MUCKAMORE ABBEY HOSPITAL INQUIRY

SITTING AT CORN EXCHANGE, CATHEDRAL QUARTER, BELFAST

HEARD BEFORE THE INQUIRY PANEL

ON THURSDAY, 4TH MAY 2023 - DAY 40

Gwen Malone Stenography Services certify the following to be a verbatim transcript of their stenographic notes in the above-named action.

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THE INQUIRY RESUMED AT HEARING 10:00 A.M. ON THURSDAY, 4TH MAY 2023, AS FOLLOWS:

MS. KILEY: This morning's witness is Mr. Louis Burns giving evidence on behalf of the Health and Safety Executive of Northern Ireland. He is ready to commence as soon as the Panel is ready.

CHAIRPERSON: Can I just mention that the Panel's Caseview isn't working this morning. We are going to get that sorted and we will get the transcript in due course. If you can go a little bit slower than we normally do, just so we have the chance to sort of assimilate and make a note ourselves if we need to.

MS. KILIE: Yes, certainly.

CHAIRPERSON: Thank you. I should say it's not Caseview, it's the government net problem.

MR. LOUIS BURNS, HAVING BEEN SWORN, WAS EXAMINED BY MS. KILEY BL AS FOLLOWS:

CHAIRPERSON: Good morning, Mr Burns. Welcome to the Inquiry. Thank you very much for your statement and for coming along to assist us. I'm not sure how long you are going to be but if it is much longer than an hour, then we'll take a break. You may not be that long.

1 Q. MS. KILEY: I don't anticipate much longer.

Good morning, Mr. Burns. We have met. As you know, I

am Denise Kiley, I am one of the counsel to the Inquiry. I am going to be asking you questions this morning and taking you through your evidence.

A. Okay.

2 Q. So you have made a statement which is dated 26th January 2023. You have a copy of that in front of you; isn't that right? 10:06

A. That's correct.

3 Q. I understand that having read that statement, you wish to make a correction to an error in a date; is that right? 10:06

A. That's correct, yes.

4 Q. Could you just explain how that arises?

A. In paragraph 7A it talks about April 2016 to February '22. That should read April 2006 to February '22. 10:06

5 Q. Okay. Is there a similar correction required then to paragraph 7F?

A. That is correct, yes. That should read April 2006 to February 2022. 10:06

6 Q. Okay. Subject to those corrections, are you content to adopt this statement that you have made to the Inquiry as the basis of your evidence to the Inquiry?

A. Yes.

7 Q. Just while you have referred to those dates, Mr. Burns, can I ask why the period that you refer to does commence in 2006? What's the significance of that date? 10:07

A. The significance of that date is that in 2006, we

introduced a new case management system for recording all our cases. Prior to that the records are not retrievable.

8 Q. Okay. Do you have paper copies of records before that period? 10:07

A. There may be some old paper copies, yes, but they would be very difficult to retrieve.

9 Q. Okay. So, your evidence before the Inquiry is based on the electronic records and therefore only from 2006 onwards; is that right? 10:07

A. That's correct, yes.

10 Q. You, Mr. Burns, explain at paragraph 3 of your statement that you're the Deputy Chief Executive of the Health and Safety Executive in Northern Ireland. How long have you held that position? 10:08

A. Since 2016.

11 Q. How long have you worked for the Health and Safety Executive?

A. I joined the Health and Safety Executive in 2000, and up to 2005 I was an inspector. From 2005 to 2016, I 10:08 was a principle inspector, mostly responsible for the Major Investigation Team. From 2016 onwards, I have been the Deputy Chief Executive over Services division.

12 Q. The Health and Safety Executive as a body was formally created in April 1999; isn't that right? 10:08

A. The current iteration of the Health and Safety Executive was indeed created in 1999 following a review, but it was in existence prior to that. It became a non-departmental public body at that stage.

13 Q. Can you explain what the significance of the Health and Safety Executive being a non-departmental body is? How does that effect how you work in practice?

A. Yes. We are a non-departmental public body with Crown status. Our employees are civil servants. We basically mirror our sister organisation in GB, the Health and Safety Executive who have the same status as ourselves. That status gives an independence, because we have an enforcement role and that enforcement role can equally be brought to the Crown as well as non-Crown bodies; so we enforce everybody. It gives us a degree of independence as an enforcement body. 10:09 10:09

CHAIRPERSON: Your inspectors, out of interest, are employed by the HSC, they are not Crown agents?

A. They are employees of the Northern Ireland Civil Service. 10:09

CHAIRPERSON: Yes.

A. Yes. Yes, they are just the same as ordinary civil servants in terms of their terms and conditions. So as a non-departmental body, we are somewhat unusual in that we have Crown status. 10:10

CHAIRPERSON: Yes.

14 Q. MS. KILEY: In your statement you explain in some detail the various obligations which arise to notify the Health and Safety Executive of incidents which arise in the work place. I am going to ask you about those in detail but, before we turn to those, are you able to explain in summary form to the Panel what the Health and Safety Executive's role is in respect of 10:10

Muckamore?

A. Yes. I suppose it's not specifically in relation to Muckamore but I can explain our role more generally and then try and move into how it would apply in Muckamore.

10:10

The first thing that we do is we bring forward proposals for health and safety regulations to the Department, and the Department will make those regulations. We maintain a regulatory framework within the health and safety arena. That then gives us -- so 10:11
the Health and Safety At Work Order gives us those functions. In addition, we enforce the provisions of those regulations within work places.

The other strand of our work is we have to promote and 10:11
provide education to people that work as to how they should maintain health and safety in their work places. It is those three sort of key strands. It is maintaining an up-to-date regulatory framework; it is the enforcement of compliance of that regulatory 10:11
framework, and that can take the form of everything from a letter, an improvement notice, a prohibition notice, right through to a prosecution. Then the third strand is to provide information and advice to work situations. 10:12

15 Q. So, is it fair to say then that the Health and Safety Executive's primary focus is in respect of the health and safety of a work place generally; is that right?

A. Yes. So, under the Health and Safety At Work Order,

the primary legislation, the sort of entry point is at work. It has to be an at work situation. If there is no work situation, it doesn't apply.

16 Q. Yes. So Muckamore comes into your remit because it happens to be a work place; isn't that right? 10:12

A. That's correct. Indeed, yes. There is people at work there.

17 Q. You have referred to the various roles, the strands of the Health and Safety Executive's role. I just want to look at those a bit more. At paragraph 6A of your 10:12 statement you explain these. If we can bring that up please. It's at page 3. At paragraph 6A you explain that the Health and Safety Executive is a regulator.

"As a regulator, a significant portion of our resources 10:13 are directed towards ensuring compliance with the relevant Health and Safety At Work statutory provisions. This is achieved through a combination of work place inspection and investigation activities which are underpinned by an Inspector's enforcement 10:13 powers".

Just thinking again about hospitals, and Muckamore in particular, does the Health and Safety Executive have a schedule or a rota which sets out how regularly it 10:13 inspects hospitals like Muckamore?

A. No, that wouldn't be the case. We have a relatively small number of inspectors and we have a very large number of places that would fall under our remit. So,

for many, many years now, we have gone on a risk-based approach. I mean, if you look at approximately 80,000 businesses in Northern Ireland, and we are working with somewhere in the region of 24, 25 inspectors, 10 principal inspectors, there's a lot of those businesses are --

CHAIRPERSON: Sorry, is that 24/25 plus 10?

A. Yes. The structure is you've got the principal inspector, and then that principal inspector will have a number of inspectors working for them. For example, we would have a principal inspector in charge of agriculture and a small number of inspectors with them.

In terms of -- there is a lot of businesses, a lot of work places in Northern Ireland that will rarely see an inspector. It's just a logistics matter; we can't be in every work place. So, we prioritise our activities where we will visit the most -- those work places which are associated with the most dangerous activities. So, medium to heavy industry will get a more -- the regime, they will see an inspector more often. Whereas where an organisation, we would recognise an organisation has got a good safety management system, they have safety professionals employed there, we will consider them to be low risk. You have that profiling of organisations to some degree.

The other thing that plays into the equation is our numbers. We have to use our inspectorate to focus on

to those higher risk activities. We do not have like a profile for Muckamore per se that it will be visited once every quarter, once every six months. That's not the way it would be.

18 Q. MS. KILEY: You gave an example there of having a principal inspector for agriculture. Is there a principal inspector for hospitals? 10:16

A. There is not somebody with that title. For some years now we have been organised that the principal inspector over hospitals would have other responsibilities as well. That person -- that would be under the public sector, and that's quite a large group of employees, if you like. So you have like the Crown bodies, you have local counsels, you have the health service, and you have education would be the four big sectors under that principal inspector. 10:16 10:16

19 Q. You mentioned prioritising industries that are high risk. How does the Health and Safety Executive assess and identify industries as being high risk?

A. There would be sector intelligence within our organisation through the groups. They would know -- we would know which industries are associated with the worst outcomes in terms of injuries, fatalities et cetera. I don't want to be disparaging about any particular industry but agriculture and construction would be two well-known high risk industries, whereas a lot of that public sector generally would not be seen as high risk. You know, they are not doing a lot of work at height, they are not doing excavations and that 10:17 10:17

sort of more high risk activity. You know, there would be a sector intelligence there where we would know this is associated with the worst outcomes in terms of fatalities and serious injuries. That's not what we would see generally in the public sector. 10:17

20 Q. Just to be clear then, are you saying that Muckamore Abbey Hospital isn't regarded as a high risk area for the Health and Safety Executive?

A. I couldn't say Muckamore specifically, it's more just the health care arena. That whole health care arena 10:18 would not be seen as a high risk industry as such. Now, that's not to say, you know -- it actually would report quite a lot of injuries to people, minor injuries in terms of slips, trips and falls and that sort of thing. In terms of, you know, very serious 10:18 injuries and fatalities, it wouldn't be on a par with the potential outcomes of agriculture, construction, heavy manufacturing, that sort of thing.

CHAIRPERSON: Sorry but just to be absolutely clear, although your organisation under the legislation 10:18 focuses on the work place, it's not just the workers in the work place, it is anybody visiting the work place; is that right?

A. Yes, it's the undertaking. It's the undertaking of the work place and how that would effect anybody. 10:19

CHAIRPERSON: Exactly. As matter of fact, it would cover somebody visiting a hospital? Not just the patients in the hospital but anybody visiting a hospital?

A. Absolutely, yes, it would.

CHAIRPERSON: Yep.

21 Q. MS. KILEY: You go on in your statement actually to give some examples of how the obligation to notify the Health and Safety Executive in particular circumstances arise. I do want to turn to those now. You set those out at paragraph 6D to F. If we start at 6D. You explain the duty to report under the RIDDOR regulations. They are the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (Northern Ireland) 1997. You say: 10:19 10:19

"Employers have a duty to inform the Health and Safety Executive of Northern Ireland of certain types of injuries and diseases suffered at work. The most common type would be injuries which result in the employee being unavailable for work for than three days. Others include specified injuries and fatalities". 10:20

Breaking that category down, in those examples that you have given, we are only thinking about employees; is that right. 10:20

A. Yes. In that first paragraph that would be employees, yes.

22 Q. The person who is obligated to make the report, is that the employer or the employee who is injured?

A. The employer.

23 Q. Okay. Can only the employer make that report then?

A. No. In the real world, anybody could inform us of an accident. It wouldn't... But the regulations ask the employer or the person in control of the location to make - which is generally the employer - to make the report.

24 Q. Okay.

A. But in the real world, we would hear about accidents from people who aren't employers, you know. Sometimes we would hear about them from solicitors and things like that, where they hadn't been reported. 10:21

25 Q. Okay. In your next paragraph then, I think you turn to explain those circumstances where the obligation to report arises in respect of a person not at work. I want to read paragraph 6E for context and then ask you some questions about that. At paragraph 6E, you say: 10:21

"There is a duty to report occurrences where any person not at work suffers an injury as a result of an accident arising out of or in connection with work, and that person is taken from the site of the accident to a hospital for treatment in respect of that injury". 10:21

Can you give any examples of the type of incident that would fall into that category, and I'm thinking, if you can, in particular about what this Inquiry is looking at and the hospital context? 10:22

A. Okay, yes. To set the context, I'll give you one which is not a hospital one and it is a sort of classic one you'll see in relation to this. If a member of the

public is walking on the High Street and there is a construction operation going on. The scaffold and all has to be built in such a way that nothing falls off the scaffold and hits that person. But say something did fall off, say a brick hit that person and that person then was taken from the High Street to the hospital and treated for that injury, that is reportable to us.

To move to a hospital situation. Say, for example, a visitor went to a hospital and there was water on the floor, they slipped, they break their arm. If they require hospital treatment as a result of that, that accident to that visitor would be reportable to us.

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10:22

26 Q. Okay. What about in, for example, a circumstance such as this: What about in a hospital where an employee, as part of their job, has to restrain a patient and, as part of that restraint, the patient suffers an injury, say a broken arm, and has to be taken to a different hospital then for treatment. Would that sort of example fall into the category which you have described at 6E?

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10:23

A. It's possible, yes, that might do. It depends. There is a caveat in the regulations about if it's treatment under the care of a registered medical professional. If the situation you're describing doesn't tick those boxes, so it is not a registered medical professional, and somebody was in the situation that you described and, for argument's sake say they broke their arm, the

10:24

patient had their arm broken and they were taken then to a hospital to get treatment, yes, I believe - now without going into the specifics of an incident just in general - I believe that is potentially reportable under these regulations.

27 Q. Okay. You referred there to an exception for medical treatment, which you describe in greater detail at paragraph 6F, so I am going to read that just to ask you a bit more about that exception. You say at 6F: 10:24

"In addition a report must be made where any person not at work suffers a major injury as a result of an accident arising out of or in connection with work at a hospital, but this is qualified insofar that where the accident causing death or injury to a person arising out of the conduct of any operation on, or any examination or other medical treatment of, that person which is administered by or conducted under the supervision of a registered medical practitioner is not reportable". 10:24 10:25 10:25

Is that the exception that you were just referring me to?

A. Yes. Yes.

PROFESSOR MURPHY: Can we just clarify what registered medical practitioner exactly means. Does that include, for example, registered nurses? 10:25

A. I think that is possible, that it would include a registered nurse but I can't say that definitively.

The obvious example would be a doctor or a surgeon.

DR. MAXWELL: The registered medical practitioner is the protected term for people registered with the GMC. I think it's a protected title.

A. Okay. 10:26

28 Q. MS. KILEY: It's a matter, isn't it right, Mr. Burns, that is defined specifically in the RIDDOR regulations.

CHAIRPERSON: So we may have to go into the regulations.

MS. KILEY: There is a particular definition but it is with reference to that protected term. 10:26

DR. MAXWELL: That is a protected title.

29 Q. MS. KILEY: So there is a specific definition of a medical practitioner. To the lay person, that sounds like a very wide exception. Does it operate in that way? 10:26

A. I have to say that we wouldn't see those types of -- like somebody under the treatment of a doctor, we generally would not see those reported. I can't say whether it operates widely. I don't know because I don't know. If we don't see it, we don't know what's going on. 10:26

DR. MAXWELL: Can I just ask. I know there have been Prosecution in England by the GB Health and Safety Executive where neglect was involved. Would this caveat apply if it was felt that it happened under the supervision of a registered medical practitioner but the care was negligent? 10:27

A. So, there is a distinction here. Under the RIDDOR

regulations, you have those statutory reporting things. That doesn't bar us from actually investigating it. Even if it is not reportable, we can still investigate. So, you know, we would hear of things that would happen. They may not be statistically reportable under RIDDOR but we would still investigate. And we have taken right through to prosecution things that have happened in medical settings. Recently we had one. So we do get involved in those things, even though theoretically they may not be statutorily reportable. 10:27 10:28

We would have things reported. If they reported something that was under the care of a registered medical professional, we wouldn't send it back and say that's not reportable, we would look at it. If that makes sense. 10:28

30 Q. MS. KILEY: Just thinking about the discussion which we have had and the exceptions that are applied to reporting, I think it's fair to say it's not easy to identify always what is reportable. Would you agree with that? 10:28

A. That's very true.

31 Q. If that is the case then, how does the Health and Safety Executive ensure that incidents which ought to be reported to it are reported? 10:28

A. Okay. So this goes back to where we provide education. We would do some promotion in terms of RIDDOR. It would be on our website. We have an easily accessible electronic form for people to report. In this type of

an environment, the Trusts, the health care education, they have good systems in place. They employ people to manage health and safety within their locations so that we would have a confidence that the reporting is good there, albeit subject to those difficult interpretations sometimes.

But, you know, other sectors - and I am not going to name them - underreporting would be an issue. There isn't really much you can do about it. If people don't report and we are not physically on the site, it's very difficult to catch underreporting. Where we would catch it would be sometimes a solicitor will contact us and say have you been made aware of an injury to my client, an accident that he was involved in. Sometimes when inspectors would go out, they would look at accident books and, you know, they would maybe find one or two that should have been reported but weren't reported, so they would encourage them to report them.

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If the systems in an organisation were bad enough, we could actually put an improvement notice on the organisation to improve their reporting. But in general, underreporting is an issue in some sectors, we would believe.

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10:30

CHAIRPERSON: I'm sorry, Ms Kiley. Is a failure to report an offence?

A. Yes.

CHAIRPERSON: Can you give us some idea of how often

that's prosecuted?

A. In my time, I think there have been one or two times it's been --

CHAIRPERSON: It is extremely rare?

A. It's extremely rare, yes. Yeah. I mean in terms of prosecution, prosecution tends to be for the most serious outcomes like fatalities and serious injuries. So, you know, again it's back to a resource issue; we cannot prosecute everything. We would deal with that by way of -- and if you go back to the Robens report, Robens made provision for those sort of more lesser breaches to be dealt with by way of improvement notice, which requires the organisation to correct what is wrong. If they don't comply with the improvement notice, we would prosecute for that now. 10:30 10:31 10:31

32 Q. MS. KILEY: Can I just ask while you have mentioned improvement notices and prosecutions, can you explain to the Panel what the Health and Safety Executive's enforcement powers are?

A. The powers of an inspector are in Article 22 of the Health and Safety At Work Order, and are quite extensive powers. They include powers of entry. We can take samples, we can seize things et cetera. You then move on through, I think it's 23, 24, 25, improvement notices. If we come across a breach of the regulations which does not give rise to serious or imminent danger, so like reporting problems or things like that, we can issue an improvement notice. They have 20 days. The times is specified, so they have 20 10:31 10:32

days to correct the breach, or they can appeal to an industrial tribunal, which has the effect of suspending the notice until the tribunal makes the decision.

10:32

The next stage up is if an inspector is out and they come across a situation which, in the opinion of the inspector, gives rise to serious or imminent danger. So, the classic one would be an unguarded machine where somebody could get dragged in, or work at height on a scaffold with no edge protection, or work on a roof, for example. Serious danger, prohibition notice, it has immediate effect. The work must stop immediately. Even if they appeal to the industrial tribunal, the prohibition notice remains in force.

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10:33

Up to the next level then. We can refer cases to the Public Prosecution Service and if they accept the case, the evidential test et cetera, their tests, then that would be moved on into court.

10:33

Most of our offences are triable either way, but because we concentrate on the most serious ones, the fatalities, the serious injuries, I would estimate in the region of 80 or 90% of cases are Crown Court cases. They are viewed as a serious matter.

10:33

33 Q. Okay. So, prosecution is the highest enforcement power that the Executive has?

A. That's correct, yes.

34 Q. Thinking of the whole range of enforcement powers, has the Health and Safety Executive ever used those powers in respect of Muckamore Abbey Hospital?

A. Not that I am aware of, no.

35 Q. Has it used them in respect of any hospital in Northern Ireland? 10:34

A. Yes. So, we prosecuted a number of health care situations, hospitals. I would need to go back and look whether we've issued notices, but I do remember issuing a notice in a health care situation many years ago. So yes, I would expect there have been notices issued but there certainly has been prosecutions. 10:34

36 Q. That's in respect of enforcement. Thinking now about inspections, has the Health and Safety Executive ever inspected Muckamore Abbey Hospital, to your recollection? 10:34

A. I'm not -- I can't say that they have. I have no record of them having inspected it, no.

37 Q. Okay.

A. They have had dealings with it. At the end of my statement there is a couple of examples where they have dealt with some issues at Muckamore. 10:34

38 Q. Yes. I am going to actually turn to those now. You deal with those at paragraph 7 of your statement, which is entitled "HSE NI Roles and Responsibilities in Respect of Muckamore Abbey Hospital", and you provide us with some statistics. I want to read paragraph 7A, bearing in mind the correction you made at the outset. You say: 10:35

"In the period April 2006 to February 2022, HSE NI received some 306 RIDDOR reports. These included 234 categorised as assault, violence-physical assault or violence-result of a deliberate criminal act. All 234 related to injuries sustained by employees".

I just want to ask you some questions about that paragraph in particular, Mr. Burns. In terms of overall numbers, so 306 reports over a 16-year period roughly, how does that number compare to reports received from other work places that the Health and Safety Executive regulate? 10:36

A. Specifically in that category - and that's a defined category within RIDDOR, that assault, violence-physical assault or violence - that would certainly be on the high side. I mean, other sectors where you would see that would potentially be places like the police. You know, we would see quite high levels of reporting of assault and violence to police. But yes, that would certainly appear to be on the high side. 10:36 10:36

I mean, you wouldn't, for example -- you wouldn't see anything really reported, for example, in the manufacturing sector under the assault and violence. It's something very peculiar to that public interface, you know. So you've got health care situations - although that would be unusually high even within a health care situations - prisons, police. Those are 10:37

the environments where you would see that sort of category coming through.

39 Q. Just then comparing those numbers to other hospitals, you said there it would be, I think, unusually high compared to other health care areas. Are you saying that that number for Muckamore is higher than other hospitals in Northern Ireland? 10:37

A. I can't say definitively but it would certainly appear so, yeah.

40 Q. You refer to that categorisation, assault and violence, result of a deliberate criminal act. That is a particular category under RIDDOR, you said? 10:37

A. Yes.

41 Q. Can you explain a little bit more how RIDDOR categorises notifiable incidents? 10:38

A. So, if an employer goes on to our system, our online system, to report an accident, they have to tick a particular box. That would be one of the boxes. Now, whether it fits exactly the circumstances, you know, they will make an approximation. Yes, the most likely or the one that most fits this incident would be that. But that can cover a wide range of things. It's really to help us with statistics and things like that. You know, if you go on there, there would be other boxes that they could tick, for example falls from height, fall over two metres, fall over six metres, that sort of thing. That would be the one they would pick for these types of situations. 10:38 10:38

42 Q. In respect of those particular reports from Muckamore

Abbey Hospital, it's the employer, so the Belfast Trust, who identify that categorisation. Is that right?

A. Yes.

43 Q. You say that all 234 incidents which were in that category were related to injuries sustained by employees. Are you able to say were those injuries sustained by employees as a result of an interaction with patients? 10:39

A. Yes, that's correct. 10:39

44 Q. All of those?

A. Yes.

45 Q. If that is the case, that reference to result of a deliberate criminal act seems to the lay person perhaps a little unusual in a hospital patient perspective. 10:39 Does the Health and Safety Executive give any guidance to employers as to selecting the appropriate category whenever notifying the Health and Safety Executive of incidents?

A. Not as such. As I say, that wording, "the result of a deliberate criminal act", that's specified in the regulations. So no. 10:40

46 Q. But there are other options that could be selected; isn't that right?

A. There are other options, yes. You know, if it's -- well, I don't know. No, there wouldn't be another option in this situation. If a member of staff was physically attacked, that's the box they would tick. Now, I can't say or I won't say that it was a 10:40

deliberate criminal act because there are situations where it could be a deliberate criminal act. For example, if you can imagine a cash in transit delivery person. They take the cash box out of the back of the vehicle and they walk across the pavement and somebody physically assaults them. You know the situation I am talking about. That is a deliberate criminal act, so that would be categorised. If that employer was reporting that accident or that injury to the cash in transit person, they would tick the same box as, for example, the Muckamore situation that you're talking about. It's just a generic category, if you know what I mean. 10:40 10:41

DR. MAXWELL: Are you saying that by ticking that box, you are not necessarily saying you believe it was a deliberate criminal act, you are saying it was assault or violence against the employee? 10:41

A. Absolutely, yes.

DR. MAXWELL: But it doesn't necessarily mean you think it's a criminal act? 10:41

A. That's correct, yes.

47 Q. MS. KILEY: Returning then to thinking about the overall numbers between that period April 2006 to February 2022, does the Health and Safety Executive conduct any analysis of trends in reporting? Does it go back and identify whether there were particular years, for example, where there was an escalation in reporting? 10:42

A. Yes, the principal inspector would. All the

notifications that come in, the principal inspector, or, if the volume was significant, the inspectors would do it. So, all the cases that come in would be considered by the group. They would keep an eye on trends. Yes, they would, yeah. 10:42

48 Q. What would happen if a trend upwards, for example, was identified, if it seemed that there was a high level of reporting?

A. Yes. If there was like a major upturn in the number, then the group probably would take some sort of action 10:42 at least to make some inquiries as to what was going on; were the systems in place doing as best they could. This is not a perfect science, you know. We certainly don't have all the answers specifically in relation to this category of accident. It's not a church of 10:43 perfection. If you guard a machine and you keep the guard on and you maintain a guard, that is a church of perfection, nobody is going to be able to get into that machine. This is not a church of perfection. You cannot totally prevent these situations from happening. 10:43 So, if there was, as your describe, a major upturn in the statistics around this category in a health care scenario, we may well get in touch with the organisation, check that they had the systems to achieve the best outcome, they have them in place. 10:43 Which generally the Trusts do have for this sort of thing.

49 Q. Are you aware of whether there was any periods where there were upturns in reporting during the period that

you've referred, so 2006 to 2022?

A. Not any particular spikes as such, no.

50 Q. The Inquiry has received some evidence from the Belfast Trust that shows that there was a significant increase in their internal reporting of violence and assault of staff by patients. That was for the period from 2013 to 2018. Are you able to say whether the Health and Safety Executive encountered a similar or corresponding increase in reporting? 10:44

A. No, I am not able to say that. No. 10:44

51 Q. Okay. You then explain that at paragraph B that there were other categories of injuries including handling, slips trips and falls et cetera. But at paragraph 7C you say this:

10:44

"Out of the 306 accidents reported, 302 related to injuries sustained by employees. Of the four which resulted to injuries to non-employees (patients), the breakdown was falls two, slip, trip one, and injury to a finger following a de-escalation event". 10:45

Thinking particularly about those four that you have referred to for non-patients, are you able to explain any more detail about those to the Panel, the nature of them and the approximate time that they were reported? 10:45

A. No. I don't have that detail with me, no.

52 Q. But the Health and Safety Executive would hold that information, would they?

A. That should be retrievable, yes.

53 Q. What sort of information does the Health and Safety Executive get about an incident whenever it is reported?

A. Okay. From memory, the form would be there's details about the person making the report, the employer. Then there would be details of the injured party in terms of their gender, age, their personal details. There would be location, so where it happened. There would be the type of injury. There would be the type of outcomes. So if a person had a very minor injury and was off work for more than three days, not counting the day of the accident, that sort of information was there. If it was a major injury, so, for example, if there was a broken arm or something like that, that sort of information is there. So, the actual type of injury. Then there is a free text box where they can put in some more information if they want to about the accident. 10:45 10:46 10:46

54 Q. Okay. Continuing to think about numbers then, there were four reports in respect of injuries to non-employees, patients in this circumstance, over that nearly 16-year period in respect of Muckamore. Earlier on you refer to some instances where the Executive would consider that there is underreporting. Would those four incidents over a 16-year period in respect of injuries to patients suggest an underreporting to the Health and Safety Executive? 10:46 10:47

A. I couldn't answer that. I don't know. It would really be a question for the Trust. I couldn't say whether

that would point to underreporting or not. I don't know.

55 Q. Okay. You do say at paragraph 7D that the Health and Safety Executive didn't carry out investigations into any of the above reports. So, that's in respect of the entire 306 reports; is that right? 10:47

A. That's correct, yes.

56 Q. Why did the Health and Safety Executive take the decision not to investigate any of those?

A. To put in context, we would receive approximate numbers. So the lowest category, the over three days, we would receive approximately 1,700 of those per annum. 10:47

57 Q. That's across all industries?

A. Across all industries. The next level up, you would have the majors. I think we would receive between 200 and 300 major injury accidents per year. Then the next category up above that, the fatalities. There is diseases as well. But if we go up to the fatalities, we would receive anywhere between maybe five and 25 per year. That gives you an idea of the numbers that we're dealing with. You know, you have to go back we have 40 professional technical members of staff. So, we do examine all the accidents but, you know, we just simply don't have the resources to go and look at everything. That would explain one part of maybe why these weren't looked at, or they didn't result in an inspection or somebody going and actually looking at them. 10:48 10:48 10:49

The other part of this is that the Trusts and many of these sectors in the health care sector, they actually have very good, well-resourced health and safety management units. It is not that they are given a complete by-ball, so to speak, but they do have good systems in place. They have professionals employed within their organisation to manage health and safety. So, it's that risk profile that we would look at. Yes, I accept that the numbers here appear high but it's over a 16-year period. So, it's the risk profile of the organisation; they have well-established health and safety management systems, and overlaying that is we have our own resource issues. 10:49 10:49

CHAIRPERSON: Just pause for a second, sorry.

58 Q. MS. KILEY: Just thinking about that element you've referred to as well-established health and safety overview mechanisms, how can the Health and Safety Executive assure itself that they are working properly if it doesn't actually go out and inspect in respect of Muckamore? 10:50 10:50

A. So, we would have quite a lot of interactions with the health and safety people in the Trusts around all sorts of things. For example, control of legionella and that sort of thing. There would be -- you would have that interaction and you get a feel for, you know, the organisation takes health and safety seriously. 10:50

59 Q. But you have referred, for example, at paragraph 7E as to Health and Safety Executive knowing that institutions such as Muckamore utilise a number of

strategies to mitigate the risks of physical assault on staff. These include risk assessment, instruction, staff training such as the management of actual or potential aggression, staff numbers, de-escalation techniques, care plans and building layout.

I am just wondering how does the Health and Safety Executive, if it is taking those factors into account when assessing the risk of health and safety instances at Muckamore, how does the Health and Safety Executive assure itself that those things are actually being put in place and are effective if it is not actually carrying out any inspection?

A. Well yeah, the duty is on the employer to make sure those things are there. You're right in the respect that we don't potentially always have an assurance that every organisation is doing the right thing, but it is our estimation, if you like, because we are not physically there. But given our other interactions with the Trusts around those more traditional areas, such as the control of legionella where we would be -- that's where we would normally operate machinery guarding, legionella control, those sorts of things. If we see, like, a Trust is performing well on those, it does give us an assurance that generally they are managing health and safety well.

Now, there are many dark corners which maybe the light isn't shone into, I would accept that, yes. But it's

not physically possible for us to give ourselves an assurance of every single work place, you know. Not just in the health care sector. You know, there would be construction sites, there would be manufacturing sites, agriculture sites, that we don't get to. So, we don't have an assurance of absolutely every single site in Northern Ireland that health and safety is well-managed but we do promote good practice for health and safety. 10:52

Certainly if we see trends or that sort of thing, we would go and have a look and see what was going on. It is not possible in every situation to have an inspector on the ground, you know. I think there is about 80,000, potentially 80,000 Vat registered businesses. So, you are talking about 30 odd on the ground inspectors. We are not going to be everywhere to give ourselves that assurance, you know. 10:53

60 Q. You explained an earlier that therefore the Health and Safety Executive takes a risk-based approach and concentrates its efforts on high risk industries? 10:53

A. Yes.

61 Q. In looking at the figures of reporting in Muckamore, you had indicated that the 306 reports did seem high. Does that not indicate that Muckamore might be a high risk area and therefore justify the injection of resources from the Health and Safety Executive? 10:53

A. Well, it's back to this as to what can be achieved. I know that we would have been in touch to make sure that

those training things were in, the de-escalation techniques, the layout et cetera, et cetera.

This might not come across well but even if we are out there, we may not be able to prevent these situations occurring. I have looked at some of these accidents and some of these instances occurred in very innocuous situation. For example, you have a member of staff who was walking with a patient, if that's the right term, and it appeared everything was going all right and then all of a sudden there was an out-of-the-blue attack. Now, I'm not saying everybody who works in these situations will be subject to that, I am not saying that at all, but there is only so much you can do. Our legislation is underscored by 'reasonably practicable'. So, in my view and I know, talking to a colleague here, what the Trusts were doing in terms of the training, the physical layout, the training of staff, the de-escalation techniques, that appeared to be reasonably practicable. But this is not a church of perfection; you can have the best systems in the world, you will not prevent these situations from happening.

10:54 10:54 10:55 10:55 10:55

As I say, a situation where a member of staff is walking along, talking to a patient, and then just bang, out of the blue this happens, the best systems in the world won't prevent that from happening. I am not saying that's any reason for us to sit back and ignore all of this, but we have to be realistic about what our

intervention could achieve.

DR. MAXWELL: Could I just ask. You talk very much about the risk mitigations around an individual instance, making sure there is a guard on a machine or somebody physically looking at it. 10:56

A. Yes.

DR. MAXWELL: Do you ever look at structural elements such as staffing and supervision of staff?

A. Yes, we do. I mean, an example I would give is I used to be an inspector in Discipline Services, so you would 10:56 have had prisons within that sector. In my time there, there definitely was a system for what was called diminishing task line. So, if you had a full staff compliment on the wing, you would have visits, you would have exercise, you would gym visits, you would 10:56 have classes et cetera. This is going back like 15/20 years when I was doing this. There was a regime, so if X number of staff were not available, certain things went down to a diminishing task line so eventually visits went down. If you ended up with basically very 10:57 few members of staff on the wing, then you would get towards lockdown.

I can't say in the health care setting whether I have ever seen that. I haven't really been an inspector in 10:57 the health care situation. In theory you possibly could have that diminish task line approach, if possible, but it's not going to mitigate against this sort of unforeseen instance occurring.

CHAIRPERSON: But that is just one example?
DR. MAXWELL: Exactly. That's not the only reason potentially for these situations arising.
A. But we wouldn't -- we wouldn't generally look at staffing numbers. That's a matter for an employer, you know. We wouldn't have the expertise to -- 10:57
DR. MAXWELL: Even if you think that might have contributed to the incident, or even if somebody might reasonably assume that contributed to the incident?
A. I can't speak about specifics because, as you know, we didn't look at these. But yes, if we did, you know if you asked us to go and look at something, we probably would look was there sufficient number of staff, were the staff trained. Yes, those are the sorts of things we would look at. 10:58
DR. MAXWELL: And supervised presumably?
A. Supervision would be. Yes, there is a specific duty in our legislation around supervision of employees.
CHAIRPERSON: Just looking at the Prison Service, which you do know about, if you found an incident had been created because there was a lack of staff, there had been a long lockdown, there was a riot, whatever it is, would you then make recommendations or serve an improvement notice in relation to staffing? 10:58
A. We could do, yes. We have never done that, you know. We have had discussions with the Prison Service in the past, but we generally took the view that that diminishing task line was a reasonable approach where they found themselves without sufficient staff to run 10:59

their regime.

CHAIRPERSON: So, that leads to your conclusion that it is not therefore worth issuing an improvement notice?

A. No. To issue an improvement notice, you have to find a breach of -- there has to be a breach of the legislation. 10:59

CHAIRPERSON: Right.

A. So there is nothing in legislation that specifies a staffing regime.

CHAIRPERSON: I see. 10:59

A. You know, to run a wing of a prison, there is nothing in our legislation would say you need 15 warders or that sort of thing. It's risk assessment.

DR. MAXWELL: But as I understand it, your legislation is about risk mitigation. So it's getting risk as low 11:00 as reasonably possible, which is not removing all risk, I understand that. I suppose the question is how far away from the actual incident you go. I've never worked in a prison but I can imagine if you reduce prisoner activities, that will raise their frustration 11:00 and therefore make assault on a prison officer more likely because of their frustration. So, could you not say that that isn't an appropriate mitigation in the longer term?

A. Oh, in the longer term, yes, yes, but those situations 11:00 in the prisons would have been short-term. You know, for example, if you had a number of officers didn't turn in that day through illness. Absolutely, if it went on for sometime, we would definitely ask them do

something about it.

DR. MAXWELL: Potentially if there were insufficient staff or insufficiently supervised staff in the longer term, that could potentially lead to an improvement notice? 11:01

A. It could do, yes, yep. If that was giving rise to these type of incidents, yes, yep. In this situation, if you had reduced the regime for the patients and that caused like a serious upturn in the number of these, yes, we could potentially. 11:01

Now, I think we would have discussions with the Trust as to try and mitigate this, you know. Generally, I think my understanding is where we have had discussions with the Trust about any sort of thing, they are very 11:01 receptive, you know, they are very aware of the problem and they tend to try and fix it. To go straight to an improvement notice may not always be necessary.

DR. MAXWELL: No, I appreciate that, it would be the last report resort -- 11:02

A. It would, yes, once you get to that --

DR MAXWELL: -- but it is still possible.

A. It is still possible, yes, you could. If it was a persistent problem, you could do that.

62 Q. MS. KILEY: Just continuing that example. For example, 11:02 if the Health and Safety Executive became aware that there was an issue with staff numbers or supervision of staff at a hospital, might that trigger, for example, an inspection of the facility?

A. Oh, absolutely, yes. Yes, yep.

63 Q. So, that's the prior step to enforcement. Must there always be an inspection before enforcement action is taken?

A. Yes, because notices are served in the opinion of the inspector. The inspector would have to be there and gather some sort of information, you know, see what was happening, talk to the staff et cetera. But things like you're talking about there, about insufficient staff numbers, that's not reportable. You would have to get that information from somewhere else. Where that information would normally come from - and again I am thinking of the prisons again, sorry to keep going back to what I know - the Prison Officers Association, which is their union, they would alert us to this sort of thing. We would hear through -- trade unions would be the normal way of that. Or we have a complaints; people can make complaints to us. Sometimes we would hear from employees in organisations, like we don't have sufficient time to do this work, and we would get involved in those, you know.

DR. MAXWELL: If you had an RIDDOR report which was investigated, that might be another way of becoming aware of long-term staffing pressures?

A. Yes, yep. If we did look -- if we had have looked at all of these and staffing was an issue throughout these. But now to the best of my knowledge, when I looked - and I have done a scan of these - I'm not sure that staffing was coming up as being a factor, you

know, in the issue.

DR. MAXWELL: But they weren't investigated.

A. Well, I say they weren't investigated. There is a certain amount of information comes with them, it will describe the incident. 11:04

DR. MAXWELL: Okay.

A. In the free text box, they will say to us, and the one that I told you about was walking, the member of staff is going to open the door to let the patient come in after them and they got their hair pulled. You know, 11:04 they do provide a certain amount of free text information to describe what happened in the incident. So we do know, you know, it's not that we are totally blind to what happened in the incident. Those would all be read. 11:04

DR. MAXWELL: Okay. I don't know if I can ask this but you can stop me if I can't. Did any of the unions ever raise any concerns about the staffing in Muckamore?

A. Not that I am aware of, no.

64 Q. MS. KILEY: I asked you earlier to think about the 11:05 overall numbers. You had indicated that the numbers of reporting that you described, the 306 incidents, seemed high. Obviously that's looking back now at a particular period. They come into the Health and Safety Executive at a point in time as individual 11:05 reports.

Was there ever a point in time where the Health and Safety Executive stood back and thought that's a high

number of reports? If that was the case, was investigation considered at a wider level? So, not simply thinking about investigating individual reports but taking a step back and looking at the trend of reporting and thinking about using the power to investigate generally.

A. No, I am not aware of that happening.

65 Q. Is there generally a process for that sort of analysis, so analysing trends in reporting and notification and using that to feed into your risk assessment mechanism that you have described to identify what is a high risk industry? 11:06

A. Yes. There would be a process for that but it's competing resources. We have to -- we have a finite number of resources. You can see in our public sector it covers health care, education, councils, and the Crown. So it's a massive sector, you know, and there would be a lot of competing priorities there. 11:06

66 Q. So it didn't happen in the hospital sector?

A. Not that I am aware of, no. 11:06

67 Q. You mentioned not investigating. Even whenever the Health and Safety Executive does investigate an incident, does it do anything with the information? Is there an informal discussion with an employer, or is it really a paper-based type exercise? 11:07

A. No. There would be some -- so, if you think of those, you know, roughly 2000 RIDDORs that come into us every year, they would all be examined by the inspectorate at some level. Yes, they would select ones for

investigation. Now, maybe with hindsight some of these could have been selected. But I know -- I mean I used to work in this sector - health care wasn't in it when I worked in it - but at times in the past we've literally had two people working in this sector. 11:07

CHAIRPERSON: So when you say this sector, you mean the public sector?

A. The public sector, yes. It's being covered by two people. It is a resource issue. If we had the resources, we could certainly do more but we have 11:08 finite resources. I go back to the point that you're dealing with other parts of the state, the Trusts, et cetera, and they are well resourced and generally well-managed with professional health and safety people employed in them. So, that does move them, in our 11:08 opinion, into a better managed, lower risk profile.

68 Q. MS. KILEY: Okay. That is incident reporting. There is another element that you have referred to in your statement, and indeed you referred to it just briefly earlier, and that's complaints that the Health and 11:08 Safety Executive can receive.

You have identified complaints that the Executive received in respect of Muckamore at paragraph 7F. These are distinct from the process that we've just 11:08 been talking about, about notification under RIDDOR; isn't that right?

A. Yes.

69 Q. In what circumstances can Health and Safety Executive

receive a complaint in respect of a hospital? Thinking particularly about Muckamore, what sort of things can be complained about?

A. We can receive a complaint from anybody. It's open to anybody to make a complaint. So, they can e-mail us, they can telephone us or there is an online forum, so there is any way you could imagine. We get complaints from parents whose younger people are out at work and they don't feel they are being well-treated in the work place, so we would get those sort of complaints. Trade unions would make complaints to us. Employees themselves would make complaints to us. We get quite a few, for example, where you would get a construction job at the house next door, you know, and they say it's probably a little bit of they don't want them to be there so they see them without hard hats or something like that. All sorts of complaints. It's a fairly easy system to make complaints. When those complaints come in, they would be considered and then they would go to the groups for some sort of action. 11:09 11:09 11:09 11:10

70 Q. Thinking about the Muckamore context, though, how would people know that they could make a complaint to the Health and Safety Executive? If I am relative of a patient, how do I become aware that I can make a complaint to the Health and Safety Executive? 11:10

A. If you went on to our website, you would see it there. We are also a body under the public interest, the whistleblower's legislation. We are a nominated body that you can make a complaint to under that.

I don't know but whether, for example, the parent or the relative of a person in Muckamore would think of coming to us as the first port of call, being honest, I doubt they would. I think they would probably see other organisations such as the Public Services Ombudsman maybe, or the RQIA or somebody like that, as a more natural place to go to for what may be care issues.

71 Q. Yes. 11:11

A. I think the perception that they may have of us is that we are more dealing with industrial situations, which is true to some degree. We may not be their natural first port of call to come and make complaints to.

72 Q. Is it right then that in considering any complaint that it does receive, the Health and Safety Executive focus remains on health and safety of the work place in the way that you have described earlier? 11:11

A. I think that's a fair comment, yes. It would be, yep.

73 Q. You have given some examples. In the period April 2006 to February 2022, you say the Health and Safety Executive received two complaints. The first one was on the 10th January 2019, a member of the public made a complaint about the care of a relative at Cranfield 2 Ward, Muckamore Abbey Hospital. Specifically, he found his relative standing alone in the car park at the front of the building. The complaint was investigated and upheld. The Trust revised its risk assessment for managing patients leaving Cranfield 2; provided a copy 11:11 11:12

of the Trust Adult Mental Health and Learning Disability Absent Sent Without Leave procedure, and reviewed the Trust incident reporting system, Datix. So, that complaint was investigated, in comparison to the earlier RIDDOR reports. What caused the Health and Safety Executive to consider that complaint ought to be investigated? 11:12

A. Complaints are more likely to be investigated. Because they are made -- because of the way they come in, you know, they come in from a person will ring in et cetera. It's hard to explain but, you know, probably because we don't get that many complaints about this type of institution, we would select it for investigation. But we consider all complaints. I suspect what came into consideration there is you had a patient in care who was potentially outside of the care in a vulnerable situation. So we deemed that, that something had to be done about it. So we made -- I think from memory, inquiries were made and there was some sort of discussion as to how this had happened and then how it would be prevented from happening. 11:13 11:13

74 Q. That's what I wanted to ask you. What sort of investigation takes place? Who does the Health and Safety Executive meet with; what procedures are followed? 11:13

A. I don't know specifically about what happened here but it could be -- it could range from -- so, the Trusts, because their focal point would be their health and safety management people, so initial contact with

always be made with them. It depends. They could investigate; they could share their findings with us. It could be sorted out relatively quickly. They give us the paper work, they explain how it is going to be prevented, tell us what happened, if that's enough to deal with it. Above that then, you could have a site inspection.

75 Q. Do you know if a site inspection took place in respect of this incident?

A. I don't, no. 11:14

76 Q. Okay. One of the things that you say happened as a result was that the Trust reviewed the Trust incident reporting system, Datix. In hearing other evidence, the Inquiry has heard a lot about Datix. Are you able to explain any more about what the issue with incidence reporting was in respect of this complaint? 11:14

A. No, I'm not. Sorry.

77 Q. Does the Health and Safety Executive retain records in respect of that complaint?

A. Let me see. Yes, we would have, yeah. 11:15

78 Q. Are they held electronically then on the case management system you referred to earlier?

A. Yes. Mhm-mhm.

79 Q. The second complaint then that you refer to was described at paragraph F2. You say on 9th December 2020, a complaint was received in relation to a building layout issue and how it inconvenienced staff who needed to exit a care situation quickly. The complaint was partially upheld and was resolved by the 11:15

Trust.

So again, that was an incident then that was investigated; is that right?

A. Yes. 11:15

80 Q. Are you able to tell the Panel any more about the circumstances of that incident? I don't want you to give us any names but are you able to tell the Panel any more about the nature of the issues that arose?

A. I don't have the detail but I can certainly get it for the Panel. I can get those. 11:16

81 Q. It's on the system.

A. Yeah.

82 Q. Finally then, I wanted to just ask you a question generally about the Health and Safety Executive. We have looked there at very specific incidents and the Health and Safety Executive's response to incidents that were reported to RIDDOR and to complaints that were reported to it. But as you know, the Inquiry is investigating the Muckamore Abbey Hospital and incidents there from 1999 to 2021. As you are also aware, in 2017 there were made public allegations of a series of incidents of abuse in Muckamore. Are you aware of those? 11:16 11:16

A. Yes, yes. 11:16

83 Q. I wondered, having -- that attracted media attention and was in the public at that time. I wondered then at that time if the Health and Safety Executive had knowledge about that? Did it consider doing anything

about that and exercising any of its powers in respect of Muckamore?

A. So, we didn't have knowledge of abuse. No, we didn't have knowledge of that, no.

84 Q. In 2017, whenever a series of incidents emerged and were in the media, did anybody report anything to the Health and Safety Executive? Did anybody come along and say these issues have arisen, you might have an interest here? 11:17

A. Not that I am aware of, no. Abuse isn't a category within RIDDOR, so it wouldn't naturally be reported to us, if that makes sense. But no, we didn't. Nobody, as far as I am aware, came along in around that '17 onwards to say this is something that you should have a look at. 11:17 11:18

85 Q. So, you say abuse isn't a category within RIDDOR, but we have already explored the type of issues that may be reportable under RIDDOR. If the Health and Safety Executive don't have knowledge of those incidents, how can you be sure that they are incidents that weren't required to be reported to you? 11:18

A. Sorry, I'm not...

86 Q. You say abuse isn't a reportable incident, but there are a number of incidents or a number of categories that are reportable. What I am saying is if the Health and Safety Executive haven't looked into those incidents, how do you know, how can you be satisfied, that they don't fall into those categories that are notifiable and reportable to you? 11:18

A. Well, we don't know. If we don't have the information, we don't know. There would have to be an injury involved in it or there would have to be an accident, and those are defined terms. But if we haven't been supplied with the information under RIDDOR, which, as we have been through, most likely they wouldn't be RIDDOR-reportable, we wouldn't know. 11:19

DR. MAXWELL: You talked about having intelligence and having confidence in the health and safety function within hospitals or health care Trusts, and you have accepted that abuse may result in injuries which would make it fall within your area. If there was an injury that resulted from abuse in a work place, that would fall under RIDDOR and therefore under the remit of the Health and Safety Executive? 11:19

A. Yes, that's right.

DR. MAXWELL: At one point you talked about having to do this assessment of where you put your resources because you can't inspect everything. I suppose I am wondering whether there was any discussion when it became in the public domain that there was abuse and possibly injuries, whether there was any discussion about increasing the level of concern about health and safety management within the Trust? 11:20

A. No, there wasn't. No, there wasn't. That term "abuse", I'm not an expert in this at all but I am slightly concerned. Although that category does talk about deliberate criminal act, that was written more for employees being attacked. Do you remember the 11:20

example I gave you about the cash in transit delivery person? You know, in that situation, we wouldn't -- the person who was the robber in that situation, we would take nothing do with them because that is not a matter for us, that's a criminal act, that's a matter for the police. Now, I don't know in this situation that you're talking about where the dividing line falls here, you know.

DR. MAXWELL: No, and I understand that.

A. I don't want to be prejudging anything but if a member of staff deliberately did something that's beyond us, we would not take anything to do with that. 11:21

DR. MAXWELL: I don't think it's been established whether it was a deliberate criminal act. I was just wondering whether there had been any discussion about changing the risk categorisation of the Trust when that came out? 11:21

A. No. I mean, I accept that hasn't been established and I am not trying to say that that was the case, but the reporting that came out in 2017 may have led to that viewpoint. But we didn't carry out any reassessment of the situation. I think it's worth making clear that where you have that deliberate act by anybody, whether they are at work or not at work, that deliberate act would not be within our remit. We would not investigate that. 11:21 11:22

CHAIRPERSON: Is the reality that once the PSNI get involved, you wouldn't look into it?

A. That's correct. In these situations if it was a

deliberate act of violence, we would not look at the person carrying out that. Now we do work with the PSNI in terms of corporate manslaughter and those sort of investigations but they have primacy. But where there is a deliberate criminal act, we would not look at the perpetrator. But I caveat that, that's not what I am saying happened here but in terms of any assessment carried out post 2017, that may have been a factor. 11:22

87 Q. MS. KILEY: Okay. I have no other questions, Mr Burns? 11:23

THE WITNESS WAS QUESTIONED BY THE INQUIRY PANEL AS FOLLOWS:

CHAIRPERSON: Could I just ask this: Do you publish your role in hospitals? In other words, do you make sure that there is a notice on the notice board in public to say you can contact the HSE? 11:23

A. Yes. It's called the health and safety at work poster, it is a statutory thing that must be in a work place. You won't see it on every ward, you will maybe see it in certain areas of hospitals but whether -- you know, I have never really seen it in public areas, it is more for employees, to know where to contact us if they want to tell us that something is not right. But there is a statutory poster that must be displayed. 11:23

PROFESSOR MURPHY: Do you do any public engagement exercises to raise awareness?

A. We do have campaigns. Yes, we do have campaigns. I can't think of any specifically in recent years in

hospitals. Sorry, that's not right. We have run, for example, patient handling campaigns and things like that, because we would be aware of injuries where members of staff have been injured with lifting and handling patients. So, we have run back campaigns and things like that with the staff, and the unions would work with us on that as well. 11:24

CHAIRPERSON: Thank you. Is there anything else?

MS. KILEY: Nothing from me, Chair.

CHAIRPERSON: Mr Burns, can I thank you very much indeed for your assistance to the Inquiry. I have a few words to say those present but they don't involve you. So, can I ask you to go with the secretary to the Inquiry, and thank you very much for your attendance. 11:24

THE WITNESS: Thank you. 11:25

CHAIRPERSON: Thank you, Ms. Kiley. Just to say this. As you all know, the Inquiry is not sitting next week, that's the week commencing 8th May. Module 6 is scheduled to start the following week, the week commencing 15th May. I just want to mention that it may be necessary for the Inquiry to alter the schedule in relation to some of the evidence relating to Module 6. We will be sitting in the week of the 15th but we are going to provide an update tomorrow to all core participants, and it will also go on the website, about any alteration to the schedule of witnesses. So, you can watch out for that, as it were, if you are interested. 11:25

In the meantime, can I thank everybody for their attendance and we will next meet on 15th May at 10:00 a.m. Thank you.

11:25

THE INQUIRY ADJOURNED TO 10:00 A.M. ON MONDAY, 15TH MAY 2023