been -- that wasn't clear in --

126 Q. It's not recorded in the files?

A. No.

127 Q. The next page is page 18, but I will ask the technical team to show only, on the screen, paragraph 35 onwards. Thank you very much. These paragraphs - and I'll not read them - but they deal with the discovery of incidents on CCTV and the response of the hospital to that. 10:22

Paragraph 36, the first sentence refers to, effectively, a delay in informing families. 10:22

A. Yeah.

128 Q. What was the cause of that delay?

A. I've no idea.

129 Q. Could it have been avoided?

A. I honestly don't know. There was a churn of staff and senior people, perhaps it was associated with that. I don't, I truly don't know. 10:23

130 Q. If procedures and policies, if safeguarding policies were being used correctly, would that delay have been avoided? 10:23

A. Oh, sorry, I missed -- this was bad -- I was responding to the fact that senior people did not appear to know that the CCTV was in operation. Apologies. So I can't account for the delay in informing the families. Families were very distressed by that, by the knowledge that there was delay. And that should have been foreseen. So I can't account for the delay. 10:23

131 Q. Okay.

A. Perhaps wondering how to deliver the awful news or who

should do it. But I don't know.

132 Q. Paragraph 38 over the page. And we can show the full page. That details an incident regarding a patient who sustained fractures during restraint. Did the review team have any follow up in terms of that particular patient to know what happened in respect of that incident, the outcome? 10:24

A. No. But I know it's something that we discussed, the disjunction between what is apparently shown on -- well, what is seen on the CCTV and what is written in the documents. 10:25

133 Q. If we can go down to paragraph 44, page 20, this goes through the various measures put in place in terms of patients' protection plans. And I'll give you a moment just to look at that, because I'm going to skip to another paragraph in a second. (Short pause) if you're ready, Dr. Flynn, then we'll go to page 27, paragraph 82. It says there, there was no single document across all files, which was labelled a protection plan. How do those two paragraphs sit with each other for the reader, Dr. Flynn? 10:25 10:26

A. Yeah, just going back... (short pause) practice did not correspond with that which was written in the documentation.

134 Q. Can you expand on that a little bit? I think I know what you mean, but... 10:27

A. Yeah, I suppose it's information about enhanced monitoring as a typical response; what does that look like when a ward is understaffed? I think there was a

consensus among the review team that it was unlikely to be very specific about the nature of the monitoring, its duration, whether or not it took account of, for example, peoples' visits to the toilet, the bathroom. And staffing levels two-to-one, really they were not going to happen on some of the understaffed wards.

135 Q. Dr. Flynn, is it fair to surmise that, although there were no documents labelled a protection plan, that there were, the previous paragraph would suggest that there were protection plans in place, but perhaps not in a formal document, is that the best way of putting it? 10:28

A. Yes, indeed, yes. Or not associated with an individual, they were more generic. So we will not use weighted blankets, for example. 10:28

136 Q. Chair, I'm conscious of the time. I'm not sure if now is an opportune time for a break or indeed if the witness is going to require --

CHAIRPERSON: Because we've started early, and I think you need to be away sort of fairly early this afternoon, we'll take two slightly shorter breaks this morning, and it may be that we'll need to sit through lunch, but we'll see where we are at about one o'clock. So we'll take a ten minute break now. Okay? But can we try and keep it to ten minutes? Thank you very much indeed. 10:28 10:29

SHORT ADJOURNMENT

CHAIRPERSON: Thank you. Please sit down. Thank you.

137 Q. MS. BRIGGS: Dr. Flynn, I'm going to go to paragraph 47 of the report --

A. May I intervene and just re-visit the last observation about the disjunction between the protection plans, the two paragraphs you've identified? My recollection is that we had many discussions with staff about the practice and the processes of safeguarding. And paragraph 44, that you identified, these included staff suspension, reporting staff to the nursing and midwifery council, et cetera. That accounts for -- that will have resulted from discussions with staff. 10:43 10:43

More clumsily, we have described outcomes in the relevant appendix, and the outcomes of particular allegations or reported abuses, some of which included protection plans, but not many. 10:43

138 Q. Thank you very much, Dr. Flynn. If we can go to paragraph 47 then. It's page 20, I think. The sentence in bold, and I'm going to read it into the record: 10:44

"There was indeed a culture, a tolerated set of norms or work practices which were harmful and disproportionate. It was shaped by the use of power, relationships and place in which the wards were closed. Visitors, relatives, as well as professionals, were advised whether or not they could visit due to unsettled patients. Individual staff members were 10:44

comfortable working with certain staff and cut and paste records concerning the use of seclusion, for example, were not challenged."

What evidence was relied upon to the statement that professionals were advised as to whether or not they could visit due to unsettled patients? 10:44

A. Accounts of professionals themselves. I'm thinking of the commissioners from other trusts and those responsible for either reviewing a patient's circumstances and in anticipation of potential transfer to community settings. 10:45

But particularly it was the families who described this as well, and there was just, they were saying similar things. 10:45

139 Q. Did the professionals themselves describe to the review team a difficulty accessing wards, or was that the report of families?

A. Both described that. 10:45

140 Q. And in terms of individual staff members being comfortable working with certain staff, is that something that the review team was told about?

A. Yes.

141 Q. Or how was that discovered? 10:46

A. We were told about that, yes.

142 Q. And without naming any names, who by?

A. Staff who were uncomfortable with certain practices at the hospital. And I think I recall that being a

conversation from a member of staff working on a ward who sought out a conversation, although we had not time tabled one with that person.

143 Q. And the reference there to cut and paste records, was that something -- 10:46

A. There were phrases that were used so frequently, it just spoke of laziness to us.

144 Q. Yes.

A. We couldn't think that there were identical events that resulted in the use of seclusion, and yet that was 10:47 implied by the paperwork.

145 Q. Was the reference to cut and paste records, was that something that --

A. That's my term, our term that we use.

146 Q. You saw that from the papers themselves? 10:47

A. No, I, that's a term I use, because these constant phrases kept coming up or...

147 Q. So that was based on your own reading of it?

A. Of our observations of the reports, yes.

148 Q. Was that issue addressed with staff or spoken to by the 10:47 review team with staff, the fact that there were records cut and pasted -- to the review team's --

A. Saying identical things? It would have been discussed, because we didn't hold back. We were very keen that people should not wait for a report, so I did have very 10:47 regular briefings with senior people at the hospital.

149 Q. And what did the senior people say about that allegation in particular?

A. I do not recall. But people did take account of what

we were saying, people made notes. Whether or not they became available afterwards, I couldn't say. But we did share information, that was one of the early undertakings; if there are things that render us uncomfortable, we will tell you -- that need attention rather. 10:48

CHAIRPERSON: Just on the cut and paste records, you may not be able to recall staff admitting to it, but the way you worded it is perhaps interesting; cut and paste records concerning the use of seclusion, for example, were not challenged. So that seems to indicate that you have spoken to staff about it. 10:48

A. Yes. I'm pretty sure we did - I did, I'll take responsibility for this. And I would have set out the phrases or the terms that were used consistently within these records. I cannot recall what they are. 10:48

150 Q. MS. BRIGGS: The next few paragraphs, 48 through to 50, they refer to the work of the social work team.

A. Hmm.

151 Q. Is it right to say that that is a team who assisted with the hospital's investigation following the safeguarding CCTV events being discovered? 10:49

A. I wouldn't know. I think...

CHAIRPERSON: Well, I think we know about that.

152 Q. MS. BRIGGS: Yes. The social work team, for example, it's not attached in any way to the review team? 10:49

A. No, no.

153 Q. They are within Muckamore?

A. Sorry, yes.

154 Q. And it also refers at paragraph 49 to a fact finding being conducted with families of patients who were placed in PICU and Six Mile, and there's information there at paragraph 49 to 50 about what families reported. Is that the review team's own information or data? 10:50

A. Yes, that's the fact finding. Yes, indeed, it is.

155 Q. Is that that fact finding conducted by the review team itself --

A. Yes. 10:50

156 Q. -- or was that the social work team?

A. Ours.

157 Q. Paragraph 53, the Inquiry's page 22. It states there that the social work team has highlighted, among other things, that most events occurred during weekends. 10:50 Does the review team endorse that view, based on its own investigation?

A. We didn't endorse that view, because sometimes the information within the files was not -- was insufficiently specific. For example, never on 10:50 Tuesdays, we wouldn't know. But there was sufficient consistency from colleagues in the social work team that it merited documenting.

158 Q. That being the view, then, of the social work team --

A. Yes. 10:51

159 Q. -- Dr. Flynn, can you assist us at all what might have been the reason, if that were true, for most events occurring on weekends, would you have any view as to why that might be the case?

A. When senior managers were not going to be present, when there was no recourse to somebody to assist in dealing with a particular scenario.

160 Q. Okay. Thank you very much. If we can go to paragraph 55, it's the Inquiry's page 22. We see there figures regarding allegations, and it's broken down into percentage in terms of the type of abuse. 10:51

A. Yeah.

161 Q. Where was that data taken from?

A. Information supplied by the hospital. We would not have been able to produce this data from the files that were available to the review team. 10:52

162 Q. So, did the hospital provide the data itself and not the information behind?

A. That's right. That's right. 10:52

163 Q. Paragraph 57, page 23. This is on the topic of seclusion. And you have given some evidence about this earlier.

A. Hmm.

164 Q. It says there: The review team was told that there was no monitoring of seclusion, and regardless of the policy it seems to be the first option. 10:52

A. Hmm.

165 Q. "We have scenarios of people who are not detained who have capacity who are being secluded and there is no form of appeal. The seclusion room is not fit for purpose. It contains a chair." 10:53

Without naming names, can you recall where that quote,

or report of a quote comes, who it came from?

A. I think I recall it was the social work team.

166 Q. And how does that statement fit with the next paragraph, that presents data on the use of seclusion?

A. It depends on our interpretation of monitoring. You can count the episodes, but not peoples' experience of being in a seclusion room. 10:53

167 Q. So the lack of monitoring of seclusion then, that --

A. Checking that somebody's --

168 Q. -- appears to be a reference to whether the experience in seclusion, aside from the bare fact of seclusion itself? 10:54

A. That's right, yes. Whether or not someone's distress persists, whether they are hurting themselves, for example. 10:54

169 Q. Did the review team become aware as to whether there was a particular person or people within the hospital who had responsibility for the use of, and the standard of the seclusion room?

A. No, I -- it was used on the ward where the seclusion room was. I don't recall there being discussions about people being taken from other wards to the seclusion room, but it was used a great deal. 10:54

170 Q. But the review team, did they have any role in finding out, for example, where responsibility for the use of that room lay? 10:55

A. It was with staff.

171 Q. Staff, okay.

A. They were dealing with the patients, they determined

when to use the room, which was, as we've indicated, excessive.

172 Q. Was there any individual with overarching responsibility for the monitoring of that room, for example? 10:55

A. No, no, I do not recall there being so.

173 Q. When seclusion is talked about, sometimes training and similar topics like that come up, and they also come up when one's talking about topics like restraint, for example, you can get staff training in relation to 10:55 those things. Did the review team look at all to the training that was given to new staff at Muckamore, for example, in the likes of seclusion or restraint?

A. No, we didn't. We were advised that the training was insufficient, and that was in the context of, you know, 10:56 it's used so often, so too frequently, you know, people clearly need training in this. It was in that spirit. But I couldn't comment on any curriculum that was available to staff.

174 Q. And without naming names, where did the report come 10:56 from that training was insufficient?

A. I think it would have been -- I'm sorry to be so nonspecific. We learned a lot from the social work team, I suspect it was from the social work team.

175 Q. Did the social work team talk about other aspects of 10:56 training, for example, CPD, continuing professional development, were there any comments or views expressed in respect of that?

A. No. If anything, I think the context was unpromising

because of the churn of staff and the use of bank staff, and that featured in discussions. Staff who have no knowledge of individuals, sometimes no knowledge of the culture of the place working with quite -- with people whose behaviour was difficult to be alongside and being ill prepared for that.

DR. MAXWELL: Can I ask, once you had been alerted to these concerns about inadequate training of the ward staff by the social work team, did you actually go back to any of the senior nurses and seek more information from them about this? 10:57

A. No, we didn't. It was something that we documented and we shared as we went along. These are things we're learning. So that would have been with some of the senior managers at Muckamore Abbey, who were based at the hospital. And it would have been in the spirit of, you know, have we got this right? Because we would not have documented something if we'd been given evidence to the contrary. 10:57

DR. MAXWELL: I'm just wondering whether you spoke to the ward sister, who would presumably be responsible for monitoring their staff's skills? 10:58

A. The ward sisters were forthcoming. I recall them being more upfront about the challenges of managing new staff who were from banks. 10:58

176 Q. MS. BRIGGS: If we can go back to page 23 -- sorry, go forward to page 23. Paragraph 61 and 66. We don't need to specifically -- if we just pull up 61 on the screen. But the reader can see that paragraph 61 and

66, they make reference to the fact that staff claimed, and safeguarding records cited, that some patients were habitual complainers. And you have talked about that earlier in your evidence, that it was recorded that they have a history of making complaints. 10:59

Was seeing that type of entry, history of making complaints, was that common amongst the different hospitals' wards, their specific records?

A. Yes. 10:59

177 Q. So that was a hospital wide practice, if I put it that way?

A. Yes. I can't -- it's either a third or two-thirds of the files included that reference. Apologies, I need to check, it's in the body -- 10:59

178 Q. It's in the report, Dr. Flynn, and we have the report.

A. Okay, apologies.

179 Q. There's also reference, I think it's paragraph 66, of the lesser ability of some patients to recall times and dates. And in the same section there's reference to 11:00 mental capacity status as being included in the reports as being relevant to the safeguarding files. Is it the review team's view that some reports were effectively screened out - and I'm using your own words on that --

A. Mm-hmm. 11:00

180 Q. -- for a combination of some or all of those factors?

A. We were troubled that clinicians determine whether or not, on occasions, there should be a safeguarding investigation, on the basis of perceived, presumed

capacity on behalf of the patient. I was struck that it was too easy to say, well, that event couldn't have happened, because this person wasn't on duty on Tuesday when the patient says this event happened. It seemed to me that a more humane response would have been, clearly something has happened, whether it was on Tuesday or not is neither here nor there, but something has happened. But there didn't appear to be any subsequent interrogation, that was it, it was closed, close the issue, that's it, it's finished. 11:01

181 Q. So, some of those factors then would result in a file being closed?

A. Yes.

182 Q. Is that --

A. Yes, that's right. 11:01

183 Q. And who would have been responsible for closing a file, would the review team have taken or gathered any knowledge as to who would be responsible for closing a file?

A. Well, it would have been discussed with the person in charge of the ward. They would have had, you know, the say and agreement. And I suspect with some relief as well, because it was less paperwork to fill in. 11:01

184 Q. Okay.

A. Not that the paperwork was terribly illuminating. 11:02

185 Q. And when one thinks about these factors in combination, perhaps if we could go back to Inquiry's page 14 at paragraph 24. When one thinks about the fact, or the review team thought about the fact that there was

sometimes entries about a history of making complaints, or that a patient had a lesser ability to recall times and dates or perhaps lacked capacity, when one looks at these numbers then at paragraph 24, would the review team take the view, therefore, that these numbers of 11:02
complaints or adverse incidents are effectively distorted --

A. Yes.

186 Q. -- by those factors?

A. Yes. 11:03

187 Q. And at what stage in the review team's process was that realised?

A. When we received this so-called high level analysis data, which was available to the Trust. I mean, there was a phenomenal amount of reporting, reporting upwards 11:03
to the Trust, which was geographically quite remote from the hospital.

188 Q. And if the reader looks at more depth -- in more depth at those numbers, one can see a very high number comparatively of abuse of staff by patients. 11:03

A. Yes, indeed.

189 Q. 3067 incidents?

A. Hmm.

190 Q. What forms of abuse was that said to cover? Was there any information provided in that respect? 11:03

A. No, but staff did describe being punched, kicked, with patients who were reluctant to attend a particular activity or to do as requested, whether it's go to the table to have a meal, for example.

191 Q. Was information provided as to whether this covered just physical abuse or whether it covered other types of abuse?

A. No, it wasn't that fine-grained. And in fact I think we said that its limitation is there's absolutely no back story to this. 11:04

192 Q. Mm-hmm, okay.

A. And it might be one person responsible for many incidents, but we can't determine from this information. 11:04

193 Q. Can there be anything read into the fact that comparatively there is a higher number, a much higher number, of abuse of staff by patient; does it indicate, for example, that there was a fundamental problem or problems with the management of some patients? 11:04

A. I wouldn't take that view, given the basis -- given the uncertainty regarding the reporting, recording of information of this nature.

CHAIRPERSON: So, if we look at these numbers again, we ought to be extremely cautious? 11:05

A. I would be cautious, yes. The staff did report being harmed on occasions, but so did patients. Were staff more attentive to reporting, were they more likely to be believed when they reported than a patient reporting harm? I don't know. 11:05

194 Q. MS. BRIGGS: Would there have been any use in, for example, given what you've said, looking at a comparator hospital elsewhere, would that have been any of any assistance, given what your evidence has been?

A. Possibly, possibly.

195 Q. Did the review team discover whether there was an awareness within Muckamore senior management as to the high numbers of abuse of staff by patient versus what appears to be a comparatively, what is on the page a comparatively low number of abuse of patient by staff? 11:06

A. I don't think that featured in discussion with senior managers. I do not recall that.

196 Q. And what is "abuse other"?

A. Pardon? 11:06

197 Q. Sorry, the last bullet point on paragraph 24 says "abuse other", a total of 2059 incidents?

A. That is a quotation in the italicised text. The only difference is I've highlighted the numbers.

198 Q. Does the review team know or can you recall what the other was? 11:06

A. No.

199 Q. Can we go back to where we were? I think we were at Inquiry's page 25. Paragraph 65, there's reference there to clinicians determining whether there should be a safeguarding investigation. 11:07

A. Hmm.

200 Q. Did that arise from any safeguarding policy?

A. No, not that I recall. Well, there wasn't a policy.

201 Q. Was that a procedure that had been approved by senior management? 11:07

A. I suspect -- well, it doesn't matter what I suspect, I don't know.

202 Q. Paragraph 71, it's just down the page. It says there:

"Three files referred, thresholds". And then it goes on to describe what it says in those files regarding thresholds.

A. Yeah.

203 Q. Is the existence of thresholds, is that proper procedure in line with any policy, or was it at the time? 11:08

A. Yes, people referred to thresholds principally, but also criteria, does it meet the criteria? And this is very ambiguous territory. I mean, for example, there was one phrase: "Meets the criteria for not referring to the PSNI", that occurred a few times. You think, what is this? You know, has a crime been committed? If so, then necessarily refer to the police. If not, then why are you referring to the police? But it just creates enormous uncertainty for staff and managers. 11:08 11:08

204 Q. But in terms of the policies in place at the time, did they refer to thresholds? Was that the proper --

A. Yes.

205 Q. -- approach under the procedures? 11:08

A. They did refer to thresholds, yes. Serious harm, yes.

206 Q. The last quotation there says: "This does not meet the threshold of serious harm under new policy".

A. Yes, I believe those were the three documents from the Belfast -- produced by the Belfast Trust. 11:09

207 Q. What three documents are you referring to there?

A. I think they're cited right at the beginning. Yes, the protocol. So this would be, it's on paragraph 5 in the review methodology.

208 Q. Okay.
A. The document, "adult safeguarding, prevention and protection in partnership", and protocol for joint investigation. And the "adult safeguarding operational procedures".
209 Q. Thank you very much, Dr. Flynn. And the new policy that was referred to in that quote, were the review team satisfied that that policy did in fact exist and had been provided with it?
A. These were fairly recent policies, they're dated around 2016, 2015, the first one. So yeah.
210 Q. Thank you very much. Paragraph 79:

"The PSNI regarded the evidence of new staff and/or staff who were shadowing hospital staff prior to patients moving out as particularly compelling. They were new to a ward's custom and practice and spoke up. However, without exception, they were ostracised and had no support from management in the process."

What was the evidence supporting that?
A. From the police.
211 Q. The police said that staff were ostracised and had no support from management?
A. They described that, yes, the experience of staff leaving after a very short period of time. That is not bank staff, but people who elected to work at the hospital and then decided it wasn't for them, some of whom were obviously troubled by practice they

witnessed.

212 Q. Are you referring specifically here to staff members who undertook a process of making a complaint, that they left quickly and were unsupported and ostracised, that that information came from the police? 11:11

A. Yes. Yes.

213 Q. Did staff members themselves say anything about having no support from management in the process or being ostracised when --

A. We didn't meet former members of staff. 11:11

214 Q. Did the review team accept, based on what it was being told by the police --

A. Yes, we did.

215 Q. -- that the hospital failed to assist whistle blowers?

A. Yes. Yes, we did. 11:12

216 Q. Governance and leadership were two parts of the Terms of Reference, and those are dealt with at pages 29 to 31 and page 33 respectively. I am going to ask a very general question first, Dr. Flynn. 11:12

Plainly, the report finds a number of failings regarding the care received by patients at Muckamore. What, if anything, did the review team find regarding who was responsible for those failings, without naming names? 11:13

A. Without naming names, it has to be the people at the top, the people who are responsible for the day-to-day operations of the hospital. I mentioned a churn. I was supportive of certainly one of the new directors,

who I believed had enormous investment in persisting with the closure of the hospital and securing community based services for people. Others, it appeared, were less engaged with that. There has been, I think, a belief that this hospital won't close, because they said it 30 years ago and it's still here. I mean, I've heard that comment.

So, certainly the people at the top and those responsible for supervising staff at a ward level, so that's the sisters of the wards. 11:13

217 Q. Okay. And in terms of leadership and governance, did the review team look to the management structure itself? I think, if I recall right, earlier in your evidence you said you were provided with such a structure. 11:14

A. Yes, indeed, yeah.

218 Q. One might expect to see, for example, that structure being provided in a report or shown to the reader. Was there any reason why that wasn't the case? 11:14

A. No, there was no particular reason. I think some people had gone even within the period of the reviewing period. So it would have been out of date. It wasn't updated when we were there.

219 Q. Were the staff members who were still in post at the time on that particular structure, were they all spoken to or interviewed by the review team? 11:14

A. Oh, yes. Yes, indeed.

220 Q. If we can go to page 29 at this stage, and if we can go

down to the governance and quality assurance section. I'm not going to read that entire section, it goes on for a couple of pages, but did the review team consider that governance and quality assurance was effective or ineffective at Muckamore? 11:15

A. It was ineffective.

221 Q. On what grounds?

A. That challenges that were known persisted. That people continued to be harmed. That families experienced exclusion and disbelief when they sought to draw 11:15 attention to their relatives' circumstances. That peoples' health status was not as it should be for people of equivalent age. That people had long and uneventful days. They desperately wanted to be active, to have a purpose, and yet that didn't happen, for 11:16 example.

222 Q. Was the review team satisfied that there was a system for governance and quality assurance in place and that the problem was that it wasn't being followed, or was this problem that there wasn't a system in place, or 11:16 was it somewhere between the two?

A. It would be between the two. There was a great deal of documentation about it, but the reality was that things -- people experience their days as unchanged, and families reported that things did not change, even 11:16 once complaints were investigated, for example, really powerful feedback complaints, things were unchanged. And our own sense of, for example, being around the hospital, we could see why families described distress

at the appearance of their daughters and sons and brothers and sisters, because of the clothes that they were wearing and the inattention to their appearance, for example.

CHAIRPERSON: So, just for my own elucidation, because as you know, I'm not a medical person at all. But when you talk about governance, what you're really describing here are the consequences of what you perceive to be the failure of governance -- 11:17

A. Yes. 11:17

CHAIRPERSON: -- rather than governance itself, because you don't actually deal, I think, with the structure of governance --

A. No, we don't.

CHAIRPERSON: -- in your report. 11:17

A. There were many documents about governance. And the hospital produces shed-loads of documentation. However, its implications for the day-to-day lives of people is absolutely unknown.

CHAIRPERSON: And so that's what you were dealing with? 11:18

A. Yes.

CHAIRPERSON: The result upon patients and carers and relatives rather than trying to describe governance at the hospital itself?

A. That's right. I mean, it would be terrific if I could say yes, there were periods when people knew they were going to be supervised, when there were occasions, when ward teams got together and described what it was that they needed to do to enhance the experience of 11:18

patients, but we're not able to do that.

223 Q. MS. BRIGGS: Page 33 is the leadership section. If we can pull that up. Again, I'm not going to read it, but just to be very clear about it, what was the review team's conclusion regarding leadership at the hospital; was it adequate, inadequate or somewhere in between? 11:18

A. It was in progress. There were new directors, a new director, the one I've referred to, and someone who was, I believed, shaking up some of the people who'd been there for some time. But it was in progress. 11:19

224 Q. Okay.

A. And I think it's fair to say that the trust of some families was so damaged that they did not believe that new faces, new managers would be sufficiently consequential to improve the lot of patients. 11:19

225 Q. Okay. The Terms of Reference, Dr. Flynn, they task the review team with using the RQIA assessment definitions of well led when it's asked to assess leadership at Muckamore. Those definitions are not mentioned in this part of the report. Were they used by the review team? 11:20

A. No. No, we learned of clinical leadership, there was a great deal of clinical leadership and deference to the clinicians. So the psychiatrists had a role, but -- that was significant at the hospital. I don't know whether that remains the case. 11:20

226 Q. I'm going to turn to clinical leadership in a moment, but was there any reason as to why the review team didn't use the RQIA assessment definitions of well led in assessing leadership?

A. Because we could not make sense of that in their own inspection reports, although --

227 Q. You couldn't make sense of, sorry, the definitions themselves, or...

A. The definitions and their failure in their own reports to cite examples of this. And because we didn't have that, it just seemed it would have been a stab in the dark to say that this unit was well led, and that was not, for example. 11:20

228 Q. And if we turn to clinical leadership, paragraph 100, page 33, it says there in the second sentence: 11:21

"The team was advised that the hospital has recently endorsed collective leadership and that although the psychiatrists are supposed to provide clinical leadership, historically it has not happened." 11:21

A. Hmm.

229 Q. Was that an individual that advised the review team as to that? Is that a quotation? 11:21

A. It is a quotation. But it was a shared view, it was a number of people made this observation.

230 Q. Okay.

A. You know, they're supposed to be the clinical leaders, but their leadership strays beyond that of clinical matters; cite, for example, this person really shouldn't attend a training course about keeping yourself safe, they're not up to it. 11:21

231 Q. And what was the review team's views about clinical

leadership, aside from what it was being told?

A. They were responsible for peoples' medication, that's the leadership we witnessed. They were responsible too for determining peoples' suitability for transferring out of the hospital, or rather they had a considerable say in that. 11:22

232 Q. Was that adequate or inadequate?

A. I don't know how it was experienced by their colleagues. It was helpful to have a psychiatrist as a member of our review team who was -- who experienced disquiet at the work of clinicians. I don't want -- perhaps I should withdraw that. He was interested that his own practice did not align with that of the clinicians we met. So, for example, he was very clear that assessment and treatment should not exceed six months. And if it does so, then the patient will deteriorate and there are no therapeutic gains. He questioned the therapeutic contribution of clinicians at the hospital. 11:22 11:23

233 Q. Thank you very much. I'm going to come to the recommendations in the report in due course, but one can see - well, one will see that there are no recommendations regarding leadership or governance. Is there any particular reason for that? 11:23

A. Yes. The hospital needs to close, full stop. 11:23

234 Q. And on that point, the closure of the hospital, which is something that was recommended in the report, how does the lack of governance and leadership at the hospital impact on what the quality of governance and

leadership in the community might be?

A. It should galvanise, or be the catalyst for the Trusts in orbit around Belfast to secure services for people within their localities, within the boundaries of their own trusts. It did appear that for some, that was happening, in some cases that was happening. But it wasn't consistent. It does require the political will and statements that are as absolute as this hospital will close on this date.

11:24

235 Q. Okay. The report also says at paragraph 109 - I'm going to ask the technical team not to go there on the screen - it says that the review was advised of a lack of general medical services at the hospital.

11:24

A. Mm-hmm.

236 Q. It seems to be a quote by a staff member. Did the review team find any other evidence of a lack of general medical services at the hospital? Did it see that for itself?

11:25

A. We talked with some families about the health care of their relatives and we learned of their experience of this. You know, at a kind of mundane level, we met people who had no teeth, for example. People whose appearance was not suggestive of any care, careful attention. And reflected, shared the reflection of some relatives that if they are at not looking out to ensure that he even wears his own clothes, what else are they not paying attention to?

11:25

11:26

We were also struck, we learned of people, quite young

people, taking quantities of laxatives, for example, when attention to diet might have been more appropriate.

237 Q. And on the topic of a lack of general medical services at the hospital, did the review team find any evidence that those -- that concerns were being raised about that by staff members on the ground to management? 11:26

A. No, we didn't. In fact, Michael's paper, Michael Browne's paper concerning health status and the future populations of young people was circulated, I think, fairly promptly amongst senior staff at the hospital. 11:27

238 Q. And who would have responsibility for providing general medical services to patients; would it be the hospital itself or the Trust or a combination?

A. It would be the Trust. There is a practice, and I don't know whether it prevailed at Muckamore as sometimes psychiatrists taking a lead role in establishing whether or not somebody requires medical attention, but I don't know whether that prevailed at Muckamore. 11:27

239 Q. Okay. There is reference at paragraph 109, I believe - I'll not ask -- I'll ask the technical team not to put that up - but there is reference I think at that paragraph to the difficulties that people with learning disabilities suffer in terms of their general health comparative to the general population. 11:28

A. Yes.

240 Q. And a reference is made to appendix 7, where that's dealt with in more detail.

A. Yes, that's right.

241 Q. What did the review team find, if anything, was the awareness amongst practitioners or staff on the ground at Muckamore regarding the particular health vulnerabilities and health needs of patients? 11:28

A. We were seen through a safeguarding lens, we were troubled at peoples' isolation, for example, in seclusion, we were troubled at the use of restraint and medication and the implications for that long-term. And necessarily the distress of families, that people were bruised and sometimes in pain for a constable period before they were, they had an X-ray, for example. 11:28

242 Q. If we can go to page 36, the conclusions, paragraph 118: 11:29

"The hospital's compromised progress in resettling long-stay patients and in addressing the acute need arising from mental health delayed discharges impact on safeguarding and are compromising the capacity of the hospital to provide assessment and treatment." 11:29

I'm going to ask you a little bit about delayed discharge. Did the review team discover whether there was a system in place to monitor discharge? 11:29

A. No, it was more of a hand wringing experience of commissioners from the trusts orbiting the -- and using Muckamore Abbey Hospital. And their own experience of asserting that there are no places for people to go.

For my colleagues in England, and Michael had recently worked in Scotland, we were struck at the want of imagination in terms of identifying ways of creating community services that did not involve place hunting for vacancies in nursing homes and care homes. We were struck too that there did not appear to be any promising relationships with housing associations to provide accomodation, or indeed with sheltered housing for older people. 11:30

And there is not the tradition, we understood, in Northern Ireland -- we understand, in Northern Ireland, of charities providing services for former residents of long-stay hospitals.

243 Q. Okay. If we focus on the topic of delayed discharge. In terms of advocacy in the process of discharge, what was seen by the review team in that regard? Who, if anyone, advocated on behalf of the delayed discharge patients? 11:31

A. Families. So families expressed their distress that people were promised, perhaps accomodation, perhaps a service that was not realised. 11:31

244 Q. Okay. What about external advocacy groups?

A. As I described, the external advocacy within Muckamore was focused on a smoking shelter. 11:31

245 Q. Paragraph 121:

"It is possible that repeated exposure to chronic and low level allegations to outbursts of distress,

behaviour and violence directed at peers and staff are perceived as normal at the hospital."

Who possibly perceived those things as normal, staff or patients or both? 11:32

A. Both. This is what happens, it's a hospital for people with learning disabilities.

246 Q. Okay. I'm going to go down to the recommendations in the review team's report. It's the Inquiry's page 40. There are two principal recommendations. The first one 11:32 is:

"The review team recommends that there must be evidence of a renewed commitment to enabling people with learning disabilities to have full lives in their 11:32 families and communities. And secondly to services which understand that ordinary lives require extraordinary supports which will change over the life course."

11:33

Who was the review team seeking that commitment from?

A. Senior personnel in Belfast, but also the Department of Health.

247 Q. When you say senior personnel in Belfast, do you mean the Belfast Trust? 11:33

A. Sorry, the Belfast Trust, yes indeed.

248 Q. And No. 2 then, I'll not read it all, but it says:

"An updated strategic framework for Northern Ireland

citizens with learning disability and neurodevelopmental challenges, which is co produced with self advocates with different kinds of support needs and their families."

11:33

And then it goes on to say about the transition, the community based services, requiring the contraction and closure of the hospital.

I think we've touched on this earlier. That aligns with the Bamford policy at the time, isn't that right? 11:33

A. That's correct, yes.

249 Q. And you had said at the outset of your evidence that that was a view endorsed by the review team from the very outset, it was a consensus among the review team? 11:34

A. Yeah.

250 Q. Did the review team form any view as to how quickly resettlement of all long-stay patients from Muckamore could be achieved?

A. It's certainly much easier to realise if there is a definite date set, established by politicians and senior people in the Department of Health. 11:34

251 Q. Did the review team take any view as to what might be achievable or beneficial or --

A. No, we didn't. Although individually Ashok and Michael and myself had experience of timeframes in similar settings in England and Wales. 11:34

252 Q. I want to give you an opportunity to reflect on where Northern Ireland is now, with these two

recommendations, the reports November 2018, and we're now in May 2023. Has there been a shift, have these recommendations been achieved? The hospital is still open. But aside from that, have these recommendations been achieved in any sense? 11:35

A. No, it was crushingly disappointing to learn of the consultation about the future of Muckamore Abbey last year. And as far as I know, there isn't an updated framework. I regret -- I suppose, I regret now that we did not, although we were boasting that we have not got 11:35 hundreds of recommendations, I regret that we did not insist that there was something in the form of a consensus statement from the Trusts in Northern Ireland setting out what their aspirations were for people with learning disabilities over their life course, developed 11:36 with people with learning disabilities and their families over the life course, I regret we didn't make that really explicit.

I think the commissioners came close to it, saying we 11:36 should be working closely together, we should be working with families. I think in retrospect, I should have said, we need a consensus statement. I have subsequently discussed that with the Belfast Trust, but they can't take a lead on this without the 11:36 collaboration of the surrounding trusts.

I'm not promising that that would have made a difference either of course, but...

253 Q. In terms of the recommendations themselves, there isn't one that specifically relates to revising safeguarding policies or processes, for example, in the hospital?

A. No.

254 Q. Was there any reason for that? 11:36

A. Where would you start? They were familiar with, as I've said, shed loads of paperwork and practices that were clunky and dealing with criteria and thresholds which were contentious. Where do you start? I suppose it was "leave it". The policy -- Northern Ireland, or 11:37 rather some professionals I've come across in Northern Ireland were really quite satisfied that they have a policy that shapes safeguarding practice.

My view is rather different; I think we need some 11:37 legislation, such as we have in the Care Act and the Social Services and Well-Being Act in England and Wales respectively, which makes very clear when there should be a safeguarding inquiry and how we might use learning from that over time. 11:38

The policy in Northern Ireland is, as this work demonstrates, has not been consistently drawn upon, and that's perhaps because policies merely set the parameters in which decision-making takes place. 11:38

255 Q. There's a learning identified section in the report at page 39.

A. Hmm.

256 Q. If that could be pulled up on the screen. I don't

intend to go through it, Dr. Flynn, but it appears to relate more specifically, comparative to the Terms of Reference to Muckamore itself.

A. Yes. So, just very briefly; we have said that it should not be so difficult to deal with an allegation, or evidence of an allegation concerning harm or evidence of harm. It should not be as difficult as it has become at the hospital. And it really makes it very clear that it's not feasible for psychiatrists to establish whether people with learning disabilities have the capacity to benefit from, you know, the scrutiny of safeguarding adult activities or participate in training. So that was where we dealt with it. It's just a mess, frankly. 11:39 11:39

257 Q. And, Dr. Flynn, was there any role for the review team mapped out in terms of tracking improvements or following progress at Muckamore, specifically in terms of this learning, or indeed any of the other recommendations in the report? 11:39

A. I was invited to return to meet some of the families and, I think, I shared with the Inquiry team correspondence with some of those families. And I was also invited to reflect on what it was I learned from senior people at the hospital, senior managers at the hospital, one in particular. And I was encouraged that the numbers were reducing, continued to reduce of people at the hospital. 11:39 11:40

258 Q. Are you referring to -- I think it's dealt with in your second statement, your revisits to Muckamore --

A. Yes.

259 Q. -- followed by your attendance at a board meeting in September of 2019?

A. That's right, yes.

260 Q. Aside from meeting with the families, as you've described, and your re-visit to Muckamore, which we will come to, and your attendance at that board meeting, which we will also come to, was there any other formal role mapped out for the review team, or indeed yourself, in terms of tracking progress against these recommendations? 11:40 11:40

A. No, there wasn't. And that's not something that a review team can insist upon or...

CHAIRPERSON: Can I just ask, has there been any informal tracking, or has there been continued contact with -- 11:41

A. There has been intermittent contact, and I've encouraged that, I very much wanted some of the people that I was working with to know about, for example, the service which I'm a trustee that supports people with learning disabilities across north Wales, for example, and another service that I also was a trustee of that supported people throughout Wales, and gave them, provided some modest information about the work of the challenging behaviour foundation in England and their efforts to demonstrate that people described as having severely challenging behaviour do not need to be in assessment and treatment units. 11:41 11:41

So, that sort of information, I pinged over to individuals that I met, but those individuals are no longer there.

CHAIRPERSON: And so, apart from the minutes, that I think we're going to look at, have you attended other sort of formal meetings or informal meetings with the Trust to see how things are changing? 11:42

A. No. I have -- last year I had contact with Kathy Jack about possibly meeting some families from Muckamore Abbey. 11:42

CHAIRPERSON: And did that occur?

A. With two families, yes.

CHAIRPERSON: Right, okay. Thank you.

261 Q. MS. BRIGGS: Thank you, chair. There's reference in multiple sections in the report to staff members who families say provided good quality care? 11:42

A. Yes, indeed.

262 Q. Did the review team take any view as to whether this was due to the systems in place or whether it was due to individual staff members taking it upon themselves to... 11:43

A. It was individuals whose work was highly rated, those who took time and paid attention to, particularly to the appearance of their daughters and sons, and wanted to learn about how to bring out the best in their daughters and sons. So wanted to learn about their histories and spend time knowing, for example, how their families interpreted different kinds of behaviour. 11:43

263 Q. Those staff members that were providing good quality care, the review team didn't put that down to the system in place, it was down to those staff members?

A. The individuals, yes.

264 Q. There are a number of appendices to the report, and I don't intend to go through them all, but there are some questions in respect of some of them. 11:43

A. Mm-hmm.

265 Q. Appendix 1 is a census framework, it's at page 46.

A. Mm-hmm. 11:44

266 Q. Was that census framework put in place in Muckamore?

A. No.

267 Q. Why not?

A. I'm afraid you'd have to ask them. It seemed to me and to my colleagues - Michael was familiar with it, 11:44 Michael and Ashok were familiar with it, Bryce and Mary were not - but as we looked at it, we thought it was so important, because it engages not just with the experience of people with learning disabilities, but with their families and with staff. And it seemed that 11:44 that was, had incredible merit.

So, for example, having a sense of significance, so people with learning disabilities feel recognised and valued as a person of worth, that their actions and 11:44 existence are of importance and that they mattered. And for families to feel that their caring efforts were valued and appreciated and to have an enhanced sense of self.

And then for staff to feel that their practice was valued and appreciated and that their work and efforts matter. We like the tiered approach to this. But we could only commend it, you know, we thought it had enormous merit in looking at how individuals were supported at the hospital.

268 Q. Thank you, Dr. Flynn. Appendix 4 is the Inquiry's page 62. It deals with workforce issues at Muckamore Hospital.

A. Yes. 11:45

269 Q. If we could go down to page 65. This section deals with the ratio of RNLDs, that's registered staff to HCAs, non registered nursing staff. The report describes the low ratio of registered nurses compared to health care assistants at Muckamore? 11:46

A. That's right.

270 Q. Did the review team consider how health care assistants are supervised, given that low ratio?

A. No, we didn't.

271 Q. Is there any reason for that, Dr. Flynn? 11:46

A. No, no particular reason.

272 Q. Okay. In terms of the responsibility for the staff issues which are detailed throughout that appendix, where did responsibility for addressing staffing issues lie; did the review team take any view as to that? 11:46

A. No, it was against the backdrop of a hospital that is closing, that has a very compromised reputation, why would people want to work there? It had a traffic of bank staff working there, I understand some of whom

have been there for some time. But, no, we didn't, no. It's a huge risk, however, a huge risk.

273 Q. Did the review team find any concerns about staffing being flagged within Muckamore itself or beyond?

A. Oh, yes, the refrain "we don't have enough staff" was frequently heard. And again, Bryce was interested in this, it was part of his previous working life, and again it was circulated amongst the senior staff at Muckamore Abbey when Bryce drafted it. 11:47

274 Q. Did Bryce or the review team see evidence of it being raised beyond Muckamore to the likes of the Trust level? 11:47

A. I would have to ask Bryce.

275 Q. Okay. Paragraph 2 at page 62, this is about nurse staffing being viewed as insufficient. The second sentence there says: 11:48

"It should be noted at this point that little evidence was provided that shortfalls in care resulted."

11:48

How, if at all, did the review team find that staffing issues at the hospital impacted the health and well-being of patients at Muckamore?

A. It was presented largely as the rationale for not being able to do things with patients "we don't have the staff", that was the refrain. 11:48

276 Q. Appendix 5 is the Inquiry's page 68. It details the thematic approach taken by the review team to the RQIA reports. And it becomes clear to the reader of the

report that the thematic approach, i.e. an approach by theme was an approach adopted by the review team --

A. Hmm.

277 Q. -- and it doesn't, would it be fair to say, seem to be an approach adopted by the RQIA itself? 11:49

A. That's correct. That's correct, yes.

278 Q. And the report - and correct me if I'm wrong - but it would suggest that the RQIA takes a ward based approach?

A. That's right. 11:49

279 Q. What was the review team's view of the benefits of a thematic approach over, for example, the ward approach taken by RQIA?

A. Well, I suppose it revealed that voices of protest were muted by the, was it 12 patient experience, something 11:49 or other. I think some level of inertia arose from the repetition of recommendations, and as a result of which people became accustomed to poor services. Spending time with people on the wards and in their families led us to believe that, even an exercise of a day in the 11:50 life of somebody, would arguably have yielded a more rounded account of peoples' experience of the hospital, than an inspection report that resulted in tens upon tens of recommendations, to no effect.

280 Q. Part of the Terms of Reference was to look at how 11:50 previous RQIA reports were implemented at the hospital?

A. Hmm.

281 Q. And you've touched on that already in what you've just said.

A. Well, yes, it was a challenge at the outset. I couldn't see the merit in spending days and possibly weeks setting out all the recommendations concerning a particular ward, given the evidence that arose from the safeguarding practice at the hospital. I couldn't see the merit in spending time doing that and almost doing a stock take of the RQIA's own homework. 11:51

282 Q. Page 76 at paragraph 20. After the thematic kind of approach, after the thematic approach is set out, it says there: 11:51

"The endurance of these themes has not yielded to effective remedies thus far."

A. Hmm. 11:52

283 Q. What is meant by that?

A. That in spite of all these reports, in spite of all the recommendations, things are not that different. The belated transfer of any ideas to professional practice is part of the picture. And some of the observations they make, you know, I'm just looking at one page and there's a quotation: 11:52

"Seclusion rooms were examined and reflected trust policy." 11:52

In isolation, you might think, well, that's okay, policy is being adhered to. But if you knew that the seclusion, the extensive use of the seclusion rooms by

three people over a period of years, then you might think, well, good grief, we should know about that. It was almost as though we were looking at a very different, very different institutions.

284 Q. Was it the review team's view that the recommendations of RQIA weren't being adequately implemented, given the persistence of themes? 11:53

A. No question. And there was a weariness at the hospital expressed at different levels that the inspection reports were less than helpful. 11:53

285 Q. One of the themes is restricted practices, it's dealt with at page 74. And restricted practices there includes restraint and seclusion. And the reader of paragraph 74 might conclude that RQIA had raised issues about that. Was there any evidence that staff at Muckamore had acted upon those concerns, for example, through new policies or new training? 11:53

A. No, there was no evidence of that.

286 Q. Did the review team look to that?

A. No, we didn't specifically look to that, no. I don't know whether it's relevant, but it seemed to us that there was an incredible enthusiasm for new forms at the hospital. So within that paragraph of restrictive practices, there's a footnote about the different types of assessment and planning tools. And given that we gleaned these from the inspection reports, I think there are over 25 we cited, we couldn't understand why the RQIA would not say, isn't this a problem for the hospital, it's not as though you've got hundreds of 11:54 11:54

patients there, but you're using all these different planning tools, how do we know which one to reach for on the shelf?

287 Q. Another one of the themes, the only other one I'm going to go to, is record keeping, it's page 75? 11:55

A. Yeah.

288 Q. Again I think when one looks at that, there were issues being raised by RQIA in respect of record keeping. Did the review team look to when those issues were being raised as to whether subsequent to that there was any 11:55 improvement in the record keeping?

A. No, because that was our experience of the records around safeguarding - they were poor.

289 Q. So the review team's view was that - tell me if I'm putting words into your mouth - the records were 11:55 consistently poor?

A. Yes, I mean there were glimpses in one or two of a very different sort of practice, but no, they were poor.

290 Q. If we turn to Inquiry's page 77, the RQIA were given an opportunity to respond to the briefing paper. 11:56

A. Hmm.

291 Q. Can I ask you exactly what is the briefing paper in this context? Is it an earlier version of the report?

A. It must be a slightly earlier version, because they don't tally, and that's my error, I should have ensured 11:56 that when they make reference, for example, to page one, paragraph 3, that it tallies exactly.

However, it really is a case of -- I think it's

possible to discern the section of the appendix that they are referring to.

292 Q. Looking at the RQIA's responses in whole, in their entirety, in your view, were the responses of the RQIA justified? 11:56

A. I understood them. There was push back. What can I say? Nobody particularly enjoys their work being challenged. But it seemed to me that in spite of what it was that they were doing, what they were seeing, they relied heavily on documents and had done, that's 11:57 the nature of their work, and yet things did not change. And families were extraordinarily critical of their work and dismissive of it.

CHAIRPERSON: Can I just ask this: I suppose the test is not whether you enjoyed the push back or not, but 11:57 whether it caused you to revise your opinion?

A. No, it didn't.

CHAIRPERSON: Right.

A. We did discuss it, but no, we were very comfortable with the -- with where we'd arrived at. 11:58

CHAIRPERSON: Thank you.

293 Q. MS. BRIGGS: Thank you, chair. I'm going to ask you a little bit now about what happened after the final report was published.

CHAIRPERSON: Are you already to keep going, Dr. Flynn? 11:58

A. Yes, that's fine, yes.

294 Q. MS. BRIGGS: Sorry, I misspoke there, I said published when it was produced, the final report was produced?

A. Produced, yes, that's right.

295 Q. Because it's right to say the final report itself was never published, isn't that right?
A. Yes, that's right. Although chunks of it, sections of it appeared in, I can't remember, one of the Belfast papers.
296 Q. Aside from that, who was the report shared with?
A. The Belfast Trust.
297 Q. And I think you've mentioned earlier in your evidence that it was shared with families, is that right?
A. Oh, sorry, yes. I accompanied one of the directors and delivered it to, I think there were probably about eight, eight or nine families, who had most particularly contributed their experience. 11:58
298 Q. And aside from the Belfast Trust and families, are you aware whether it was shared with any other groups, for example, the PSNI? 11:59
A. No, I'm not, no.
299 Q. Are there any other groups that you're aware that it was shared with?
A. Well, I would like to think it went to the Department of Health. Well, it must have gone to the Department of Health for Richard Pengelly, who was the lead at the time, to make comments about the nature of activities at the hospital. 11:59
300 Q. And it's right to say that although the report itself wasn't published a summary document was published, isn't that right, a summary of the report? 11:59
A. Yes. And actually, I remembered drafting something for an easy read for some of the, for people with learning

disabilities.

301 Q. In terms of that summary document, I think it was published in February 2019, do you recall that?

A. I'm afraid I don't, no.

302 Q. Do you recall how that came to be that there was a summary document published, but the report itself wasn't? 12:00

A. No, I don't? And the summary, I think -- are you referring to the one I did on the easy read, or the summary at the front? 12:00

303 Q. It's not an easy read, it's a copy of the report, it's short, it's available on-line and it's --

A. Oh, okay.

CHAIRPERSON: It's about six pages, I think, it appears on the Trust's website. But did you draft that, or did the Trust? 12:00

A. I must have drafted it. Well, I will look at it again and be able to confirm.

CHAIRPERSON: Could you let us know in due course?

A. Yes. 12:00

CHAIRPERSON: Okay, thank you.

304 Q. MS. BRIGGS: Thank you, chair. At this stage we're going to move on to your second statement, it's very short. If that could be pulled up on the screen, please. You detail in this statement your oral report to the Belfast Trust board on 5th September 2019. 12:00 Within the minutes, which are exhibited to this statement, you refer to a re-visit to Muckamore in June 2019.

A. Right.

305 Q. I think that's at the eighth page of this statement with the exhibit. Can I ask you about that re-visit, was there one or more than one?

A. There must have been one. I don't recall, I don't recall more than a single visit. And that was me, not my colleagues. 12:01

306 Q. Okay. How did that come about?

A. That would have been a request from the director with whom I distributed the report to families, I gave copies of the report to families. 12:01

307 Q. Was that an announced or unannounced visit to Muckamore?

A. It would have been... unannounced, I guess.

308 Q. Who was aware that you were going to attend in advance, if anyone? 12:02

A. People who were perhaps summoned to a meeting, they would have known in advance. I'm afraid I do not recall the specifics of it, I'll have to check back.

309 Q. And -- 12:02

CHAIRPERSON: Sorry, when we talk about unannounced, this wasn't an inspection?

A. No. Oh, no.

CHAIRPERSON: This was turning up to a meeting with the board? 12:02

A. To meet people --

CHAIRPERSON: Sorry, not the board

A. -- and it was kind of a how are we doing more of a meeting of that nature, so...

310 Q. MS. BRIGGS: Dr. Flynn, I am asking you specifically about the re-visit to Muckamore ahead of your attendance at the board meeting. Was there anyone aware that you were coming in Muckamore?

A. Some would have been -- would have known, yes. 12:02

311 Q. And you talk about your re-visit in your address to the board a little bit. But can I ask you what you recall at this stage about your re-visit, what it was you saw, whether you saw any improvements or not, as the case may be? 12:03

A. I'm referring to this because I... yes, so in the re-visit, I -- ah, yes, apologies, I'm so sorry.

312 Q. No, take your time, Dr. Flynn.

A. I expressed disappointment that the number of patients being discharged was compromised by new admissions, and 12:03 that included readmissions of people who had been discharged and the experience of their placements had not worked out.

So the number of patients remained constant. At the 12:04 time that was about 60 people. And it seemed there was a terribly low -- so that really low threshold for admitting people just persisted, it continued to be the default placement.

12:04

In contrast, some of the ward reviews were really upbeat, in that, there was a pharmacist present, it included psychologists and peoples' support staff, and they were very focused on discharge arrangements for

the individuals whose reviews I sat in on. There were probably about three of those. And there was some investment in creating activity plans, so at least setting out what it was known about peoples' preferred activities and -- so there were some modest changes there.

There was a carers' forum, which I suspect was pretty bruising for the staff, but it was there and they were meeting some of the senior managers of Muckamore Abbey, and that was an important shift, because previously they had -- some families reported the difficulty of talking to anyone in a senior position.

There had been no progress in spite of the interest in so-called collective commissioning across Northern Ireland, there had been no progress there. And some, I suppose, continued disappointment that commissioners were still looking to provide us, to come up with vacancies rather than exploring effective supports for individuals around individuals rather than place hunting, as we've called it.

313 Q. When you made that re-visit to Muckamore, were you aware that you would be addressing the board that September? The re-visit was in June according to the minutes and your re-visit --

A. Probably not. But if they asked me to do it, then I'd have said yes, of course I would do it.

314 Q. So that re-visit wasn't made in the knowledge that you

were going to be addressing the board?

A. No. And if anything, when I think back, it's probably resulted from me sending bits of information, as I've described, to the people who were senior at the hospital at the time and sending information that I thought would be helpful to them. 12:06

315 Q. And that board attendance, that was by invitation, is that right?

A. Yes. Yes.

316 Q. From the board itself? 12:07

A. I guess the chair, I guess the chair of the board.

317 Q. I can see you're looking at the minutes. At page ten of the Inquiry's page numbering, it's the last page of the minutes, you make a number of conclusions when you speak to the board. And some of these look like recommendations, or suggestions, to put it more mildly. Were these taken forward and agreed by the board? 12:07

A. No, I was warmly thanked for my contribution. There was no guarantee that any of these would be taken forward. 12:07

318 Q. And do you know whether any of them were in fact taken forward?

A. No, I don't. I thought that the response to allegations made in the media, I thought there should have been a response rather than silence. I felt families deserved that. But families needed that response initially rather than through the media. I don't know that there is a redefined statement of purpose. There isn't a closure date. There's a 12:08

consultation about its future. I don't think we're further forward in terms of the creation of specialist short-term facilities. I do hope that there will be an acute care resource that is much, of a much different scale, much smaller, in Belfast, not remote from the city. And I don't know about the RQIA issuing further notices concerning the hospital. And there is no bold or well formulated regional effort in progress as far as I can make out. 12:08

319 Q. Thanks, Dr. Flynn. The fourth bullet point is what I'm going to ask you specifically about. 12:09

A. Okay.

320 Q. It says there:

"As an interim measure, consideration should be given to the Northern Health and Social Care Trust and the Southeastern Health and Social Care Trust being allocated their own acute care resources, separate buildings on the MAH site, for which these trusts have total responsibility." 12:09 12:09

A. Yes. I think that arose because of the frustration of the professionals I met, who said, you know, you're sort of waiting in turn for your people to go and where they are on the prospective transfer. And it just seems -- it seemed bizarre to me that you wouldn't take responsibility, and perhaps even do it by saying, look, you know, you're discontinuing the use of this ward, why not put our people together and we'll take full 12:09

responsibility for that.

It would also have addressed, I think, the experience of the hospital that commissioners were highly critical of practice at the hospital, so they would service these wards with their own staff. It wasn't to be, of course. I mean -- and it wouldn't have been -- from a patient perspective, what would that have been like? You know, it was an idea that was thrown out in the spirit of food for thought. Not one of my finest hours. 12:10 12:10

321 Q. So, given what you're saying, can I assume that that isn't an idea that's been trialed or done any where else to the best of your knowledge?

A. To the best of my knowledge, no. 12:10

322 Q. How was that suggestion received?

A. I do not recall any particular surprise at it.

323 Q. Was there any conversation with the various trusts who might have been affected with such a recommendation?

A. I don't know that these minutes were circulated beyond this. 12:11

324 Q. Okay.

A. In fact, it's helpful to see the minutes. I didn't receive them myself.

MS. BRIGGS: Chair, panel members, those are my questions. Following any questions that the panel may have, I'm going to ask that we take a short break, and after that break I will address the chair on an application for a restriction order. And I would also 12:11

ask that the application itself be made subject to restrictions, having regard to the MOU with the PPS and the PSNI.

CHAIRPERSON: Certainly. Well, what I think we'll do is we'll take a break. When we come back, I'll ask my colleagues whether they have got any further questions, and we can do that before any application for a restriction order. And then you can make a restriction order. 12:11

Once that has been dealt with, whether or not I make the order, how much more have you got to deal with? 12:12

MS. BRIGGS: I think a maximum of 15 minutes, chair.

CHAIRPERSON: Right. So why don't we take a quarter of an hour now and then we'll come back at approximately half past twelve and deal with that. Thank you very much, Dr. Flynn, again, thank you. 12:12

SHORT ADJOURNMENT

12:34

CHAIRPERSON: Thank you. Can I just say straightaway, the reason the panel are not with me is because they've indicated to me they have no further questions of this witness and nor do I.

MS. BRIGGS: Yes, chair. 12:34

CHAIRPERSON: We therefore move, I think, to your application for a restriction order, effectively on behalf of the PSNI and PPS, I think.

MS. BRIGGS: Yes, that's right, chair.

CHAIRPERSON: So, so that people can, who have signed the confidentiality agreement can hear the application and, therefore, what follows, we're going to have to rise again, I'm going to have to rise again so that the live feed is cut, the feed to room B is cut. Those who 12:35
wish to join by Zoom can do so, provided they've signed a confidentiality agreement. So I'll rise again. Will ten minutes do it?
MS. RICHARDSON: Yes.
CHAIRPERSON: So I'll sit again at quarter to. 12:35
MS. BRIGGS: Thank you, chair.

SHORT ADJOURNMENT