MUCKAMORE ABBEY HOSPITAL INQUIRY

SITTING AT CORN EXCHANGE, CATHEDRAL QUARTER, BELFAST

HEARD BEFORE THE INQUIRY PANEL

ON TUESDAY, 18TH APRIL 2023 - DAY 34

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 ON TUESDAY, 18TH DAY OF APRIL, 2023 AS FOLLOWS:

CHAIRPERSON: Good afternoon. Thank you. So we've got two witnesses, I think, this afternoon, Ms. Preece and Dr. Brady. 13:58

MS. TANG: Yes, that's correct.

CHAIRPERSON: It may mean, I think, that we'll have a slightly longer afternoon than we normally do, because we'll need to take a short break between the witnesses. But we will see how we get on. 13:58

MS. TANG: Yes. Thank you, Chair. Good afternoon, Chair, Members of the Panel. Can you hear me okay? Thank you. As you've said, this afternoon we will be hearing evidence from Ms. Lyn Preece, who is appearing on behalf of the South Eastern Health and Social Care Trust, then followed by Dr. Brady, who is appearing on behalf of the Western Health and Social Care Trust, and my colleague Ms. Briggs will be taking her through her evidence. 13:58 13:59

Ms. Preece's statement is in relation to Module 2 and it's covering two discrete topics in that module. The reference for the statement is STM0841. There are no exhibits to that statement, Chair, and unless there's anything further at this stage, we can call the witness, Ms. Preece. 13:59

CHAIRPERSON: Yes, that's fine, thank you.

MS. LYN PREECE, HAVING BEEN SWORN, WAS EXAMINED BY MS. TANG AS FOLLOWS:

MS. TANG: Good afternoon, Ms. Preece. We met briefly earlier. My name is Shirley Tang and I'm one of the counsel team on the Inquiry. You've provided a statement to the Inquiry on behalf of South Eastern Trust, and that was dated 24th January 2023, is that correct? 14:00

A. Yes, that's correct. 14:00

1 Q. And you have a statement in front of you?

A. I do, yes.

2 Q. Now, the statement in front of you is 15 pages long. It has no exhibits, isn't that correct?

A. That's correct. 14:00

3 Q. Are you content to adopt the contents of that statement as the basis of your evidence to the Inquiry?

A. Yes, I am.

4 Q. I'm not going to read through the statement, but I will take you to certain places within it in the course of dealing with the questions. But I'm going to remind you initially of the topics that you were asked to look at in your statement, the first of which was the -- they were in relation to Module 2, healthcare structures and governance. And the first aspect of that was the interrelationship between the Trusts regarding patients admitted to Muckamore Abbey and then also to outline the provision for community-based services. 14:00 14:00

So, moving to your statement, beginning at page 0841 and looking at paragraph 1.2, you've mentioned there that, prior to taking up your current post, you were in the position of Assist Director for Adult Disability Services. Can you tell me how long you did that role for?

A. I was in that role from May 2020 until August 2022.

5 Q. And have you always worked in South Eastern Trust?

A. I've worked in South Eastern Trust since 2004.

6 Q. And what did you do before that? 14:01

A. Prior to that, I had a series of management roles in England. Sorry, I lived there for a period of time.

7 Q. Yes. Have you ever worked at Muckamore?

A. No.

8 Q. No. So, thinking about South Eastern Trust 14:01 particularly and looking at page 0842, paragraph 3.2, I want to focus in on South Eastern Trust and just the positioning of it. Roughly, what size of population would you estimate South Eastern Trust would cover?

A. South Eastern Trust has a population of approximately 14:02 345,000.

9 Q. Yes. And you mentioned at some point later in your statement that at any given time, around about 1,500 patients are thought to have learning disability?

A. Correct. 14:02

10 Q. So, when it comes to patients who are admitted to Muckamore from South Eastern Health and Social Care Trust, who actually funds that care, if they go to Muckamore?

A. That's centrally funded. Muckamore is commissioned to provide hospital care and treatment to patients from the South Eastern Trust, from the Belfast Trust and th Northern Trust. So, historically that has been commissioned to the Belfast Trust to provide those services.

11 Q. And roughly how many people from South Eastern would have been admitted to Muckamore over the period of time that the Inquiry is interested in?

A. I'm not sure of that number, but I can certainly have a look. I know that the Belfast Trust kept records of patients that were admitted over the timeframe of the Inquiry. So I couldn't provide that to the Inquiry specifically for the South Eastern Trust. 14:03

12 Q. Would you be able to say how many South Eastern Health and Social Care Trust residents are in Muckamore at the moment? 14:03

A. There are six.

13 Q. Six, thank you. So if someone is admitted as an inpatient to Muckamore from South Eastern, is there a handover responsibility to the Hospital social worker or how does the ongoing responsibility work? 14:03

A. Well, when a patient is admitted to Muckamore, there's a responsibility for that patient, for their care and treatment, lies with the Belfast Trust. The key worker or the social worker from the South Eastern Trust would maintain involvement for the duration of the patient's stay and liaise very closely with the multidisciplinary team in Muckamore Abbey, and that would include social 14:02 14:03 14:03

work services within the hospital.

14 Q. So, can I just clarify that; whenever you mention the key worker liaising, would they be -- would they hold any responsibility for that patient while they were in Muckamore or is the responsibility for the patient solely in the hands of Muckamore staff by that point? 14:04

A. My understanding is that the patient is the sole responsibility for the Belfast Trust, but the South Eastern Trust would have a key role in the management of that patient through discussions and multidisciplinary team meetings, for example. 14:04

15 Q. I'm looking at the last section of paragraph 3.2.

A. Mm-hmm.

16 Q. If I could take you to the sentence, maybe it's up on the screen, the very last one, it begins "Throughout the period of admission": 14:05

"Throughout the period of admission, the South Eastern Health and Social Care Trust key worker continued to have contact with the individual and liaised directly with ward staff to monitor progress outside of the formal meetings." 14:05

Can you tell me what kind of progress was the key worker monitoring? 14:05

A. It would be the care and treatment progress of the individual and whether or not the individual would be ready for discharge. And the other liaison role that person would have would be into the community in terms

of the appropriate provision of a community service, whether that be to home placement or whether that would be to a more specialised community provision.

17 Q. Would it typically be the case that the key worker who was assigned to a patient from South Eastern Trust who was admitted to Muckamore, would that key worker typically have known that patient quite well, or might it be with a patient they hadn't worked with before? 14:06

A. They are more likely to have known that patient quite well prior to their admission and will have had a role in working with the patient, the service user, and their family prior to admission. 14:06

18 Q. And would they have been -- you made some reference I think at some point we're going to come on to about formal meetings. 14:06

A. Mm-hmm.

19 Q. Formal meetings and direct liaison with ward staff. Would the key worker have been part of planning the treatment that was given in Muckamore or did they have a different role? 14:06

A. They wouldn't have had a role in planning the treatment for the individual, that would have been the responsibility of the medical staff. They would have an input to perhaps the information about the patient prior to their admission to the Hospital, so they would've contributed to information about how that patient functions in the community. 14:07

20 Q. You've made reference in paragraph 3.2 to a post-admission meeting. I just wanted to check with

you, if for any reason the person's key worker isn't able to attend that post-admission meeting, would it still go ahead?

A. Yes. There wouldn't -- there would be a need for perhaps the team leader or a more senior person or another member of community staff to be involved in that meeting. So, yes, it would have gone ahead.

21 Q. So if a person who knew the patient well from their community life wasn't available to input to that meeting, how would the background information about that patient have been secured, what would've happened? 14:07

A. Well, it would be custom and practice and certainly in our policies and procedures that a key worker or a social worker is supervised very closely by a team leader. And they would have the knowledge through those supervision sessions of a patient or service user, so they would have that background information. 14:07 14:08

22 Q. And in terms of that person with the background information making sure that the Muckamore staff looking after the patient had all of that, was there any kind of policy or protocol that, within a certain amount of time that the admission happened, that that background information had to be furnished to the Muckamore staff? 14:08

A. I'm not sure if there was a specific period of time. I know that Muckamore were very keen to have the post-admission meeting immediately after admission, so it could be within a week or two weeks of that admission being made that people would come together 14:08

and have those discussions.

23 Q. It might sound a bit of an obvious question, but the post-admission meeting, was that about treatment planning or might it have been about discharge planning, or what kind of things would you expect to have been covered in that? 14:09

A. All of those things. It could be about the care and treatment that the individual required during the admission period; very quickly there could've been discussions about discharge planning and what might this individual need following care and treatment in terms of managing whatever placement they might need in the community, the bespoke arrangements, for example. All of those things would have been part of that discussion at the post-admission meeting. 14:09

DR. MAXWELL: Can I just interject? Would that include setting discharge criteria? So, in some services, on admission you're clear what needs to be achieved for the patient to be discharged.

A. It might not have been called a discharge criteria, but I would imagine, yes, that there would be certain elements discussed at that meeting that would involve the discharge, what this patient needs prior to the discharge. So, yes. And that would be very individualised to each patient. 14:09 14:10

24 Q. MS. TANG: So, the key worker, as a South Eastern Health and Social Care Trust employee, I take it, would they have had regular direct contact with the patient whilst they were in Muckamore?

A. Yes. And I'm just referring to paragraph 3.3, when, in 2011, we appointed a dedicated liaison officer for that role, and that person would've had specific responsibility to attend ward rounds, talk to the patient and also talk to medical staff and the multidisciplinary team. During that time, we also had advocacy services for patients, so they would've had direct contact with the patient's advocate as well.

25 Q. So this is a period of time from 2011 onwards that this new model, that's the liaison model, came in? 14:10 14:11

A. Yes.

26 Q. Before that, if I'm understanding you correctly, it was a key worker. And might they not have been part of the ward rounds or the ongoing decision-making then?

A. Yes, they would've been part of the ward rounds and they would have had had individual contact with the patient and with the staff on the ward. So the model that was put in place, the new model from 2011, replicated the practice before that, but this was a dedicated role from 2011. 14:11 14:11

CHAIRPERSON: And can I just ask, whether it's the key worker pre-2011 or a liaison officer post-2011, would they have retained notes in relation to the treatment of the patient or, if specific issues arose, would they be coming back to your Trust? 14:11

A. Yes, they would. And they would be held and contained within the service user's personal file.

CHAIRPERSON: Thank you.

27 Q. MS. TANG: Thinking about the move to the liaison

officer model, was there a particular focus that that post was designed to bring that wasn't there before.

A. It was designed to bring more of a focus on the resettlement agenda, and that was to ensure that those patients who had been there for a specific period of time, or for a longer period of time, that there was an identified focus on those patients to ensure resettlement happened within timely manner.

28 Q. Is it the case that there was a degree of frustration that resettlement needed to happen a bit faster or... 14:12

A. Well, in the South Eastern Trust, there was a consistent flow of patients discharged; in that period of time there was 67 patients from the South Eastern Trust that were discharged. The six remaining patients, three of those patients are delayed discharge and the other three are within that early cohort of resettlement. So, there was a degree of success in the resettlement population over that period of time.

29 Q. You've used a phrase "delayed discharge", and that was mentioned in paragraph 3.3. Can you clarify what made a patient classified as having a delayed discharge?

A. It's a person who was admitted to hospital after 1st April 2007. The resettlement population are those cohort of patients who were in hospital prior to that date and needed a particular focus on resettlement. Anyone who was admitted after that timeframe and couldn't be discharged in a timely way became known as delayed discharge patients.

30 Q. So, just making sure I'm clear on that. So a person

could be a delayed discharge not necessarily because the package of care was or wasn't available, it's more that there was a perception that they should be fit for discharge?

A. That's correct. 14:14

31 Q. Thinking about contact that the liaison officer might've had with the patient or the patient's family, would there have been a link between the family and the patient to any extent, or what was their...

A. Well, yes, they would've acted in the same way as the key worker would've done and had a very clear and distinct role with that liaison between the family and the patient and the Hospital. So, yes, they would've had those links with the family members. 14:14

32 Q. Did they have a safeguarding remit for the patient? 14:15

A. That wasn't their primary function. Their primary function was the liaison role in terms of the resettlement. So they wouldn't have had a safeguarding specific role and function.

33 Q. Would you say, though, that there would be an expectation that they would be mindful of safeguarding considerations, or what way did that -- 14:15

A. Yes, it would be an expectation that if there was issues brought to their attention during a ward round or a hospital visit, that they would have raised that as a safeguarding concern and issue. 14:15

CHAIRPERSON: And I'm sorry, Ms. Tang, you're probably just about to ask this, but how would that be escalated within your Trust?

A. That information would've been brought back to the team manager and that would've been escalated and raised either through the Adult Protection Team in the Belfast Trust as an issue for them to investigate, and that's how it would have been escalated, you know, if a particular incident was brought to the attention of the liaison officer or the team manager, then it would've been managed by the Belfast Trust at that time to investigate that.

CHAIRPERSON: Again, there'd be a record of that, presumably there'd be a record of that? 14:16

A. Yes.

CHAIRPERSON: Both the escalation and the correspondence with the Belfast Trust?

A. That would be the expectation. 14:16

CHAIRPERSON: Thank you.

34 Q. MS. TANG: We know that the evidence as heard, as being heard by the Inquiry refers to family members describing things like bruising on their loved ones, perhaps people who've lost teeth, people who've lost weight over the time in Muckamore. Do you recall any such concerns being raised by families or staff in contact with patients in Muckamore? 14:17

A. Not during my time in the role of adult disability, in adult disability services, no. 14:17

35 Q. And if, for instance, such concerns had been raised, was there a policy or a procedure in place for dealing with issues and complaints of that nature?

A. Yes, there's the adult safeguarding procedures that is

in place regionally that all the Trusts work to. So it would be the expectation that any incidents of that nature or any episodes of that nature would be dealt with through those policies and procedures.

36 Q. In your experience, how common would it have been for people with learning disabilities in receipt of care to, for instance, lose teeth; is that something that happens? 14:17

A. I would imagine that would be unusual.

37 Q. Unusual. Weight loss, is that something commonly observed? 14:18

A. That, again, would be, in my experience, unusual.

38 Q. I also mentioned bruising or other injuries?

A. Well, as part of a patient's care and treatment plan, there could be elements of - I'm trying to think of the word - restraint, that is part of a treatment plan. But that restraint is very carefully managed and monitored and should not cause injuries to a patient. If that has occurred as part of the restraint, that should be very well documented and recorded. 14:18

39 Q. And looking back, would you say that, prior to the allegations of abuse that did come out about Muckamore, was it viewed as a safe place for patients to go?

A. Yes.

40 Q. The allegations of abuse came to light; did South Eastern make any changes to how they interacted with Muckamore after that time? 14:19

A. Well, I suppose because there was a focus and a level of scrutiny around what had potentially occurred at

Muckamore, I think that caused key workers, managers and staff to be vigilant, a bit more vigilant, about care and treatment. As far as I understand, there wasn't any written documentation that asked us to do anything differently, or we didn't create anything that asked us to do anything differently. But I do know that there was a sense of increased vigilance around patients.

41 Q. I want to move to paragraph 3.5, which is on page 0844, and just to focus in a bit on resettlement and the work that was being done there. There's reference to the Senior Management Team in South Eastern Trust attending "regional resettlement meetings held by Muckamore to review Belfast Trust's progress regarding resettlement and delayed discharges." Is it correct to say that there were targets applicable to the Trust in terms of numbers of patients to re-settle? 14:19 14:20 14:20

A. Yes.

42 Q. And would it be the case that there was a shared sense of responsibility for achieving those targets or how would you describe the dynamic there? 14:20

A. I didn't personally attend any of those meetings, but I understand that there was a strategic element to those meetings, insofar as they were attended by senior managers of each Trust to consider resettlement in its widest form and whether or not there was opportunities to develop schemes that would've been shared amongst the neighbouring Trusts, for example. 14:21

So, I'm sorry, I missed -- can you repeat the question?

43 Q. Sure, yeah. It was really just to try and probe the dynamic of the meeting, of that strategic meeting that was looking at resettlement and the Belfast Trust element of it, the South Eastern Trust element. What was the tone like of those meetings? 14:21

A. Well, as far as I - and as I say, I didn't attend any of those meetings, but as I understand there was a performance element to those meetings, as well as a more strategic discussion and coordination and oversight of how resettlement was going to be achieved by all of the Trusts. 14:21

44 Q. So do I understand correctly, as far as you know, that these meetings, whilst there were Trusts at them, would there have been perhaps Department of Health or health board folks there as well to -- 14:22

A. Yes. And there was performance management meetings held by the Department of Health as well to look at the priorities for action targets, and they would've been about resettlement and how resettlement was being achieved against those targets. 14:22

45 Q. Do you recall, from your own involvement as a manager, the funding decisions that were made around resettlement, would they have been made by this kind of strategic body or were those decisions about how to withdraw funding, for instance, as a patient re-settled, was that made between the two Trusts? 14:22

A. That was made between the two Trusts. How Muckamore was commissioned, as I said earlier, was centrally

commissioned. Anything -- when a patient was fit for discharge and a placement, for example, became available, the responsibility for funding that placement lay with the Trust. So, for example, if a patient was discharged from Muckamore from the South Eastern Trust, the Trust would have paid for that. As far as I --

CHAIRPERSON: You mean the South Eastern Trust would've paid for it?

A. Yes, of course. It's not my understanding that any funding would have been withdrawn from Muckamore to facilitate that. In fact, I know that that wasn't the case, that the South Eastern Trust, they had paid in full for the patient's --

CHAIRPERSON: And this probably shouldn't even need asking, but it's probably best that it is aired; can we take it that funding would not be in any way a decisive factor in relation to whether a patient was re-settled or not?

A. No. And one of my comments was going to be that it would never have been, in my experience, that funding would have been part of those discussions.

CHAIRPERSON: Thank you.

46 Q. MS. TANG: So, when we talked about delayed discharges earlier, just to be clear, are you saying that people were never delayed because of funding?

A. That's correct. The delay has been in relation to the appropriate placement provision for that individual, to meet their needs, regardless of the funding.

47 Q. Looking then at paragraph 3.6 on the same page, please, there's reference to children being admitted to Muckamore Abbey. Were children from South Eastern Trust ever admitted to Muckamore Abbey, in your experience? 14:24

A. Yes.

48 Q. And were they always admitted to children's wards?

A. It's my understanding that, prior to the Iveagh Centre opening in 2010, there was Conicar Ward in Muckamore Abbey that was solely for children. So, yes, they would've been admitted to the Conicar Ward. 14:25

49 Q. And are you aware of there ever being a time when a child had to be admitted to an adult ward or somewhere that wasn't specifically for children?

A. Not in my experience. 14:25

50 Q. So, when did the admissions of children cease entirely then?

A. Well, when the Iveagh Centre in Belfast opened in July 2010, it's my understanding that children were no longer admitted to Muckamore beyond that point. 14:25

51 Q. Yes. Can I clarify, what is classified as a child? What age? What's the cut-off that you were working to?

A. It's a person under 18.

52 Q. A person under 18. And looking at paragraph 3.6 again, there's mention of the Trust invoking the Looked After Children Procedures to ensure that there was a robust monitoring arrangement in place. That phrase "Looked After Children", most of us would think of that as children out in a placement, out in a care setting. Is 14:25

it the same as procedures that you might find in child protection?

A. Not necessarily. Looked After Children Procedures are in place for children who are no longer living, or not able to live, with their family and they are, therefore, classed as children in care of the State, if you like. And whilst this is a hospital setting, it is custom and practice, and good practice, to put in place those Looked After Children Procedures to ensure that there's a robust monitoring and review arrangement in place to ensure that those children's needs and the assessment is met. 14:26 14:26

53 Q. What kind of monitoring would actually happen in those scenarios then for children who had been in Muckamore?

A. Well, the Looked After Children Procedures ask for a meeting to be convened within two weeks of the child's admission and then a further meeting in three months and then six-monthly after that. In terms of children who are admitted to Iveagh, possibly Muckamore prior to that, there would've been an expectation that these meetings would've happened much more frequently, because of the Hospital arrangements and because their needs might change. So it wasn't that there was a meeting every six months; it might've been called a normal LAC review, a formal LAC review, in six months, but there would've been meetings in between those times. 14:26 14:27 14:27

54 Q. Okay. I want to move on to focus on the community-based services element of what your statement

addresses. So that begins at page 6, looking at paragraph 4.1.2.

A. Mm-hmm.

55 Q. I want to ask you, how did the Trust prepare Muckamore patients for resettlement? What did they do? 14:28

A. So, as part of the discharge planning process, there would've been a range of individuals invited to attend and participate in multidisciplinary meetings that would've considered all aspects of that patient's needs. And as outlined there in the statement, it 14:28 would've been a range of professionals, such as speech and language, occupational therapy, physiotherapy, if that was required, and any other professional that needed to be involved with that patient.

14:28

What would've happened then is those multidisciplinary professionals would have formulated a discharge plan and agreed what the patient needed beyond their hospital treatment and what they would've needed into the community, and that would've been arranged through 14:29 whatever community placement was -- that met their needs.

56 Q. Paragraph 4.2 refers to community learning disability teams. At what point did they start, was that 2007 or did they start -- come into being before that? 14:29

A. Community learning disability teams were in place before that.

57 Q. All right.

A. But they were in place as part of the two different

Trusts within the South Eastern Trust area. So that would've been the Down and Lisburn Trust and the Ulster Community and Hospitals Trust. The model was similar.

58 Q. And in terms of that model, the professions that you described just now and that you refer to in the paragraph above, are those the professionals that have always featured in that type of team model or has it changed over time? 14:29

A. It probably is those professionals that were always around then and now. Included in that group might be psychology and psychiatry. 14:29

59 Q. Is that a more recent addition or are those professions ones that would've --

A. They have always been part of that cohort of staff.

CHAIRPERSON: Could I just ask, in relation to the discharge planning process, at what stage would the relatives or parents of the patient be involved? 14:30

A. Well, it's my understanding -- I don't know if parents and carers were in attendance at those meetings, but certainly they would've had full information about what happened at those meetings and what decisions were made. So they might have been involved by way of information following those discussions and be part of that process but not necessarily be engaged in the meeting. Parents were, and carers are, invited to attend some of those discharge planning meetings, as I understand it. 14:30 14:31

CHAIRPERSON: Well, that's what I was asking. They were invited to --

A. As I understand it, yes. But I will clarify that, just so that we're --

CHAIRPERSON: Could you?

A. -- absolutely clear. Yes.

CHAIRPERSON: It's really the extent to which the family or carers would be involved in, not only receiving information, but providing information. 14:31

A. Sure. I'll clarify that.

60 Q. MS. TANG: Thank you. Would the community learning disability teams have played a role in supporting families of a person with learning disability who wasn't, at that point, admitted to Muckamore, they were maybe still living at home? 14:31

A. Yes.

61 Q. Looking then at the behavioural support services that are referred to - I think that's mentioned in, again, the same paragraph, 4.2.1 - when did that behavioural support service begin? 14:31

A. I started in the service in 2017 and it was in place then. My understanding is that it was in place long before the Trusts amalgamated. But I can't be sure of an -- I can't be sure of the date. 14:32

62 Q. Okay, thank you. Looking at the intensive support service that's referred to, would that have been available to support families to try and keep people at home rather than be admitted? 14:32

A. Yes, that is -- would be the core function of that team. And essentially, they would be helping to support an individual to live in the community for as

long as possible and to try and build services around that individual and their family to maintain their placement at home. So, yes, they would be involved, very much, in that community level.

63 Q. In practical terms, would that have meant that someone from that team would've went out and spent a lot of time with the family, or would they have been commissioning additional support to help? 14:32

A. It would've been provided by that team.

64 Q. That team? 14:33

A. Yeah.

65 Q. Okay. Moving down to paragraph 4.2.2, you've made reference to the forensic service. And I wanted to clarify with you, was that a South Eastern Trust service or was that provided jointly with Belfast Trust? 14:33

A. It's a South Eastern Trust service alone.

66 Q. It's your own team. And can I take it that a risk of offending in a patient would usually dictate a different pattern of support and supervision? 14:33

A. Yes, it's tailored to meet the individual needs of the patient and -- or the individual in the community. So, yes, the forensic service would've provided appropriate intervention necessary to that offending behaviour.

67 Q. You've made reference to Tier 3 level. Can you just explain what you mean by Tier 3 level? 14:34

A. Well, Tier 3 level would be those more complex individuals that would require a more complex and in-depth response. So it's patients or service users

living at home that might need a more intensive support, if you like. So it's that level of patient that we would be discussing or talking about.

68 Q. So if a patient who had those more complex needs was admitted to Muckamore, would they have been, for want of a better word, looked after by the liaison officer that we spoke about earlier, or would there be a specific person who could deal with the forensic liaison? 14:34

A. It's my understanding that if a patient who was involved with the intensive support service was admitted, then that information would've been shared with the Belfast Trust in order to ensure the best care and treatment plan. It could be that the forensic service, the individuals within that service, would be part of the Muckamore decision-making process and be part of the care and support within the Hospital. 14:34 14:35

69 Q. I'm thinking about the forensic definition, as such; how many -- we talked about 1,500 or so patients at any given time with a learning disability, you estimated, in the South Eastern area. How many of those would you say typically might have some forensic element to their presentation? 14:35

A. I don't know the exact number, but I think the numbers are small. And again, I can find that out for the Inquiry and for the Panel. 14:35

70 Q. Okay. Looking down then to paragraph 4.4, which is on page 8 of the statement, there's mention there that there's ongoing work to progress the transfer of

psychiatry resource from Belfast to South Eastern Trust to provide a locally based service. Has that been the plan for a long time, or how long has that been the intention?

A. Well, it has been discussed in my time. And certainly there was a move to shift that resource from the Belfast Trust to the South Eastern Trust. And then we moved into the pandemic and that didn't become a priority at that time. But I understand now that that's being progressed. 14:36

71 Q. So, when you say in your time, roughly when would you have first been aware of those discussions happening?

A. Around 2019.

72 Q. 2019. And is it your understanding that there were any discussions of that nature or any desire to have a South Eastern liaison disability psychiatry service, a local service, before then? 14:36

A. Yes, I think those discussions had been ongoing before then, but I think in -- they got a bit of traction, those discussions, around 2019. And then, unfortunately, we were hampered by the pandemic and some other factors that delayed that from happening. 14:37

73 Q. Mm-hmm. So can I just probe that a little bit? Why was there a sense that you needed your own South Eastern local service, as opposed to drawing on the Belfast Trust service? 14:37

A. Well, I think in our experience, and certainly in my experience, when you have a local consultant psychiatrist that is employed by the South Eastern

Trust, or employed by their local Trust that they provide services into, it makes that process a bit more manageable. And because the psychiatry services were being managed from the Belfast Trust, that made that process slightly more complicated. But it is important, I believe, to have those services provided locally.

74 Q. Would it be the case that it was not as easy to get hold of or to speak to a psychiatrist then about a patient because they weren't a local psychiatrist? Maybe, was it harder to access Belfast Trust -- 14:38

A. Not necessarily, no. That person would have been solely providing services, community-based services, to residents in the South Eastern Trust, so that person was not hard to get hold of or be in touch with. Very accessible. 14:38

75 Q. But you just wanted your own South Eastern --

A. Yes.

76 Q. Can I ask you, picking up again on paragraph 4.4, why were the psychiatrists then based at Muckamore? 14:38

A. Well, it was a historical commissioning arrangement that goes back to the '90s, I understand, that it was always in place that the psychiatry was based in Muckamore Abbey Hospital rather than being based locally. And they provided, and were commissioned to provide, services through Muckamore to the community, to patients -- to inpatients and patients in the community. 14:39

77 Q. So, within that consultant cohort in Muckamore, were

there people who always looked after South Eastern Trust and the catchment area it covered, or how did they divide up the --

A. I understand it to be that they looked after patients who came from the South Eastern Trust, yes. 14:39

78 Q. And would you have said that those Muckamore psychiatrists who were allocated to South Eastern Trust, did they contribute to the community learning disability teams as well, or how did that interaction work? 14:39

A. Yes, they were part of the community learning disability teams and very much a feature in discussions about patients who were either in Muckamore or in the community.

79 Q. I want to move down to paragraph 4.5 and to talk about day centres a little with you. Can you just describe what the typical day in a day centre actually was like, what happened there? 14:40

A. Well, it can be very much tailored to the person's individual needs. Each person will have a profile of what their needs are. They will also have a profile of their likes and their dislikes. And their care and support provided to them in the day centre would be very much tailored around that. For example, if somebody benefited from going for a walk, that would be facilitated. Or if somebody liked music or had any other interest, that certainly would've been, and is, catered for within the daycare provision. 14:40 14:40

80 Q. So was the day centre a place where you might expect a

person going to to have any kind of clinical assessment or monitoring of their condition or was it more of a social care or social interaction facility?

A. It's both.

81 Q. Both. 14:41

A. So there is the opportunity for in-reach from psychiatry, from other multidisciplinary professions to in- reach into the day centre while the person is there, but also it is for a social opportunity for individuals. 14:41

82 Q. Thinking again to paragraph 4.5, you mention also day opportunities. Is it the case, have I understood correctly that day centres were the initial approach and that, as time moved on, the focus moved on more to day opportunities for people? 14:41

A. That's correct, yeah. That happened around 2015.

83 Q. We note from paragraph 4.5 that there were around 557 short sessions. And can you just explain to me, what do you mean by "short sessions"?

A. Sorry, I'm struggling to find the... 14:42

84 Q. It's 4.5.

CHAIRPERSON: Where is it, Ms. Tang? Four point five point?

PROF. MURPHY: At the end of 4.5.2.

MS. TANG: 4.5.2, apologies. Yes, the very last sentence in that. 14:42

A. Sorry, I'm not sure I am on the right --

CHAIRPERSON: No, nor am I.

MS. TANG: 4.5.2.

A. The last sentence in that?

MS. TANG: Yes, it refers to 557...

A. Oh, yes.

CHAIRPERSON: Can we just read it out, so that it's on the record? 14:43

MS. TANG: Yes.

A. So:

"This resulted in the increase of approximately 300 places. This has continued to grow, with currently 557 14:43 community-based day opportunity."

Is that the sentence you're referring to?

85 Q. Yes, that's right. So, I suppose the thing to clarify there was, is that 557 people receiving these 14:43 placements or is that a combination of the type of places but a person might be getting more than one...

A. Yeah, it's a combination of places or opportunities for people. And, do you know, what could happen for somebody is that they could have a range and a mixture 14:44 of services. So, for example, they could attend a day opportunity service on one day and then maybe attend a day centre on another day in the week and perhaps then have a direct payment. So there was a mixture of services, or there is a mixture of services provided to 14:44 people, depending on their needs. So that forms part of that.

CHAIRPERSON: Can you just - I'm not a medical person - can you just explain what the difference is between a

day opportunity and spending time at a day centre?

A. Yes. So, a day opportunity gives people more opportunity for skills and to increase their skills around work and education and training. So, for example, a day opportunity might be a person able to spend some time in a coffee shop, doing some meaningful work. A day centre might be for those individuals with more complex needs -- 14:44

CHAIRPERSON: Yes, I understand.

A. -- who aren't able to have that capacity or have that level of skill to be able to do that. 14:45

CHAIRPERSON: Fine.

86 Q. MS. TANG: So, is it correct that day centres are still part of the services that are provided to people with learning disability but, where possible, day opportunities are offered? 14:45

A. That's correct, yes.

87 Q. You have, looking at paragraph 4.6, you have referred to a statutory duty to offer direct payments in place of traditional services. Can we just clarify, does that duty, is that something that comes up under the carers and direct payments? 14:45

A. Yes.

88 Q. Yes. For direct payments, how many people are actually in receipt of direct payments? 14:45

A. Let me just see. Because I do think I have said it here. So in 2021, between 2020 and 2021 we had over 200 people in receipt of direct payments. That might have changed, because I know that the provision of

direct payments increased over Covid pandemic, where more direct payments were offered than traditional services such as domiciliary care packages.

89 Q. Would it be fair so say that direct payments is the direction of travel the Trust is expected to go in, or -- 14:46

A. Well, direct payments is part of a menu of services wrapped up in what we describe as a self-directed support framework. So, the self-directed support is really a way in which a person can manage their own budget, so aligned to their assessed need. So, if somebody has a need for a particular provision of service, they can choose to spend that payment or that managed budget on whatever it is that they believe will meet their needs. So that could be a direct payment, it could be another, you know - and it is different for everybody - but it could be a gym membership, it could be somebody to come and provide a short break, for example. So, it's part of a menu of services available to people with a learning disability. 14:46 14:47 14:47

90 Q. So when the term "direct payments" is used, does that mean that the person who is in receipt of a direct payment, are they physically handed the money to pay someone to do things for them or does someone else actually do the transaction of paying for a service? 14:47

A. Well, it's managed through carers and support - parents. And that would be paid -- there's an organisation called The Centre for Independent Living, who would provide support to families to manage the

direct payment so that they can employ a person to provide for -- to provide their services, whether that be a short break or whether that be somebody to kind of provide some support and care to them.

91 Q. And is there a safeguarding presence within the direct payments structure, or who looks out for the person with learning disabilities who's receiving... 14:48

A. Yes, there are policies and procedures around the direct payments in terms of how it's managed and how it's governed. I'm not sure of the detail of that, but again that's something I can help the Inquiry with if you want that level of detail. 14:48

CHAIRPERSON: And could I just ask, the graph that you've set out, helpfully, on page 12 and you mention at the bottom of 4.7.1 that the number of individuals receiving direct payment has gone up to 224. 14:48

A. Mm-hmm.

CHAIRPERSON: What about the size of the pot? That tells us how many people are receiving it, but not how much the pot is and whether the pot's gone up. You understand what I'm getting at? 14:49

A. Yeah. I don't know the detail of that. I suppose it's our position that if somebody is assessed as requiring a direct payment, that that direct payment would be made. In terms of how that aligns with the budget, I'm not sure. I know that our direct payment, we have an overspend in direct payments, but that's aligned to a person's needs and wishes. And so it's something that we manage within our finance department, but we would 14:49

not deny somebody a direct payment if it was within their assessed need because of money or resource.

CHAIRPERSON: You just go over the budget?

A. Yes.

CHAIRPERSON: All right. 14:50

92 Q. MS. TANG: Would you say direct payments are popular with people, or are people somewhat reluctant to move on to that basis?

A. It really depends on the family and the person. There is certainly a cohort of people who like to have that 14:50 autonomy and they like to have that -- be able to spend that direct payment on whatever it is that they require. There are other families who don't like it and other families who would prefer the Trust to deliver their services in the more traditional way. 14:50

93 Q. Are there times when a direct payment arrangement falls through and the person has to go back to a more traditional model or...

A. Well, it has been very challenging over the last couple of years in terms of the number of people who are 14:50 available to provide care and support to families, and families tend to rely on friends and other people that they might know or who is familiar with the person to provide that care and support. So, yes, it has been challenging, but I don't know of anybody who has had to 14:51 go back to a more traditional service because of that.

94 Q. Would you say that, in terms of staff to meet the demand for community support, are there shortages of staff to provide that kind of care in community

settings?

A. Well, it's certainly been a challenge from the Covid pandemic. And we are -- I mean, in terms of the direct payment model, it would be the responsibility of the family to identify a person that they believe to be suitable to provide the care and support for their loved one. For the more traditional services, such as daycare, it has been challenging to recruit and retain staff over the last number of years. And certainly in the South Eastern Trust, we are continuing to do a rolling recruitment process to ensure that there are very few gaps or there are no gaps in staff provision to families. 14:51 14:52

95 Q. So, could there be a situation where, if you had been unable to get enough community care staff, that somebody could end up having to be perhaps admitted to somewhere like Muckamore because they couldn't be maintained at home or couldn't be maintained in their normal supported living arrangement? 14:52

A. That would be very unusual. A person would be admitted on the basis of their clinical need, not on the basis of the lack of support in the community. 14:52

96 Q. So if there was insufficient support in the community and the person couldn't remain in a supported living or home placement, where would they go in that scenario? 14:53

A. Well, the Trust has a mechanism for monitoring and managing those people. There's a community integration process in place. And what that is, is a monthly meeting to consider a range of people in different

groups. So, for example, we would look at children who are transitioning to adult services. We would also look to the Muckamore population. But within that cohort, we would also consider those people who are in the community, and we would refer to those people as community pressures. So we would be aware of those people who might be struggling in the community, with their family or in a supported living facility, for example, and it would be at that meeting that you would discuss and arrange additional support for those people. 14:53 14:53

Now, that could come from the intensive support teams, if that was required, or it could come from the community learning disability teams. It would be unusual for individuals not to be known to us, that there would be a sudden decline in somebody's presentation; we would tend to know who those people are and be able to put in place a support service for them. 14:54 14:54

97 Q. So, do I understand you correctly that if somebody was struggling, for whatever reason, to manage in a supported living environment, for instance, that from what you're saying, I'm hearing that you would put people around them, rather than necessarily take them out of that supported living arrangement? 14:54

A. That's correct.

98 Q. Are there ever times, though, whenever, whether it be staff shortages or whatever else, that you simply can't

keep someone in that place? And if those times happen, where do they go?

A. I suppose that's quite difficult to answer. Because not, in my experience, has that happened as a consequence of staff shortages. 14:55

99 Q. Okay.

A. There has always been a way in which we -- if it's the right place for the person at that particular time. If their needs have changed to such an extent that they need to be moved to another placement or they need to 14:55 go elsewhere, that's different from the Trust not having the resource to support them in the placement. And in my experience, we wrap around that person. And there are always mechanisms and ways in which we can do that for families and for individuals. 14:55

100 Q. That subject brings us on to paragraph 4.8, if we can bring that up, and the topic of short breaks. At what point would the short breaks on offer have really relied on admission to Muckamore? Was there a point in time in the past whenever that was a short break? 14:56

A. No, I wouldn't have known Muckamore to be used as a short break facility.

101 Q. Okay.

A. Sorry, just to clarify that bit; it might have been used as part of a person's care and treatment, that 14:56 occasionally there are individuals who might do well with a short admission to Muckamore. That's not described as a short break, that's described as part of their care and treatment, that they would benefit from

a short period in Muckamore to address whatever needs or presentation they might have at a particular time.

102 Q. Thank you. So, what types of locations would short breaks typically have involved the person going to?

A. Sorry... 14:57

103 Q. What I'm getting at is, are short breaks typically in community settings or might they be in other settings?

A. They tend to be community settings.

104 Q. And is that then a care facility or what types of...

A. Well, there's two types of short breaks; there's 14:57 overnight short breaks that is provided in a community facility, for example. And the South Eastern Trust operates one seven-bedded residential facility, and that's a statutory service. We also commission beds from the voluntary sector, which is described as 14:57 overnight short breaks. Direct payments can be classified as a short break if the person uses that for going out during the day, for example, and be supported in the community. We also spot purchase short breaks.

14:57

So there's different types of what could be considered to be a short break.

105 Q. And when you say "spot purchase", do you mean buy a nursing home bed for a period of time or...

A. Yes, we have commissioned beds that we pay for and rely 14:58 on. But if somebody needs something outside of that, we would purchase that separately. And that's known as a spot purchase.

106 Q. Do people who indicate that they would like a short

break, perhaps carers who say 'We would really like to avail of this', are they typically accommodated in their request for a short break fairly quickly, or how long might people have to wait?

A. I suppose because the South Eastern Trust knows its population and knows the individuals very well, they would know which families would require short breaks, whether that be overnight or some other provision. So, families are offered routine short breaks, for example. So, a family might benefit, or might have in place a short break for their loved one once a month, for example, and that would be a routine arrangement. Other families might benefit from a short break if they themselves have an event coming up that they, you know, are unable to take their relative to. 14:58 14:59 14:59

So, short breaks are offered for a variety of reasons. Some of them can be planned and routine, other short breaks have been offered in an emergency basis when an emergency arises within a family that means somebody has to leave for a short period of time. 14:59

107 Q. Thank you. Thinking about nursing home placements, moving down to 4.9, which is on the same page...

A. Yeah.

108 Q. ... roughly, what size of nursing home would you typically use for those types of placements? 15:00

A. Well, they would be very small, so -- and I don't know the number. And again, I can assist the Inquiry with that later on. But they would be very small

facilities, for people with a learning disability, largely because of their presenting needs. So there might be places within a nursing home that would be designated for people with a learning disability.

109 Q. So, do I understand correctly that it might not be a learning disability-only facility, it might be a facility with other types of residents? 15:00

A. I'm not sure about that. But I'm happy to provide that information.

110 Q. Okay. 15:00

CHAIRPERSON: So when you say, sorry, in paragraph 4.9.2, you say that your Trust has "reconfigured its residential care provision in line with this policy and currently operates one statutory residential service for permanent placements". 15:01

A. Yes.

CHAIRPERSON: Is that for learning disability?

A. That is solely for learning disability, yes.

CHAIRPERSON: Right. 15:01

A. That particular facility is. But I beg your pardon if I kind of misled you there; so the nursing home placements -- or, sorry, the residential placements that we commission from the independent sector, I'm not sure if they are solely for learning disability 15:01 population.

CHAIRPERSON: Right.

A. But the one in the South Eastern Trust that's a statutory service is for people with a learning

disability.

CHAIRPERSON: And when it talks about permanent placement, do you know what the longest resident of that facility is?

A. I don't, no. But certainly in my time, from 2017, you know, there have been a very little turnover of people, so the people that live there now have typically lived there for a long period of time. But again, I can find that out for the inquiry. 15:01

CHAIRPERSON: Right. And you say "and currently it supports 7 individuals". 15:02

A. Yes.

111 Q. MS. TANG: Staying on paragraph 4.9, can I ask, is there sufficient capacity, in your understanding, within the care homes, or indeed supported living placements, to meet the needs of all the South Eastern Trust people with learning disabilities or autism? 15:02

A. Demand will always outstrip capacity. So, I would suggest that if we had endless resource around residential placements, nursing home placements or supported living, they could be filled very quickly. It would be our ethos, if you like, to maintain people at home for as long as possible, because that tends to be their wishes and the wishes of their family. And we would support those individuals to be at home for as long as they could and it would only be when that's no longer possible that we would plan for admission elsewhere. 15:02 15:03

The community integration meeting that I talked about earlier in my evidence was, is a way of understanding what the need is, both what the need might be in the future and what the need is right now. And it is challenging, because the capacity is not there to meet the demand. And when that is the case, then we do build a support mechanism around those families as much as possible. 15:03

112 Q. So, how does the Trust monitor the amount of demand and supply? Are there mechanisms for that? 15:03

A. Well, again, that's through our community integration process. We would know how many young adults are transitioning to adult services within a timeframe that may need a community provision in the future. We try to identify those young people from age 14, even though they might not transfer until four or five years later. But that's really to -- it does take a long time to put in place a community facility or provision that will meet that person's needs. 15:04

So, we would know how many of those young people there are, we know how many people there are in the community that would require -- who might be considered to be the community pressure group that I talked about, that might need a provision for a community placement into the future or indeed now. So we have those, we have those figures. I don't have them here, but we can get them. 15:04

DR. MAXWELL: Can I ask you, you said at the beginning of your evidence that the delayed discharges in Muckamore were absolutely not about funding, they were about practice -- the placements, availability. And we've heard from a lot of people that the patients who are still in Muckamore have particularly complex needs. So I'm wondering, given that a lot of that care is provided by the independent or third sector, if money isn't a problem, is there just not an appetite in that sector to provide the sort of residential placements for people with very complex needs? 15:05 15:05

A. I think there is an appetite. I think the challenge for everybody, including the Trusts and the independent sector - and we do work very closely with the independent sector to develop services, bespoke arrangements and very individualised arrangements for people - I think the challenge lies with the level of skill that is required to manage --

DR. MAXWELL: The workforce?

A. The workforce. Well, it's not necessarily just a workforce issue. So, yes, there could be a deficit in the workforce, but there could also be challenges in relation to the skills and expertise that a workforce would require in order to -- 15:06

DR. MAXWELL: Well, that's what I mean; not just the number, but the skills? 15:06

A. Yeah, it's the skills, the skill set.

DR. MAXWELL: There's a shortage of staff, but more than that, a shortage of staff with the right skills?

A. That's correct.

DR. MAXWELL: So the issue isn't funding, it isn't lack of appetite to provide it, it's actually about workforce and the skills of that workforce?

A. That would be my experience. And I know certainly that we have, very successfully, re-settled and placed very complex people with provider organisations and we have built around a support structure from within the Trust to those independent sector organisations in order to maintain that placement. But it's very much a real partnership working - and we've demonstrated that that does work well - but it requires real partnership between the statutory service and the independent sector. 15:06 15:07

DR. MAXWELL: So, just to follow on about the workforce, do you think the independent and third sector get enough support in recruiting and retaining that skilled workforce? 15:07

A. I would say it's very challenging for them. And I'm not sure that there is enough support out there for the independent sector, unfortunately. And I suppose it's always been a challenge for us in terms of the -- I suppose I want to be clear in what I'm saying; in order to attract the right staff and the right skilled workforce, you need to pay those staff appropriate salaries - and I'm not sure that in Northern Ireland, and even across the social care workforce, that we have reached that level - in order to attract people into the profession who can become skilled. But certainly 15:07 15:07

we have worked with independent providers who have absolutely skilled up their staff to work with very complex people and it has worked very well.

DR. MAXWELL: Just one final question on the workforce: In the contracts with the independent sector, is there a percentage for continuing professional education? 15:08

A. Yes. And I don't know what that is. And I'm thinking solely of one independent organisation who have put in place an ongoing training, or ongoing training and education for their staff in order to skill them up to a level beyond what you would describe as a support worker. 15:08

DR. MAXWELL: But is that their initiative or is that specified in the contract?

A. That is their initiative. It tends to be very expensive. But again, the Trusts would not -- I mean, the Trust resource -- 15:09

DR. MAXWELL: No, I understand.

A. If the individual requires it, it would be put in place. 15:09

DR. MAXWELL: But it's an area we might want to look at more?

A. Yes.

DR. MAXWELL: Thank you.

CHAIRPERSON: Thank you. 15:09

113 Q. MS. TANG: I've a fairly general question for you in conclusion to my questions, and that is, as I understand it, South Eastern Trust doesn't have its own assessment and treatment beds, whereas we know that

Northern Trust and Western Trust appear to have; does the South Eastern expect to have to continue to use Muckamore beds for that purpose where a patient needs it?

A. No. We're in discussions at the moment - well, certainly in our own Trust - to develop our own care and treatment provision for individuals. And I'm not in the service now, but I understand those discussions are going on about identifying a facility and putting the mechanisms in place to develop that. So that will be something in the future that will be available to South Eastern Trust people. 15:09 15:10

MS. TANG: Thank you. Those are all my questions. I expect the Panel may have some.

PROF. MURPHY: I've just got one question for you. Just going back to the nursing home placements, you know, they tend to be at the more restrictive end - so it's kind of supported living, residential placement and then nursing home is the more restrictive and very highly supportive end. And you seem to have a lot of people in nursing homes, so 93 sounds an awful lot to me. Were you saying just now that that's not all LD? 15:10 15:10

A. I suppose, just to clarify your first point there about the nursing home environment, that would be for people who have nursing needs. So they might not -- they might have a learning disability and a requirement to have, you know, nursing provision within that particular facility. So that's the first bit. So it's not necessarily that that would be a tier higher than 15:11

the supported living or the residential placement, it would be to meet that particular need for for nursing.

The second part of your question was, I'm not sure if there are learning disability patients mixed in with other patients and I said I would come back and clarify that bit in relation to the nursing home environment. 15:11

PROF. MURPHY: Okay, thank you.

CHAIRPERSON: I think we've actually asked our questions as we've gone along, probably much to the frustration of counsel. But unless you have anything else, Ms. Tang? 15:12

MS. TANG: No, my questions are complete.

CHAIRPERSON: Mrs. Preece, can I thank you very much for providing your statement and coming along to assist the Inquiry. 15:12

THE WITNESS: Okay, thank you.

CHAIRPERSON: Thank you very much indeed.

THE WITNESS THEN WITHDREW 15:12

CHAIRPERSON: Right, shall we take a ten-minute break? Thank you.

THE INQUIRY ADJOURNED BRIEFLY AND RESUMED AS FOLLOWS: 15:12

CHAIRPERSON: Thank you very much. Yes, Ms. Briggs.

MS. BRIGGS: Yes, good afternoon, Chair, Members of the Panel. This afternoon the Inquiry will be hearing

evidence from Dr. Elizabeth Brady on behalf of the Western Health and Social Care Trust. The reference of the statement is 086-1. It's 11 pages, there's no exhibits. And, Chair, unless there's anything further, at this stage I think the witness can be called. 15:28

DR. ELIZABETH BRADY, HAVING BEEN SWORN, WAS EXAMINED BY MS. BRIGGS AS FOLLOWS:

CHAIRPERSON: Dr. Brady, welcome to the Inquiry. I'm sorry I didn't have time to come meet you personally, but you're very welcome. Thank you for your statement. Now I'll hand you over to Ms. Briggs. 15:29

THE WITNESS: Thank you.

114 Q. MS. BRIGGS: Thank you, Chair. Dr. Brady, we have met earlier, briefly, today. I'm one of the counsel team to the Inquiry. You've provided a statement to the Inquiry on behalf of the Western Health and Social Care Trust, it's dated 23rd January 2023, isn't that right? 15:29

A. That's right.

115 Q. And you have a copy of that statement in front of you, is that correct?

A. I do, yes.

116 Q. And the length of that statement is eleven pages, with no exhibits, is that right? 15:30

A. That's correct.

117 Q. And are you content to adopt that statement as the basis of your evidence to the Inquiry?

A. I am, yes.

118 Q. You'll recall, Dr. Brady, that you were asked to give evidence on two areas related to Module 2, that was healthcare structures and governance, the first being the interrelationship between Trusts regarding patients admitted to Muckamore and, secondly, an outline of the provision for community-based services.

A. That's right.

119 Q. As you probably heard in the evidence earlier, I'm not going to read that statement into evidence, but I will read parts of it and take you to parts of it, okay? 15:30

A. Okay.

120 Q. If we could go then to section 1. That outlines your qualifications and your position. At the time of writing that statement, you say there that you are the Acting Director of Adult Mental Health and Disability Services and your background is as a consultant psychiatrist, is that right? 15:30

A. That's correct.

121 Q. Are you still in that post?

A. No, as of 1st April I returned to my role as an Assistant Director. I was six months in total as Acting Director. 15:31

122 Q. And who, now, has taken up the Acting Director or the Director post?

A. Karen O'Brien, the Director, has returned to her position. 15:31

123 Q. You mentioned your position before that you've returned to; can you remind us what that position is, what the title is?

A. I am now working again as Assistant Director for Mental Health Inpatients in Crisis Services, but I am also the Divisional Clinical Director, which is the lead medic, in the Adult Mental Health and Disability Services.

124 Q. You mentioned returning to that post; how long were you in that post for before you took on the Acting Director role for six months? 15:31

A. I have been Assistant Director since July 2020 and I've been Divisional Clinical Director since June '19.

125 Q. And how long have you been involved with the Western Trust? 15:31

A. I have been working in the Western Trust since February 2012, and the majority of that time as a clinical consultant psychiatrist.

126 Q. Have you ever worked in Muckamore at any time during your career? 15:32

A. I did early on in my training. I worked in Muckamore between August 2001 and February 2002 and then again from October 2003 to February 2004 as an SHO, or senior house officer, at the time. 15:32

127 Q. And have you worked across other Trusts in general, not just the Belfast Trust then and the Western Trust?

A. Yes, I worked across a number of, I suppose, legacy Health Trusts, as they were, and... So, Mater, North and West Belfast, Downshire, across the region. 15:32

128 Q. Okay, thank you very much, Dr. Brady. I'm going to turn then to the first of the two topics that you were asked to provide evidence on, that's the interrelationship between Trusts regarding patients

admitted to Muckamore. It's internal page 2, if that could be pulled up. If we could pull up paragraph 5, please, just a little back up the page. Okay, you describe there the legacy Trusts then, which you've mentioned earlier in your evidence. It's at the end of 15:33
paragraph 5 you describe the interactions, you're referring to the interactions between the Western Trust and the Belfast Trust.

A. Yes.

129 Q. You say: 15:33

"These interactions occurred over many years and included a total of 28 Western Health and Social Care Trust adult clients identified as having spent time in Muckamore within the Inquiry time period." 15:33

A. Yes.

130 Q. Is there information as to what categories those individuals might fit into - for example, the duration of their stay, the average duration of their stay in 15:33
Muckamore?

A. That information can be made available, I don't have it to hand off the top of my head. But a later paragraph gives you the type of circumstances where a Western Trust patient would've been admitted to Muckamore. So 15:34
it would've been if there were no beds within our own unit at Lakeview hospital or if there were -- to the forensic specialist beds. So there would've been a specific reason for an admission to Muckamore.

131 Q. Would you know offhand the patient that had stayed in Muckamore the longest of those 28?
A. I wouldn't know the longest length of stay, but I can find that out.
132 Q. That would be very useful if you could, Dr. Brady. 15:34
A. Okay.
133 Q. How many Western Trust patients are there in Muckamore Abbey Hospital at present?
A. None.
134 Q. None. If we go down to paragraph 8 then, please. 15:34
Here, you're referring to the types of communication between the Western Trust and Muckamore regarding Western Trust patients who had an admitted to Muckamore. You say: 15:35

"Communication would largely have been direct conversations between consultants at the point of admission and discharge. In some cases there would have been phone calls from community key workers to monitor progress throughout inpatient stays." 15:35

Can I ask you about the community key worker?
A. Yes.
135 Q. What type of individual is that, what's their discipline? 15:35
A. It would usually be a social worker, or at times a community learning disability nurse. But it would've been one of those two professions for community key working.

136 Q. How are they selected or appointed?
A. I'm not sure exactly of the exact process for appointing a key worker, but referrals would come in to community teams and would be allocated based on, I suppose, key worker capacity and also what the identified patient need is. So, if there's more social care needs identified, a social worker would be appointed; if there's a physical healthcare or medication element, it would be a nurse appointed. But it'll be done on a case discussion. And it may change as case evolve, you know, as more becomes known about a new patient. 15:35 15:36
137 Q. You mentioned that it would be a learning disability nurse if it was to be a nurse.
A. Yes. 15:36
138 Q. What about the social worker, would they have expert training in learning disability or mental health, for example?
A. To my knowledge, social work is a more generic qualification and the skills are picked up depending on the area you choose to specialise in. So there's a kind of core social work training background and a skill-set that then will be developed as you start working in a learning disability team. So it will depend on the social worker you're allocated really, how much experience they have. 15:36 15:36
139 Q. Yes, Dr. Brady, thank you very much. The Inquiry has heard evidence about care management procedures, for example on behalf of the Northern Trust, that would've

involved what they described as the community named worker.

A. Mm-hmm.

140 Q. Is that effectively the same as the community key worker that you're describing? 15:37

A. Yes. Yes.

141 Q. So it's simply a terminology change?

A. Yes.

142 Q. Okay. When you talk, at paragraph 8, about the communication - and I've read that out already into the record. 15:37

A. Yes.

143 Q. Would there be any formality to those communications, in terms of their frequency, for example?

A. No, it would've been on a case-by-case basis and on a key worker basis. 15:37

144 Q. When you say on a key worker basis, what do you mean by that?

A. I suppose it would depend, the level of contact the key worker felt they needed to maintain with Muckamore as the treating team, if there were complexities around the admission or the discharge process or maintaining contact with the community or with the family. 15:37

145 Q. Okay. You say there in some cases there would've been phone calls? 15:38

A. Yes.

146 Q. Not all cases?

A. No. And that's based on a review of the case files. We have employed someone recently to come in and review

the 28 records and they have advised me that not always would there have been evidence of contact with the Muckamore team.

147 Q. Okay. So that individual has undertaken a review of the case files and then reported to you, is that right? 15:38

A. Yes.

148 Q. And that's what's formed the basis of some of the information in your statement?

A. Some of the information, yes.

149 Q. Okay. So, might there have been cases then that communication took place at the point of admission and perhaps discharge only, there was nothing in the period in between? 15:38

A. As far as I'm aware, you know, the case notes would point to that. But given that there's nothing written down, we can't be sure what happened in between. 15:38

150 Q. Might it then have been the case that there was contact that wasn't recorded?

A. Possibly. Or it may be recorded in the Belfast Trust notes and not in the Western Trust notes. It may be that, you know, if somebody phoned a ward in Muckamore to talk about a patient, the patient who took the call will have recorded the information, but the person who made the call may not have made a record. 15:39

CHAIRPERSON: Can I just understand something very basic? When one of your patients, in the sense that they come under your Trust -- 15:39

A. Yes.

CHAIRPERSON: -- goes into Muckamore, do they remain

your patient?
A. They remain the Trust's patient.
CHAIRPERSON: Right.
A. So, yes.
CHAIRPERSON: Yes. But obviously the prime role for safeguarding and caring for that patient then moves to Muckamore? 15:39
A. Yes, whilst they're there.
CHAIRPERSON: Who's commissioning that service?
A. My understanding is it was commissioned by the Department of Health. 15:39
CHAIRPERSON: Right.
A. Particularly given that the majority of Western Trust patients in Muckamore would've been under the forensic beds or the PIC, that kind of centrally commissioned, or would've been there temporarily whilst awaiting a bed in Lakeview. 15:40
CHAIRPERSON: So they have lived in your area?
A. Yeah.
CHAIRPERSON: They're your patient, they're moved into Muckamore, the service is paid for, effectively, by the Department of Health? 15:40
A. Yeah.
CHAIRPERSON: But do you retain -- sorry to interrupt, Ms. Briggs, I know it's frustrating. 15:40
MS. BRIGGS: No, not at all, Chair.
CHAIRPERSON: But do you retain responsibility in any sense for that patient?
A. Yes, they remain a Western Trust patient --

CHAIRPERSON: Right.

A. -- accommodated in a Belfast --

CHAIRPERSON: So, if there's communication between a community key worker about the progress of that patient, are you saying no notes would be kept within your Trust? 15:40

A. That's what the evidence has told us, is that there wasn't always a record of communication throughout the person's stay in Muckamore in Western Trust notes, which are the only ones we have reviewed. 15:41

DR. MAXWELL: There are in some of those patients.

A. In some of the patients, yes, but not all.

CHAIRPERSON: And would that be when there are issues of concern, or it doesn't work like that?

A. I'm not sure of the detail of the notes that were kept. 15:41

CHAIRPERSON: No. Sorry to interrupt, Ms. Briggs. Thank you.

151 Q. MS. BRIGGS: No, that's okay, Chair. And it leads me nicely on to the last sentence: 15:41

"These interactions would not have been routinely documented in case files."

Is there a reason why it might not have been documented? I think you touched on it earlier, but could you expand on it a little bit more? 15:41

A. I suppose it wasn't necessarily custom and practice to keep the level of detail of notes that we now do, that we now know are important to be kept. So, some of the

phone calls may have been passing on information...

152 Q. So, can I take it from your suggestion that it's now known to be important to keep those notes, that there's been a change in that regard in terms of record-keeping? 15:42

A. Yes.

153 Q. When would you say that change occurred?

A. I couldn't be sure. I couldn't be sure to pinpoint it.

154 Q. That paragraph in particular focuses on the phone calls throughout a stay. Would there have been attendance at 15:42 a patient's care reviews, for example?

A. I would have to check that out.

155 Q. Would there have been contributions to their care plan discussions?

A. There would've been -- the community key worker 15:42 would've been the link person who would've known about the history and the context and the events leading to admission, so they would've been a source of information, and also a source of contact in terms of discharge planning. So they would've been involved in 15:42 care reviews.

156 Q. Okay, thank you very much. I'm going to move on to paragraph 9, it's just on the top of page 3. You say there:

15:43

"Prior to 2014, when community teams were less established, there is little evidence of care/case management processes and explicit connection with relevant professionals from the Trust of origin."

Can I ask, firstly, very basically, what's meant by a community team?

A. So, that would be the community social workers and learning disability nurses primarily. 15:43

157 Q. Who else?

A. There'd be psychology and psychiatry involved in the community teams as well.

158 Q. Was that the case prior to 2014?

A. Yes. 15:43

159 Q. Have they changed at all post-2014?

A. It's probably more that the workforce has expanded and that there's clearer roles. So the breadth and the number of professionals available in the community has expanded. 15:44

160 Q. But the types of individuals involved in the community teams, in terms of their discipline, that's remained --

A. Largely the same.

161 Q. The same, okay. And you say "largely the same"; why do you say "largely"? 15:44

A. I suppose I'm not sure of the specifics of the exact composition of the teams and if there's been speech and language involvement or if there's been behavioural support or if there's been occupational therapy, you know, in terms of year by year, who's been in what 15:44 team, so... But it's been broadly nursing and social work would be the predominant professions.

162 Q. When did community teams first become established within the Western Trust? The Inquiry's Terms of

Reference, the timeframe of it goes back to 1999. Were they in place at that time?

A. They were. I wouldn't be sure of the exact date of their establishment, but they were in place in '99.

163 Q. Okay. You mention care/case management processes. Very briefly, what is meant by that, Dr. Brady? 15:45

A. That would be under the care management policies and procedures in terms of identified -- assessing and identifying need and then providing care and support to meet those assessed needs and keeping a review of that process. 15:45

164 Q. Those are written down, those policies and procedures?

A. Yeah, they're universal, I think, across the region.

165 Q. And when you say that there is little evidence of care management processes and explicit connection with the relevant professionals prior to 2014, what exactly do you mean by that? 15:45

A. I think that goes back to the not routinely documented in case files. The evidence in the case files as they were reviewed wouldn't read across to the level of evidence we would have now in terms of care management procedures. 15:46

166 Q. So are you simply saying there, then, that there was less record-keeping?

A. I think so, yes. That's certainly part of it. 15:46

167 Q. But is your evidence to the Inquiry that the care management processes and procedures were there, the following of them just wasn't being documented correctly?

A. I think that's a big part of it. Because I suppose we have the evidence that people were having assessments, their needs were being met, there was daycare, there was supported accommodation, there was family support, there was a breadth of services offered, but the evidence behind it in terms of case notes is just not as robust as it would be now.

CHAIRPERSON: Well, I mean the old rule, I remember, as it were, from the GMC was if it wasn't written down, it didn't happen. 15:46

A. Yeah.

CHAIRPERSON: And that's the problem, isn't it?

A. That is, yes.

168 Q. MS. BRIGGS: If we take it pre and post-2014, if we go to pre-2014, how would the Western Trust know if one of its service users had been admitted to Muckamore and was being abused? 15:47

A. I can't answer that question, based on what I've reviewed so far. But I would presume it would be if Muckamore told us or if the community worker was in touch directly with Muckamore. 15:47

CHAIRPERSON: So, putting the issue of notes - which, obviously, you're plainly troubled about, if I may say so.

A. Yes. 15:47

CHAIRPERSON: But how would that get escalated? Would it get escalated within your Trust or would it be left to Muckamore to handle?

A. Again, I don't have enough evidence to suggest it was

clearly escalated within the Trust. It would be if --

CHAIRPERSON: If it happened?

A. If it happened. If we knew about it, there would've been internal Trust safeguarding processes and policies both pre and post-2014 in terms of escalation. 15:48

DR. MAXWELL: Can I just clarify then, if Muckamore had identified potential abuse, they would've started a safeguarding process?

A. Yes.

DR. MAXWELL: Would it have been helpful for Western to start its own safeguarding process, or does that just muddy the water? 15:48

A. I think it would have to come down to the nature of the incident, in terms of whether the Western Trust would contribute to the safeguarding investigation and information-gathering and protection plan or, depending on the nature of the incident, if they felt they would need to do their own, start their own processes. So I suppose it depends on the nature of the safeguarding incident. 15:48 15:49

169 Q. MS. BRIGGS: I'm going to take you back to your answer to my question, which was, before 2014, how would the Trust know if one of its service users was being abused whilst at Muckamore? And you said, very honestly, that you couldn't answer that question. 15:49

A. Mm-hmm.

170 Q. I presume predecessors of yours would be able to answer that question?

A. They should be, yes.

171 Q. And I presume that that individual, or those individuals could be identified for the Inquiry by the Western Trust?

A. They could. Or I could find them and ask -- you know, take the questions to them and bring the answers back. 15:49

172 Q. In terms of the post-2014 position then, you say at paragraph 9 there has been an increase in care management processes?

A. Yes.

173 Q. Based on the evidence you've given, would it be correct to say that what you mean there is that there has been an increase in recording of care management processes? 15:50

A. Yeah. Yeah, there's increased evidence of the care management processes and the connections with key workers and patients in Muckamore. 15:50

174 Q. So you can't say, for example, whether the use of processes itself has actually increased or decreased, you can simply speak to what you have seen in the evidence?

A. That there's more evidence of it, yes. 15:50

175 Q. Would you be aware as to whether the care management procedures within the Western Trust differ in any significant way as regards other Trusts, the Northern Trust or the South Eastern Trust, for example?

A. I've nothing to suggest they're any different than anywhere else in the region. 15:50

176 Q. What do you mean by that, "nothing to suggest"?

A. Just based on my own experience of care management and working across most of the other Trusts at some point

and my current position and meetings at Assistant and at Director level, I haven't heard anything that makes me think we're an outlier in any way or particularly different.

177 Q. Thank you, Dr. Brady. You go on to say that the care management processes "had a particular focus on discharge planning and maintenance of links with key professionals and the patient's community of origin". 15:51

A. Yes. 15:51

178 Q. What does the focus on discharge planning look like in practice?

A. I suppose it's about the shift in services if a hospital wasn't really a destination any more, it was about the resettlement agenda and it was about the idea that patients shouldn't have a hospital address, in line with Bamford and Equal Lives, it was about moving people back to the community or maintaining community placements even if they have had a hospital stay. 15:51

179 Q. Were there any established resettlement teams or resettlement-focused posts within the Western Trust? 15:52

A. Not that I'm aware of, no.

180 Q. No teams at all of any kind in relation to resettlement?

A. My understanding is it was part of the core function of the community teams. 15:52

181 Q. The Inquiry has heard evidence from the Northern Trust that the community worker would've been invited by Muckamore to attend care planning meetings organised by

Muckamore, post-admission meetings, safeguarding meetings, multidisciplinary meetings and discharge meetings. Is that also the case with the Northern Trust key worker?

A. To be honest, I'm not sure. Our numbers were much fewer and it was predominantly forensic patients who would've been in Muckamore or those who were briefly in Muckamore whilst awaiting a bed in Lakeview. So our length of stay would've been much shorter and our reasons for admission quite different from the Northern Trust, who would've had any patient with a learning disability who required hospital. So I couldn't say, but I can find out, what the level of outreach from Muckamore to ourselves was, the level of invite in. 15:52 15:53

182 Q. I think it would be useful to the Inquiry to have some sort of comparison perhaps between the position there. Perhaps if you could come back with that information? 15:53

A. Yeah, we will do.

183 Q. The Inquiry has also heard evidence about regional adult resettlement meetings held by Muckamore. And those are held by Muckamore to review the progress of all Trusts in relation to resettlement and delayed discharge. Are you aware of those and is there any involvement for the Western Trust post-holders at those meetings? 15:53 15:54

A. The ones that are ongoing currently, the resettlement board?

184 Q. The regional adult resettlement reviews.

A. Yes, the Western Trust's involved in those.

185 Q. In terms of maintaining links, as you say, with key professionals in the patient's community of origin, can you tell the Inquiry a little bit more about what exactly that involves?

A. As I say, it would predominantly have been patients with a forensic background who would've been in Muckamore, so it would've been our forensic team who would've maintained contact with both patients and the treating team during -- throughout their stay. As to the frequency, I couldn't comment. I got more an overview of the 28 cases rather than granular detail on the level of involvement. But I can look into that. 15:54 15:54

186 Q. That would be helpful if you would, Dr. Brady. And I'd asked the same question in terms of pre-2014, so I'll ask it post 2014: How would the Western Trust know post-2014 if one of its service users had been admitted to Muckamore and was being abused? 15:55

A. Again, it would be through if Muckamore told us or if the community key worker or the family advised us.

187 Q. So there's no formal procedure, it's only if the Trust is told by Muckamore, if the community key worker is made informed? 15:55

A. Yes.

188 Q. And if either of those two facts are correct and the Western Trust becomes informed, how high up the chain within the Western Trust would safeguarding issues become known? 15:55

A. Within the community team, I think some of the other directors have given the evidence that, you know,

social workers will have their supervision, so it'll be he escalated to social work manager. And if our adult safeguarding team's involved, it would be escalated through there as well.

189 Q. Would it make it as far up the chain as to you, for example? 15:56

A. I suppose certainly in my six months, we've had nobody in Muckamore, or outside of the Trust, in terms of it being escalated to director level. Our last patient was discharged from Muckamore in March '21, so there's no recent experience of it being escalated to Director level. 15:56

CHAIRPERSON: Presumably it would depend on the level of harm, if any, done?

A. I would imagine so. But again, I can go back to the evidence and find out how far any identified safeguarding went as a matter of interest. 15:56

190 Q. MS. BRIGGS: And it might also be something that your predecessors could comment on.

A. Yeah. Yeah. 15:56

191 Q. I'm going to move on then to the next section of your evidence, which is the outline of provision for community-based services. It's internal page 4. Firstly, just a general question: What's the population size covered by the Western Trust? 15:57

A. Let me see. I did note this. It's about 280,000, I believe.

192 Q. Okay, thank you very much. At paragraph 14 then - it's just down the page - you say:

"Across the Trust area there are 2,000 individuals on the master patient index with an intellectual disability".

15:57

A. Yes.

193 Q. "There are 858 on community caseloads in the northern sector and 675 in the southern sector of the Trust geography".

15:57

A. Yes.

194 Q. What is the different between the master patient index and the community caseloads?

A. So, the master patient index are individuals in the community who would be diagnosed with an intellectual disability. Not everybody with an intellectual disability requires services or intervention. So the smaller numbers on the community caseloads are those who would have an identified key worker or need for input from adult services.

15:58

15:58

195 Q. Thank you very much. If you go down to Figure 1, it's internal page 5. I'm not sure if we can zoom out on that a little bit? The title of that document, or that graph is at the bottom of the page, it's "Current Service Structures, Adult Learning Disabilities, Western Health and Social Care Trust" and it sets out the various positions. It's actually the bottom right box that I'm interested in. I'm not sure if we can zoom in again, just to bring that up? That is said to

15:58

be the head of service hospital and lead nurse.

A. Yes.

196 Q. Can I clarify, is that two individuals or one?

A. No, that's one individual.

197 Q. Okay. Did the Hospital and lead nurse then, did they cover Muckamore or just the Hospital provision within the Western Trust that is Lakeview? 15:59

A. It would just be Lakeview within the Trust.

198 Q. Okay. If we go over the page then to the other diagram at Figure 2, that is the learning disability service detail. 15:59

A. Yes.

199 Q. And we can see at the top again is the Assistant Director post. If we could zoom in, and it's the second rung on the ladder to the right-hand side - I can see it now - the consultant nurse? 15:59

A. Yes.

200 Q. Who seems to be just directly below the Assistant Director and in line with all the other boxes there.

A. Yes. 16:00

201 Q. What is the role of the consultant nurse?

A. The consultant nurse is a new position, recently created and appointed by the Department of Health. So there's one in adult mental health in each Trust and one in learning disability in each Trust. So it is a new role that's developed, I believe half clinical and then half in terms of the senior management and nursing lead in a directorate, a sub-directorate. 16:00

202 Q. And what exactly is their role?

A. So, they'll provide nurse supervision, they'll provide training, they'll develop policies, they'll...

DR. MAXWELL: Do they have a clinical caseload?

A. Not a caseload per se, but they will provide clinical input where required and, I suppose, senior leadership across the nursing teams, the nursing staff.

203 Q. MS. BRIGGS: You said in your evidence that it was recently created?

A. Yes.

204 Q. How recently? 16:01

A. In the past year/18 months.

205 Q. Okay.

A. I can find out exactly.

206 Q. Thank you very much, Dr. Brady. If we can move on then to page 7, paragraph 17, please. You describe there 16:01 the opening of Lakeview. Can you, firstly, give an overview to the Panel and to those listening and to the Inquiry an overview of the inpatient facilities that were available to individuals within the Western Trust from 1999 onwards? You've mentioned Stradreagh in that 16:01 paragraph. When did Stradreagh open?

A. I'm not sure of the exact date of that, I'm afraid. I would have to check for you.

207 Q. Would it have been before 1999, for example?

A. Yes. Yes. 16:01

208 Q. And some who live more locally might have referred to that previously as the Gransha Hospital, is that...

A. It's on the Gransha Hospital site. The Gransha Hospital was more for adult mental health and then

Stradreagh was the learning disability provision. And they're both on Gransha Park.

209 Q. Can you tell us a bit more about Stradreagh? Perhaps you can't, but...

A. Possibly not in any great detail. It was a large, old building. And as I say, I'm not sure when it opened. It would've had a much larger inpatient population than certainly Lakeview had and certainly has today. 16:02

210 Q. Was it solely for patients with learning disability needs? 16:02

A. It was.

CHAIRPERSON: So was that the Western Trust version of Muckamore?

A. Yes.

211 Q. MS. BRIGGS: You said it was large; can you say how large, how many beds? 16:02

A. I'm afraid not, no. Not at its peak, no.

212 Q. When did it close?

A. It closed - it's referred to further on...

213 Q. I think you might be looking for paragraph 22 there. 16:03

A. Yeah. 2010.

214 Q. 2010, okay. When did Lakeview open?

A. 2005.

215 Q. You say at paragraph 17 that the opening of Lakeview, in line with Bamford recommendations, resulted in reduced acute inpatient bed capacity available in the Western Trust. 16:03

A. Yes.

216 Q. Why did it result in a decrease?

A. It was about that community resettlement agenda, it was about individuals with a learning disability should not be living in hospital, they should be living in community placements and facilities. So the requirement for large inpatient bed numbers was reduced as community places developed.

217 Q. So, effectively it was reduced compared to the numbers that were in Stradreagh, is that --

A. Yes.

218 Q. Okay. You go on to discuss, in the next few paragraphs, how its capacity has been reduced further over the years - that's the capacity of Lakeview.

A. Yeah.

219 Q. And at paragraph 21 on page 7 you say that it is now at "10 assessment and treatment beds for adults".

A. That's right.

220 Q. Can you tell the Inquiry a bit more about Lakeview Hospital?

A. Lakeview was a purpose-built building. As I said earlier, it opened in 2005. It's now commissioned for 10 assessment and treatment beds for adults. There's a current inpatient population of 8 patients. Due to the complexity, they're accommodated across two ward areas. There are still a number of those who are awaiting community placement who have completed their assessment and treatment phase and are waiting for appropriate community placements either to be identified or to be able to facilitate their moves to moves, to take them on. So...

221 Q. And is it a hospital solely for learning disability patients?

A. Yes.

222 Q. Okay. What about patients with mental health difficulties, does it provide any services to them? 16:05

A. If they have an underlining learning disability. But --

CHAIRPERSON: So, a primarily learning disability --

A. It's primarily learning disability of any degree, with or without a comorbid mental health condition. It's on 16:05 the Gransha site still and nearby is Grangewood Hospital, which is the adult mental health facility. So they're both on the same site still.

223 Q. MS. BRIGGS: Thank you very much, that's very helpful. How would you say that it's different, that is Lakeview 16:05 is different, from Stradreagh, what came before?

A. I suppose it's very much focused on assessment and treatment rather than ongoing care and support, which I think the Stradreagh population largely was. It's about deteriorations in behaviours or in mental health, 16:06 about timely intervention and about returning back to the home you were admitted from or a community facility to meet your needs.

224 Q. How, if at all, would you say that Lakeview is different to Muckamore? 16:06

A. I suppose I've no recent experience of Muckamore myself. It is very much, it's a smaller unit, it's accommodated within one building. As I say, there's four people who are awaiting resettlement rather than

the larger population in Muckamore. So it's much more focused on acute episodes of care than continuing care.

225 Q. Thank you very much. Dr. Brady. If we can go on to paragraph 20, still on page 7. You say there:

16:07

"Short breaks ceased within Lakeview in May 2015".

A. Yes.

226 Q. Were there any other short break provisions before 2015, apart from in hospital-based settings? 16:07

A. Yes, there's a range of short break provision across the Trust. It was just the Lakeview short break beds that closed at that time.

227 Q. What were those provisions?

A. They're across the Trust in residential or nursing home, depending on people's assessed needs and complexities, across the Trust geography. 16:07

228 Q. Okay, thank you very much. If we can go to paragraph 23, it's at the top of page 8. At the last sentence there you talk about resettlement. You say that: 16:08

"To date, the resettlement of long-stay patients has been enabled through use of a mixed model that includes both larger scale group living and individualised specialist housing with dedicated care and support packages". 16:08

A. Yes.

229 Q. At any time during your post or previous - you might

not be able to speak to that - but have any of the Western Trust learning disabled patients had to remain as full-time patients due to the extent of their needs?

A. Well, yes and no. Yes, until we've been able to engage with commissioners or independent sector providers to provide a more bespoke placement and to train staff and to recruit staff. So, at times we'll be looking after someone who has complexities that there's no off-the-peg placement in the community and we'll have to then go out and see who can support us to develop a suitable placement. 16:08 16:09

DR. MAXWELL: Can I just ask then - and it may be something you were planning to ask later - but in the independent review of resettlements published last year, they noted that 10 people across the region who were still awaiting resettlement were on the original priority target list from 2007. 16:09

A. Okay.

DR. MAXWELL: Have you got any patients who've been in hospital since 2007 still awaiting resettlement? 16:09

A. No.

DR. MAXWELL: No.

CHAIRPERSON: Since we've stopped -- sorry, were you were you going to on?

A. I was going to say to -- from recent conversations with the clinical staff, the longest patient awaiting resettlement in Lakeview currently is about 5 years. So it's, what 2007 -- 16:09

CHAIRPERSON: Right. We didn't touch on paragraph 22

and just to ensure that it's covered, I don't think you've mentioned Ralph's Close.

A. Yes.

CHAIRPERSON: Was that for LD patients or...

A. LD patients only, yes. 16:10

CHAIRPERSON: That was?

A. Yes.

CHAIRPERSON: So, that was established in 2010. And is that still open?

A. Yes, it is. 16:10

CHAIRPERSON: So you've got Lakeview and Ralph's Close?

A. Yes.

CHAIRPERSON: And those are the two catering for inpatient LDs?

A. Ralph's Close is a supported living facility. 16:10

CHAIRPERSON: I'm sorry. Right.

A. It is still on Gransha Park, but it is a supported living facility.

CHAIRPERSON: So it's not a hospital, or it is --

A. It's not a hospital, no. 16:10

CHAIRPERSON: My misunderstanding.

A. It was the last ward and the last inpatients from Stradreagh, it was the community placement developed for them.

CHAIRPERSON: Ah. Okay, sorry. Thank you. 16:10

230 Q. MS. BRIGGS: Can you assist the Inquiry generally about the extent of inpatient provision within the Western Trust? Does the Western Trust have sufficient capacity at this stage to avoid admission to Muckamore for

non-forensic patients?

A. Yes.

231 Q. Okay. I'm going to ask you some more questions about the community provisions that are in place which are of interest to the Inquiry. Does the Western Trust have an intensive support service? 16:11

A. No.

232 Q. So, when there's an individual in crisis, there's no specific team or provision or service which can go in and visit the individual at that time to deal with that specific need? 16:11

A. Not as a separate team. It would be more that the community team would up their provision and their intervention as best they can to help manage a crisis situation. But there wouldn't be a separate team to come in and do that specifically. 16:11

233 Q. Is there a reason why there isn't a specific team for that?

A. I'm not aware of a specific reason, no. But I can find out why it wasn't developed. 16:12

234 Q. Thank you, Dr. Brady. And what about a community forensic service for learning disability?

A. We do have a community forensic team.

235 Q. Can you tell us a bit more about that team?

A. It's consultant psychiatrist-led. There's a part-time or part of a consultant forensic psychologist and social work staff work to look after individuals with a learning disability and associated forensic issues and needs. 16:12

236 Q. When was that established, that service?
A. I would have to check when it was set up. It certainly has been in place for 10/11 years at the very least.
237 Q. Okay, thank you very much. If we can go to paragraph 27, then, it's at page 8. You say there: 16:13

"For the quarter ending 30th September there were 1,950 clients in receipt of direct payments across the Western Health and Social Care Trust". 16:13

Can I ask, how does that sit with the 2,000 people on the Western Trust's master patient index?
A. That would be everybody in the Western Trust who receives a direct payment. So that may be children, it may be older adults, it may be mental health. It was 16:13 more to illustrate the nature of the growth across direct payments in the Trust as a whole.
238 Q. Would data be available, then, as to how many of those direct payments recipients are learning disability --
A. I can go and find that. It wasn't readily available at 16:13 the time of preparing the report, so -- but I can go and look for it for the inquiry.
239 Q. Thank you very much, Dr. Brady. At page 9, paragraph 28, you refer to a report.
A. Yes. 16:14
240 Q. And Dr. Maxwell has actually already referenced this report in one of her questions to you. It's the Independent Review of the Learning Disability Resettlement Programme in Northern Ireland.

A. Yes.

241 Q. Which you say at paragraph 28 "has referenced the continued position that community services are at different stages of development in each of the five Trusts." Can you provide a bit more detail on that? How does the Western Trust compare? 16:14

A. I suppose it goes back to your earlier question about the intensive support team and the resettlement teams and different Trusts used different money in different ways to meet the needs of individuals with a learning disability. So, whilst we heard from some of the other Directors about resettlement teams and intensive support services, that's not how the Western Trust has developed their services; the northern and southern sector of the Trusts' community teams, the social workers and nurses primarily, as I'd said, short breaks, daycare, psychological therapies and behavioural support, as well as the inpatient services. 16:14 16:15

So, based on our Trust geography and the fact we still have an inpatient unit, we've developed our hospital and community services differently than some of the other Trusts. 16:15

DR. MAXWELL: Is there any evidence base about which is the best model? I recognise all the Trusts have done different ones and part of it may be to do with geography, but is there an evidence base or even any plan to evaluate the different models the five Trusts have used? 16:15

A. There is. The Department has been looking at the learning disability service model in conjunction with the Trusts and with the SPPG and that is under development currently in terms of what is the best for the region, recognising we're small enough to have some degree of consistency across the region.

242 Q. MS. BRIGGS: I'm going to ask for that report to be pulled up. It's a report that's available publicly online. I think that the technical team should have a copy of it for the screens. And I appreciate that you may or may not be able to assist the Inquiry in relation to this, it doesn't form part of your evidence - although you've referenced the report in your statement, you haven't exhibited it - but I do have a couple of questions in relation to that report. 16:16 16:16 16:17

If we could go to internal page 14 of that report, it's paragraph 4.11. And it's a topic you have been giving evidence on in the last few questions, but I think it's worth asking the question anyway. 16:17

A. Okay.

243 Q. There, the report authors talk of the RQIA review of 2016 which reviewed -- I'll give you a moment to read that. Just take your time.

A. Okay. [Short pause] Okay. 16:17

244 Q. To summarise what's there, there was a review of progress made by the 5 Trusts in relation to the implementation of various standards relating to learning-disabled patients in the DoH service framework

and halfway down it says:

"The RQIA review concluded that community services have developed more as a result of historic custom and practice in each Trust area, with little sharing of practice noted regionally regarding models of care used by each team. It was difficult for the review team, therefore, to effectively compare and contrast the models of service provision across Northern Ireland. The RQIA review found that there is no agreed uniform model for behavioural support services across the 5 Trusts." 16:18 16:18

In light of the finding of a lack of sharing of practice, can you assist the Inquiry by detailing how the Western Trust satisfies itself that its model of community service provision is sufficient? 16:18

A. I couldn't formally provide any information on that. I can find additional information.

245 Q. Would that be a matter that would you need to reflect on, is that what you're telling the Inquiry? 16:19

A. In order to provide a sufficient level of detail as to how we assure ourselves our services are safe and effective, I think it wasn't something I'd specifically prepared, but I could find time with the Assistant Director and the team and our performance lead to look at that and provide information. 16:19

246 Q. Thank you, Dr. Brady. I've one more question. It's internal page 90 of the report and it's paragraph 9.10.

This refers to an unannounced inspection at Lakeview between August and September 2021, which "identified a number of matters of significant concern in relation to adult safeguarding and incident management". And then it goes on to refer to a further inspection in February 2022 "which found that progress had been made in a number of areas, however there had been limited progress with regards to adult safeguarding and incident management." The Inquiry appreciates that this is outside the remove of Muckamore, it relates to Lakeview.

A. Yeah.

247 Q. The Inquiry would be interested to know how does the Western Trust assure itself that safeguarding and incident reporting systems are being used within Lakeview.

A. Following on from the RQIA inspection, a significant amount of work has been done both on safeguarding and incident management. This has included a lot of support from our safeguarding team, as well as extensive training of the entire multidisciplinary team in Lakeview in adult safeguarding processes, procedures and practice and as well something similar for our incident management and connecting those two systems together in terms of reviewing incidents, assuring ourselves that all safeguarding issues have been considered. And further RQIA inspections have noted that progress.

DR. MAXWELL: Can I just ask, so that's how you

identify, after the event, that abuse has happened?
A. Yes.
DR. MAXWELL: Were there any key themes as to why it had happened, anything you could address to prevent it?
A. Off the top of my head, no. But in skilling up the team and in the incident review practices that have gone around it and the level of training and up-skilling, the whole ethos around adult safeguarding is shifting and changing and there's a greater awareness in terms of the culture of the unit of what is and isn't a potential safeguarding incident. So, in terms of themes, from memory, there was nothing stark that came out, but certainly there has been a sustained improvement in overall practice. 16:21 16:22
MS. BRIGGS: Dr. Brady, those are all of my questions for you. The Panel may have some questions. 16:22
CHAIRPERSON: I don't have anything else, we've asked questions as we have gone along, Dr. Brady. So can I thank you, first of all, very much.
THE WITNESS: Thank you. 16:23
CHAIRPERSON: I'll just say this, that through your evidence there have obviously been a number of occasions where you've said 'I'll go and look into this' or 'I'll look into that'.
A. Yes. 16:23
CHAIRPERSON: What I think we'll do is we'll review the transcript and then we will write to you --
A. Okay.
CHAIRPERSON: -- so there is a structure, rather than

rushing off and trying to find lots of information.

A. Thank you very much.

CHAIRPERSON: So I think that would probably help you if you know what the Inquiry is specifically interested in. 16:23

A. Yeah. Thank you.

CHAIRPERSON: So, in the meantime, Dr. Brady, can I thank you very much indeed for coming to assist us.

A. Thank you.

CHAIRPERSON: Thank you. And we're sitting tomorrow at 10:00, I think? 16:23

MS. BRIGGS: Yes, that's right. 10:00 tomorrow, Mark McGuicken on behalf of the Department of Health.

CHAIRPERSON: Right, thank you, everybody, very much. 16:23

THE INQUIRY WAS THEN ADJOURNED UNTIL WEDNESDAY, 19TH APRIL 2023 AT 10:00