MUCKAMORE ABBEY HOSPITAL INQUIRY

SITTING AT CORN EXCHANGE, CATHEDRAL QUARTER, BELFAST

HEARD BEFORE THE INQUIRY PANEL

ON WEDNESDAY, 19TH APRIL 2023 - DAY 35

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WITNESS PAGE

MR. MARK McGUICKEN

EXAMINED BY MR. DORAN 6

1 THE HEARING COMMENCED, AS FOLLOWS, ON WEDNESDAY, 19TH
2 APRIL 2023
3
4 CHAIRPERSON: Good morning.
5 MR DORAN: Good morning, Chair. Panel. 09:55
6 CHAIRPERSON: Good morning. Just give me a second,
7 sorry. We can get the witness in I think. We've got
8 Mr. McGuicken.
9 MR. DORAN: Yes, Mr. McGuicken is giving evidence on
10 behalf of the Department of Health in relation to 09:55
11 Module 3.
12
13 MR. MARK McGUICKEN, HAVING BEEN SWORN, WAS EXAMINED BY
14 MR. DORAN AS FOLLOWS
15 09:56
16 CHAIRPERSON: Can we pause for a moment. Are we -- is
17 the live feed running? Because my red light isn't on.
18 Thank you. Yes, welcome back, Mr. McGuicken, thank you
19 very much. We last saw you, I think, on the 3rd April
20 - which seems an age away. But we'll continue now with 09:56
21 your evidence. And also to remind people you will be
22 coming back to complete your evidence I think in about
23 a week.
24 MR. DORAN: That's correct, Chair. I'll say something
25 more about that. The next evidence session on behalf 09:56
26 of the Department of Health is scheduled for next
27 Tuesday. It is possible that we will reschedule the
28 evidence from the afternoon to the morning.
29 CHAIRPERSON: Right. Okay.

1 MR. DORAN: I understand that the witness has flagged
2 up a commitment elsewhere in the afternoon, but we'll
3 deal with that in due course.
4 CHAIRPERSON: All right. Okay. Right.
5 MR. DORAN: Now, also Mr. McGuicken, last day there 09:57
6 were some matters that arose that you are considering
7 further, isn't that correct?
8 A. Yes, Mr. Doran.
9 1 Q. And I understand you may be dealing with those and
10 other matters that might arise today by way of a 09:57
11 supplementary statement?
12 A. Yes, we have started to draft the statement, but I
13 think it will be -- the Inquiry's preference was that
14 we put one statement in rather than a number of
15 statements. So we have the majority of the information 09:57
16 from my previous appearance, but we can add to that
17 from today's, if necessary.
18 2 Q. Yes. That's very helpful. So we may then have to
19 organise a further evidence session at a later date to
20 deal with the matters arising from that statement. 09:57
21 Presumably you've no difficulty with that?
22 A. No, I'll make myself available to the Inquiry whenever
23 they need.
24 3 Q. Thank you. Now, just returning then to your witness
25 statement of the 13th of February 2023, and for the 09:58
26 record the reference is MAHI-STM-0891, and on the last
27 day we had dealt with Module 2 up to paragraph 4.13 on
28 page 20, isn't that correct?
29 A. It is, Mr. Doran.

1 4 Q. And we also dealt substantially with Topic A in Module
2 3 which appears at paragraphs 5.1 on page 20 to
3 paragraph 5.26 on page 25?
4 A. That's correct.
5 5 Q. And your coverage of the Module 3 issues runs from 09:58
6 paragraph 6.1 on page 24 to paragraph 16.16 on page 74?
7 A. That's correct.
8 6 Q. And I think that takes us up to Exhibit 170, isn't that
9 right?
10 A. That's correct, yes. 09:59
11 7 Q. Needless to say, we'll not be addressing all of those
12 exhibits in oral evidence today. As on the last day,
13 if we're focusing on a particular passage in your
14 statement or the exhibit, we'll ask for that to be
15 brought up on screen. 09:59
16
17 Just before your questions, I'd like to have a brief
18 look at the various Module 3 topics on the screen. So
19 I wonder if the evidence modules document could be
20 brought up, please? This I should say, Chair, marks 09:59
21 the formal beginning of our treatment of Module 3. And
22 just scrolling down, Module 3 Policy and Procedure, if
23 we could just scroll down to the list of topics,
24 please. I'm just going to read them in for the purpose
25 of introducing this session. 10:00
26
27 "Module 3 Policy and Procedure:
28 (A) Policies for delivering health and social care to
29 learning disability patients 1999 to 2021.

1 (B) Nursing care delivery model.
2 (C) Policies regarding restraints/seclusions.
3 (D) Safeguarding policies.
4 (E) Policies and procedures re medication and auditing
5 of medication. 10:00
6 (F) Policies and procedures concerning patients'
7 property and finances
8 (G) Policies and procedures re psychological treatment,
9 speech and language therapy, occupational therapy and
10 physiotherapy. 10:00
11 (H) Resettlement policies and provision for monitoring
12 of resettlement.
13 (I) Complaints and Whistleblowing Policies and
14 Procedures.
15 (J) Overview of mechanisms for identifying and
16 responding to concerns.
17 (K) Risks assessments and planning regarding changes of
18 policy.
19 (L) Procedures to provide assurance regarding adherence
20 to policies."
21
22 Finally:
23 (M) Policies and procedures for further training for
24 staff/continuing professional development."
25
26 So we've quite a list of topics to get through, but
27 we'll take our time.
28
29 Now, I wonder if we could return to the statement on

1 screen, please, and I'll be going shortly to the
2 section beginning 6.1.
3
4 But, just, Mr. McGuicken, at the risk of generalising,
5 is it fair to say that the Department's overall role in 10:01
6 these matters is to set policy at a high level?
7 A. It would be. We would set policy and strategic
8 direction, as you said, at a high level, and then that
9 will be implemented through, as it was, the Board and
10 Trusts at delivery level. 10:01
11 8 Q. So for the most part responsibility lies at Board level
12 or Trust level, or on the ground?
13 A. On the ground, yes.
14 9 Q. For the policies to be implemented in practice?
15 A. It would be. 10:02
16 10 Q. Now, presumably if a particular policy isn't working in
17 practice or isn't being adhered to, that will be a
18 matter of concern for the Department?
19 A. It would. And that would largely be flagged up through
20 the accountability and the governance structures, which 10:02
21 we covered in my previous hearing.
22 11 Q. Yes. And ultimately responsibility lies with the
23 Department to ensure that policies are being adhered
24 to?
25 A. It does. 10:02
26 12 Q. I think it's also correct to say that many of the
27 policies outlined in the statement and exhibited to the
28 statement apply right across the health and social care
29 system?

1 A. They do. They're largely generic policies which are
2 applicable, as you say, across the whole system, rather
3 than being specific to learning disability.
4 13 Q. Yes. So, for example, policies such as policies on
5 restraints, seclusions, safeguarding, medication, 10:02
6 responding to concerns, they extend well beyond the
7 specific context of learning disability and mental
8 health?
9 A. They do, Mr. Doran.
10 14 Q. Chair, Panel, I think it's important to draw attention 10:03
11 at the outset of the session to the nature of the
12 material that we're dealing with. I don't think anyone
13 would suggest that it's necessary for us to address in
14 oral evidence all of the high level documents in fine
15 detail. That would take us beyond the terms of 10:03
16 reference. So I will be focusing on the particular
17 aspects of the material that will, in counsel's view,
18 assist the panel in examining the terms of reference?
19 CHAIRPERSON: Yes, certainly. I mean it's useful for
20 us to have this material, because eventually of course 10:03
21 when we write the report we have access therefore to a
22 large amount of background information which we may
23 use.
24 MR. DORAN: Yes, indeed.
25 CHAIRPERSON: But there's no need for that to be 10:04
26 reflected in live evidence or in the transcript.
27 MR. DORAN: Indeed, Chair. Part of the function of
28 this series of modules is to make sure that the panel
29 has all of the relevant documentation relating to

1 policies, procedures, rules, regulations, et cetera, at
2 it's disposal.
3 CHAIRPERSON: Exactly.
4 MR. DORAN: Now, I've mentioned the overlap between the
5 Module 2 issues and Topic 3(a) which you've dealt with 10:04
6 in your statement and which we dealt with to some
7 extent last time, and I just wanted to recap briefly on
8 that. I appreciate that you may be addressing some of
9 these issues in your further statement.
10 A. Yes. 10:04
11 15 Q. But at the end of your evidence last time we looked at
12 four limited oversight arrangements within the field of
13 learning disability. Let me just go through them for
14 the purposes of refreshing your mind.
15 10:04
16 The first one was the Interdepartmental Ministerial
17 Group, Chaired by the Health Minister, established in
18 2007. And you deal with that in paragraph 4.8, and
19 it's overall purpose was to oversee the Bamford Vision
20 for Mental Health and Learning Disability Services, 10:05
21 isn't that correct?
22 A. It is correct.
23 16 Q. And the second limited oversight arrangement then, or
24 time limited oversight arrangement, was the Bamford
25 Monitoring Group, comprising service users and carers, 10:05
26 set up in 2009, and supported by the PCC, and you dealt
27 with that in paragraph 4.9.
28 A. That's correct.
29 17 Q. And the third oversight arrangement then is the Service

1 Framework Program Board, which has oversight of service
2 frameworks across the system, including the Learning
3 Disability Framework.
4 A. It was paragraph 4.11 that was addressed in.
5 18 Q. Yes, indeed. Then finally in paragraph 4.12 MDAG, the 10:06
6 Muckamore Departmental Assurance Group. So those are
7 the four time limited oversight arrangements?
8 A. Well, just to be clear MDAG is still ongoing rather
9 than being time limited.
10 19 Q. Yes. 10:06
11 A. So it's the current oversight arrangement or oversight
12 body looking at the structures of Muckamore.
13 20 Q. Yes. But looking at the others, (1) and (2) were stood
14 down as a result of the Bamford Evaluation Report of
15 2016? 10:06
16 A. Yes.
17 21 Q. And I think I understand you may be providing further
18 details in respect of the circumstances in which those
19 bodies were stood down?
20 A. Yes, that is some of the information on which I agreed 10:06
21 to come back on.
22 22 Q. Yes. And as regards No. 3 then, the Learning
23 Disability Framework, it was introduced in 2015, but in
24 2018 the Service Framework Program Board decided not to
25 renew it, isn't that correct? 10:06
26 A. That's correct. That's my understanding.
27 23 Q. And I think on the last occasion you weren't sure
28 whether the framework had gone into abeyance?
29 A. And we will address that coming back, Mr. Doran, in my

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1 supplementary statement.
2 24 Q. Yes. And you referred then to the overall learning
3 disability service plan or strategic plan that is being
4 developed?
5 A. Yes. 10:07
6 25 Q. And, again, that's something that you're going to look
7 at?
8 A. Absolutely.
9 26 Q. As you've said, the fourth body, MDAG, is still up and
10 running, so to speak 10:07
11 A. Operational, yeah.
12 27 Q. Yeah. And I think you indicated on the last occasion
13 that the intention was that that body would continue to
14 operate until the hospital is in fact closed?
15 A. That's our intention, yeah. 10:07
16 28 Q. So, we've dealt substantially...(INTERJECTION)
17 A. Sorry, could I -- just to clarify that?
18 29 Q. Certainly.
19 A. The decision on whether the hospital will close or not
20 has not yet been taken, so I wouldn't want it to be on 10:07
21 record that that decision has been taken in terms of
22 the hospital closure. That decision has not yet been
23 taken as to whether the hospital will or will not
24 close. So just to clarify that.
25 CHAIRPERSON: Because there is a consultation at the 10:08
26 moment?
27 A. The consultation has closed, Chair.
28 CHAIRPERSON: Is it closed?
29 A. And we're working our way through the consultation

1 responses. We do hope to put advice to the Permanent
2 Secretary on that very shortly.
3 MR. DORAN: That's understood, Mr. McGuicken. So long
4 as the hospital is open the intention is that MDAG will
5 continue to function. 10:08
6 A. That's correct.
7 30 Q. So, I'm going to move on now to deal with Topic 3(B),
8 Nursing Care Delivery Model, which begins at paragraph
9 6.1 of the statement. So if we can scroll down on
10 screen, please, to paragraph 6.1 of the statement? 10:08
11 CHAIRPERSON: It is page 25.
12 MR. DORAN: Yes. Now, in this section you address
13 policies and regulations relating to the nursing
14 workforce.
15 A. Yes. 10:09
16 31 Q. And it's correct to say again, I think, that most of
17 the documents referenced relate to the nursing
18 profession generally and not specifically to those
19 working within learning disability?
20 A. That's correct, Mr. Doran. 10:09
21 32 Q. Just some specific questions. In paragraph 6.5 - and I
22 wonder just as I refer to the paragraphs if they could
23 be brought up on screen, please? I'm not going to be
24 reading in detail from all of them, but in paragraph
25 6.5 you refer to an advisory body called the Central 10:09
26 Nursing and Midwifery Advisory Committee?
27 A. Yes.
28 33 Q. And you say that it's function is to provide relevant,
29 timely and resolved advice to the Minister. I wonder

1 can you tell the Panel anything more about the
2 composition of that body and how it works in practice?
3 A. Yes. Well, the Central Nursing and Midwifery Advisory
4 Council, as it says there, it's established under the
5 1972 Order. Its primary role is to advise the 10:10
6 Department on issues relating to Nursing and Midwifery.
7 The membership of the Committee is drawn from -- it's
8 shared by the Chief Nursing Officer within the
9 Department. The Deputy Chief Nursing Officer would sit
10 on that also with other departmental officials. All 10:10
11 Trusts are represented on it. The higher education
12 sector are represented on it in terms of the further
13 education colleges, et cetera. The private sector are
14 represented on that as well, as would the union
15 representation. It met quarterly since it's inception 10:10
16 but has not met since June 2022, just recognising the
17 number of the pressures of the system, it hasn't met
18 since June 2022. And I think that structure is
19 currently under a bit of a review, Mr. Doran, but it
20 has met continually over the years. 10:11
21 34 Q. Are the minutes of its meetings publicly available?
22 A. We can provide minutes of the meetings. I can provide
23 those in the supplementary statement.
24 35 Q. Well, I was going to ask about that, because you refer
25 specifically to the giving of advice by that Committee? 10:11
26 A. Yes.
27 36 Q. I think you referred to relevant, timely and resolved
28 advice to the Minister. Are you aware of any advice
29 that that Committee has given in the specific context

1 of learning disability nursing?
2 A. I wouldn't be aware of anything specific in that
3 regard.
4 37 Q. Is that something that could be researched?
5 A. We could certainly asked colleagues within the Chief 10:11
6 Nursing Officer Group, or ask them to go through
7 minutes to see what advice would have been provided
8 specifically to learning disability.
9 38 Q. Yes.
10 A. Now, as it has been going for quite a time, Mr. Doran, 10:12
11 we could look back and see what is available for that
12 and provide that to the Inquiry. That's no problem.
13 39 Q. Obviously the Inquiry wouldn't expect all of the
14 minutes of that Committee's meetings to be exhibited to
15 the fresh statement, but if there is anything specific 10:12
16 on learning disability?
17 A. We'll endeavour to do that.
18 40 Q. That would be helpful. Now, you refer then at
19 paragraph 6.7 to various review reports relating to the
20 workforce, and you say: 10:12
21
22 "In 2002 the Department published the review of the
23 Nursing Midwifery and Health Visiting Workforce Final
24 Report with additional review reports published in
25 2005, updated in 2007 and 2009. These reviews provided 10:12
26 a detailed profile of the workforce, including learning
27 disability nurses, identified current issues impacting
28 on the profession and made projections of the supply
29 and demand as well as setting out changes in the

1 workforce from the previous review."
2
3 Now, again, that was a high level review. Isn't that
4 right?
5 A. That would be correct. 10:13
6 41 Q. I just wanted to pick up on one point in the 2009
7 report, and you've exhibited that at Exhibit 53. The
8 page number on which the exhibit begins is 2722. If
9 that could be brought up briefly? So 2722. So that's,
10 that's the cover of the report. And I wonder if you 10:13
11 could turn then to page 2729, please. Now, I just
12 wanted to ask you briefly about the paragraph at the
13 top of the page and this of course dates back to 2009.
14 This is the 2009 report. I should have clarified that.
15 What the paragraph says: 10:14
16
17 "The report noted that agency and bank staff are
18 typically brought in to cover temporary shortfalls and
19 fluctuating workloads."
20 10:14
21 It noted that HRMS - does that refer to Human Resource
22 Management System?
23 A. I would think it does.
24 42 Q. Yes:
25 10:14
26 "HRMS does not record the use or deployment of agency
27 bank staff, making it difficult to track the impact of
28 their use. More detailed research is recommended on
29 this. A detailed examination of control systems

1 relating to the use of agency and bank nursing and
2 midwifery staff within Trusts is also recommended."
3
4 Now, again, that relates to right across the
5 profession, but I'm just noting specifically the 10:15
6 recommendations of more detailed research and a more
7 detailed examination of control systems being
8 conducted. Are you aware if those recommendations were
9 followed up after 2009?
10 A. I'm not aware if they are, Mr. Doran, but we will try 10:15
11 and find that out and come back in the amended
12 statement.
13 43 Q. Yes. That's helpful. And can we go back then to page
14 26 and paragraph 6.8 of the statement. And at
15 paragraph 6.8 you refer to the NIPEC Review of Clinical 10:15
16 Supervision of Nursing in 2006?
17 A. That's correct.
18 44 Q. In paragraph 6.8, towards the bottom of that paragraph
19 you say:
20 10:15
21 "The report indicated that there was limited evidence
22 of widespread implementation of effective systems of
23 clinical supervision across nursing in Northern Ireland
24 and included a number of recommendations to help
25 standardising..." 10:16
26
27 Or, sorry, to help standardise approach. Do you see
28 that?
29 A. I do.

1 45 Q. The exhibit then is at -- the relevant exhibit is
2 Exhibit 54 and it's at page 2740. That's the cover
3 page. And I want to look at paragraphs 2.15 and 2.16
4 and they are at pages 2755 to 6. So if page 2755 could
5 be brought up, please? 10:16
6
7 So paragraph 2.15, this refers in more detail to the
8 survey:
9
10 "During 2005 NIPEC carried out a workforce development 10:17
11 survey of the Registrant Nursing and Midwifery
12 Population of Northern Ireland as part of the design of
13 variance components of the Development Framework
14 Project. A questionnaire was issued to the total
15 Registrant population (approximately 21,500) in 10:17
16 February 2005, resulting in a 35% response equals 7,500
17 response rate. The survey provided valuable
18 information in relation to Registrant learning and
19 development experience, including formal and informal
20 learning, appraisal activity, career development, 10:17
21 personal development planning, supervision and
22 participation in learning and development activities."
23
24 Then can we move on to the next paragraph, and that's
25 2.16: 10:18
26
27 "In relation to the above survey, when asked if they
28 had undertaken supervision sessions to support their
29 role, 67% of respondents said that they had no

1 supervision..."
2
3 And the number was 4754.
4
5 "Of those who did undertake supervision 33% of 10:18
6 respondents to this question (number 2273), 70% felt
7 the experience was beneficial or very beneficial.
8 There was strong evidence to suggest that those
9 employed in midwifery, including hospital and
10 community, mental health (including specialist roles in 10:18
11 hospital and community), or organisation wide
12 specialist posts are more likely (over 50%) to have
13 supervision sessions to support their roles than those
14 employed in other areas. Those employed within
15 emergency nursing, Intensive Care and theatres, 10:18
16 including specialist roles, surgical, et cetera..."
17
18 And I won't read out the rest - are the least likely to
19 have supervision sessions.
20 10:18
21 Now, just noting those paragraphs, can we then move on
22 to page 2791, please. And you'll see there, that there
23 are a number of action - recommendations or action
24 plans relating to the area of supervision. I'm not
25 going to go through them in any detail, but you can see 10:19
26 that the timescale there is given as April 2007 for the
27 regional standard on supervision, and then you have a
28 timescale of March 2008 for the framework, based on the
29 regional standard to be developed and implemented. And

1 scrolling down, please, you have various action points
2 and time scales of March 2008.
3
4 Now, are you aware, were those deadlines met in
5 relation to the specific area of supervision? 10:19
6 A. I don't have that information available, but we will
7 try and find it for you, Mr. Doran.
8 46 Q. Yes. Another question, obviously following on from
9 that, is how exercises of this kind actually filter
10 down to facilities such as Muckamore? 10:20
11 A. Again I will try and find if that information was
12 cascaded down specifically...(INTERJECTION)
13 47 Q. I suppose the further question then is: Has there been
14 work undertaken between then and now to assess whether
15 the supervision issue has been satisfactorily 10:20
16 addressed?
17 A. I wouldn't have that specific information, Mr. Doran.
18 48 Q. Yes. But that's a matter that can be checked?
19 A. We will check into it, yeah.
20 49 Q. Now, you then -- if we can go back to paragraph 6.9? 10:20
21 You refer to the -- that's back at page 27. You refer
22 to the Strategy, the Northern Ireland Strategy for
23 Nursing and Midwifery 2010 - 2015. And you refer to
24 that as a "high level road map for nursing and
25 midwifery over a five year period". I'm not going to 10:21
26 go into the detail of that report again, it's at a very
27 - a very high level. I wonder can we just have a look
28 briefly at the broad strategic themes of that report,
29 which appear at page 2839, please? And just if you

1 look at those, those obviously are very broad strategic
2 themes:
3
4 "Promoting person-centred cultures.
5 Delivering safe and effective care. 10:22
6 Maximizing resources for success.
7 Supporting learning and development."
8
9 Now, again, this is a high level document and I'm not
10 going to go into detail, but I just wanted to ask you a 10:22
11 question which relates to the mechanics of
12 implementation of a report of that nature. How does a
13 strategy document at that high level ultimately impact
14 on practise at ground level?
15 A. We would have different ways of implementing 10:22
16 strategies. I'm not sure how this specific strategy
17 was implemented, but any strategy that I have been
18 involved in you would have a number of action plans
19 which would have deliverables. I can give an example -
20 a different example, Mr. Doran, in terms of, for 10:22
21 example, strategy in autism.
22 50 Q. Yes.
23 A. Which we're currently delivering or developing. We
24 will have a two year delivery plan attached to that
25 strategy. So you would have your high level 10:23
26 objectives, as it says here, promoting person centred
27 cultures, delivering safe and effective care, et
28 cetera, and then you would have a number of action
29 plans below that that say "and here is what we will

1 deliver" and a timescale for delivery against those
2 specific actions. So your strategy sets the high level
3 direction of travel, if you like, and then you would
4 have deliverables beneath that in terms of actions to
5 be to deliver against the strategy. 10:23
6 51 Q. Again, the action plans presumably would be at a fairly
7 broad level. What about the individual facility
8 itself?
9 A. Action plans could be at a broad level or they could be
10 very specific, depending on the nature of the strategy. 10:23
11 As I say, each strategy would deal with different
12 issues. This strategy in particular, as you say, was a
13 high level roadmap. It wasn't specific to LD, it was
14 across nursing more generally. But if there was an
15 action plan in terms of, for example, the MDAG action 10:23
16 plan, there are specific deliverables against specific
17 areas, and we would track the progress against those
18 individual areas.
19 52 Q. But as -- yes, and as distinct from this kind of
20 document, that of course is specific to the facility at 10:24
21 Muckamore?
22 A. Specific to the facilities. Yes. Yes.
23 53 Q. Now, at -- if we go back the, please?
24 DR. MAXWELL: Can I just ask a question about that?
25 MR. DORAN: Yes, indeed. 10:24
26 DR. MAXWELL: So most action plans are processes, not
27 outcome focused. There are, by its very nature,
28 actions are processes. How do you measure - even if
29 you've implemented all the actions and all the

1 processes - you've achieved the desired outcome? So
2 there will have been a number of actions associated
3 with promoting person centred cultures, how do you know
4 if they've actually worked and delivered the desired
5 outcomes? 10:24
6 A. In terms of a change of culture that is probably more
7 difficult to measure, if I'm honest. Again, if you
8 don't mind, if I take the specific example I used on
9 autism. For example, you could say that you would want
10 somebody's assessment to be done within a set number of 10:25
11 weeks. So you'd be able to measure some of the
12 deliverables of that, which would feed-back up.
13 DR. MAXWELL: But that assumes that the assessment is
14 the right intervention. There's a lot of assumptions
15 in an action plan that the actions that have been set 10:25
16 will deliver the outcomes. Do you actually measure
17 outcomes or just the delivery of the actions?
18 A. No, you would measure how the actions deliver against
19 strategic aims of a strategy. So, I'm maybe not
20 answering your question very well, and I apologise, but 10:25
21 if you look at -- this would set the high level aims of
22 where we wanted to go of the roadmap. So there would
23 be things in terms of a change. If you look at a
24 change in culture, if that was me I would do some form
25 of baselining to say "What does the culture look like 10:26
26 at the minute?", and then at the end of that you would
27 do another assessment saying "Has that culture
28 changed?"...(INTERJECTION).
29 DR. MAXWELL: A sort of audit.

1 A. Yes.
2 DR. MAXWELL: Thank you.
3 54 Q. MR. DORAN: Yes. Now, I wanted to ask you then about
4 paragraph 6.12 to 6.16, and in those paragraphs you
5 refer to a number of specific workforce initiatives in 10:26
6 the area of learning disability, and I wanted to ask
7 about five matters arising from those paragraphs.
8 First of all, I just want us to understand the
9 sequencing, and let me give you my understanding and
10 you can correct me if I've got that wrong. First of 10:26
11 all, one had the UK-wide Modernising Learning
12 Disability Nursing Review in 2012. I think you deal
13 with that in paragraph 6.11.
14 A. Would you mind if I -- I have -- I've another paper
15 which hasn't been supplied to the Inquiry, but it 10:27
16 details a chronology, and I can supply that to the
17 Inquiry as well.
18 55 Q. There's no difficulty with that.
19 A. Thank you.
20 56 Q. So the UK-wide Modernising Learning Disability Nursing 10:27
21 Review was 2012?
22 A. It was, yes.
23 57 Q. And then there was a specific Northern Ireland Action
24 Plan first adopted in 2014 but later updated in 2016?
25 A. That's correct. 10:27
26 58 Q. In 2014 the Northern Ireland Learning Disability
27 Nursing Collaborative was established?
28 A. Yes, that's correct.
29 59 Q. The Department's workforce plan in the field of

1 learning disability was published in May 2016?
2 A. I think that's correct, yeah.
3 60 Q. I think you deal with that in paragraph 6.14.
4 A. Yes.
5 61 Q. And that's distinct from the Action Plan of course? 10:28
6 A. It is, yes.
7 62 Q. And then you refer at paragraph 6.15 to a review of the
8 learning disability nursing workforce, commenced in
9 2021?
10 A. Yes, Mr. Doran. 10:28
11 63 Q. Just, can I ask, does that review, the more recent
12 review, relate in any way to the strategic plan or
13 service plan that you referenced in your evidence on
14 the last occasion?
15 A. The work initiated in 2021 was as a direct result of an 10:28
16 action on the MDAG Action Plan. So that work is
17 ongoing at the minute and we do intend to provide the
18 details of that in the amended statement, but that work
19 is as a direct result from an action coming from, I
20 think it came from the Leadership and Governance Review 10:29
21 at Muckamore, but it is part of the MDAG Plan to
22 deliver that.
23 64 Q. So there's a nexus then between MDAG and this 2021
24 review?
25 A. There is, Mr. Doran. 10:29
26 65 Q. And I think you say the report of that process is
27 awaited?
28 A. It is. We have an interim report of that workforce
29 review at the minute and we can provide that to the

1 Inquiry.
2 66 Q. That's a matter that could be furnished by way of
3 exhibit to the next statement?
4 A. It could be, Mr. Doran, yeah.
5 67 Q. Yes. Now the second --that's the sequencing. The 10:29
6 second point that I wanted to ask you about arises from
7 paragraph 6.13, and let me just read in that paragraph.
8 You say:
9
10 "As part of the Action Plan a Northern Ireland Learning 10:29
11 Disabilities Nursing Collaborative was established in
12 2014 by the then Chief Nursing Officer in the
13 department to oversee the delivery of a number of
14 learning disability specific actions. The programme of
15 work is facilitated and supported by the Northern 10:30
16 Ireland Practice and Education Counsel and the
17 collaborative includes representation from the
18 independent sector, all five health and social care
19 trusts, educational providers and the public health
20 agency. NIPEC have produced a range of reports and 10:30
21 updates published on their website. I attach a copy of
22 the most recent progress report at Exhibit 58."
23
24 Then you say:
25 10:30
26 "Following a decision in 2019 by the UK CNOs to stand
27 down the strengthening and the commitments groups,
28 along with the commissioning of a review of the
29 Learning Disabilities Nursing Workforce in Northern

1 Ireland around the same time, the collaborative was
2 reestablished in September 2022 as the Registered Nurse
3 Learning Disabilities Strategic Development Project
4 Group."
5 10:31
6 Now, my question then is, does that mean that the
7 collaborative was stood down between 2019 and 2022?
8 A. I would need to check the specific detail on that,
9 Mr. Doran, but that's certainly how it would read in
10 the statement, but could I come back and clarify 10:31
11 whether it was stood down between those times, because
12 I wouldn't like to mislead the Inquiry.
13 68 Q. Yes. Yes. It would just be -- the Inquiry would
14 obviously be interested in finding out whether or not
15 there was a hiatus in the work of that group during 10:31
16 that period and, if so, why, and how that hiatus was
17 addressed?
18 A. I will clarify that.
19 CHAIRPERSON: Could I just ask a very basic question,
20 which my colleagues probably know the answer to, and 10:31
21 its entirely my ignorance, but going back to your 6.11
22 you talk about the 2012 UK Modernising Learning
23 Disabilities Nursing Review, and then at 6.12 you say:
24
25 "In response the Department launched in 2014 the 10:32
26 Northern Ireland Action Plan."
27
28 And then again in 6.14 I think - no, in 6.13 you're
29 talking about the UK CNOs. To what extent are things

1 like the 2012 review simply read across into Northern
2 Ireland, and to what extent does Northern Ireland take
3 that review and then you have to develop your own? I'm
4 afraid it's a fundamental lack of knowledge by me.
5 A. I will try and answer as best I can, Chair. I think if 10:32
6 you look at paragraph 6.11 and exhibited at MMCG 56,
7 there are some specific Northern Ireland aspects to
8 that. For example, at page 2890, it would give a
9 comparison of learning disability nurses in GB and
10 Northern Ireland. So there are some specific Northern 10:33
11 Ireland references to that. At page 2968, in reference
12 to paragraph...(INTERJECTION).
13 MR. DORAN: Sorry to intervene, Mr. McGuicken. We can
14 have those pages brought up on screen if that would be
15 helpful, Chair. 10:33
16 CHAIRMAN: Yeah. Yeah.
17 MR. DORAN: What was the first page again?
18 A. 2890.
19 69 Q. 2890, please.
20 A. At the bottom of that page it does give the comparison 10:33
21 in terms of registered nurses across Northern Ireland
22 compared to other areas of GB. So there are some
23 specific Northern Ireland aspects to that overall
24 UK-wide report. At page 2968 - I think it is 2968 but
25 I've maybe got that page wrong. 10:33
26 CHAIRPERSON: It doesn't look like it.
27 MR. DORAN: That's 2868.
28 A. 2968 that then gives the Northern Ireland Actions,
29 which came out then of the Northern Ireland Learning

1 Disabilities and Nursing Collaborative, and the action
2 plan from there. So there are - it's not that we would
3 simply lift what is happening elsewhere in GB or UK, or
4 the Republic of Ireland indeed, but there are some
5 specific Northern Ireland actions coming out of those 10:34
6 reports.
7 CHAIRPERSON: Sure. And I think it arises later when
8 you talk about NICE, things like NICE Guidelines.
9 They're not simply read across.
10 A. Yes. No, they are adapted or... 10:34
11 CHAIRPERSON: Yeah. Exactly.
12 A. Adapt is probably the best word for Northern Ireland
13 specific circumstances.
14 CHAIRPERSON: Yes. Thank you very much.
15 A. And I think that reflects, Chair, again where we have 10:34
16 an integrated care system in Northern Ireland that you
17 wouldn't have in GB. So some of these issues would
18 need to be adapted,and Northern Irelandised, and
19 apologies as that's tried to be typed, but you know
20 what I mean. 10:35
21 CHAIRPERSON: Yeah. No, I understand. Yeah. Well I
22 think that's an important point. Thank you.
23 70 Q. MR. DORAN: The third of the five matters that I wanted
24 to address arises from the report on the Workforce Plan
25 for Nursing and Midwifery from 2016 that you mention at 10:35
26 paragraph 6.14, and I just wanted to bring up - it's
27 Exhibit 59 at page 2978. So that's the cover page - A
28 Workforce Plan for Nursing and Midwifery in Northern
29 Ireland 2015 - 2025. And you highlight in your

1 statement a specific recommendation about a review of
2 learning disabilities programs to help future-proof the
3 workforce, and I just wanted to look at the precise
4 recommendation, it's at page 3053. And I wonder if we
5 could scroll down, please, it's at -- if you keep 10:36
6 scrolling down, please, it begins with "Review", and if
7 you just scroll down further. Scroll up again, please?
8 Yes, at point 8, it's the second sentence in point 8:
9
10 "Review and future-proof the mental health and learning 10:36
11 disability nursing programs to ensure the workforce is
12 equipped to fulfil an increasing public health role,
13 manage and provide interventions to those with
14 co-morbidities and/or complex physical and mental
15 health needs." 10:37
16
17 Can you say whether that recommendation was acted on at
18 the time, or does that form part of the review that was
19 initiated in 2021, or has it been subsumed within that
20 review? 10:37
21 A. I can't say whether it was -- it was taken forward at
22 the time. It wouldn't be specific to the review which
23 is currently undertaking. The review that we're
24 currently undertaking looks more at how many staff
25 would be in post, the age profile, et cetera, of staff 10:37
26 in post, the qualifications of staff in post. So it
27 wouldn't -- that is a particular theme under education
28 programs and commissioning, so it wouldn't be part of
29 the review that we're currently undertaking. But,

1 again, I wouldn't be able to say at this stage,
2 Mr. Doran, if it has been specifically taken forward,
3 but I will endeavour to find that out.
4 71 Q. Thank you. And the fourth point then relates to the
5 work that was started in 2021 to review the learning 10:38
6 disability nursing workforce across Northern Ireland,
7 to include all sectors, and I think to an extent you've
8 answered that already. My question was going to be:
9 is there any nexus between that initiative and the
10 concerns over what had occurred at Muckamore? 10:38
11 A. Well, it is, as I've said previously, it is as an
12 action of the MDAG Action Plan.
13 72 Q. So really the 2021 initiative is as a consequence of
14 the revelations at Muckamore?
15 A. I'm not sure whether I would say it is as a direct 10:38
16 consequence, but it certainly is one of the
17 recommendations that we'd look at the learning
18 disability workforce and do some planning for future
19 needs as well.
20 73 Q. Now the final point that I have arising from these 10:39
21 paragraphs, and just by way of explanation, one matter
22 of obvious interest to the Inquiry is whether the
23 number and skills of ward staff was sufficient for safe
24 care, and you've referred to the action plans, you've
25 referred to the review that's being undertaken in 2021, 10:39
26 and in -- back to your statement at page 27, sorry,
27 page 28 at paragraph 6.15, you refer in the second
28 sentence:
29

1 "The need for continued reflection on the profession
2 and the role of the learning disability nurse is a
3 healthy method of addressing the evolving needs of the
4 learning disability population."
5 10:40
6 Now, you may not be best qualified to respond to this,
7 but improving the skills of the workforce is one thing,
8 but I suppose the next step is to evaluate the extent
9 to which that impacts on the actual quality of service
10 provided, and the extent to which it actually meets the 10:40
11 needs of learning disability patients. Has any work
12 been done or is any work being done to evaluate those
13 matters?
14 A. I think you're correct in saying that I wouldn't be
15 qualified to answer that question. This statement was 10:40
16 largely in terms of the policies as opposed to the
17 qualitative nature of whether those policies have been,
18 you know, how effective they have been. Part of the
19 recommendations you showed previously was in terms of
20 learning and development, and there is continuous 10:41
21 professional development across all spheres of the HSC,
22 including learning disability and nurses. So there
23 would be continuous development. As to the qualitative
24 assessment of how effective that has been, I wouldn't
25 be professionally qualified to give an assessment on 10:41
26 that.
27 74 Q. It's just a matter of evaluation of impact really that
28 I am getting at. But presumably that is a matter of
29 interest to the Department?

1 A. Could you may be clarify the question, Mr. Doran,
2 sorry?
3 75 Q. Well, I suppose when one introduces measures to improve
4 the skills of the workforce, or even augment the
5 numbers employed in a particular discipline, the next 10:41
6 question then is whether that actually leads to an
7 improvement of the service on the ground?
8 A. Yeah.
9 76 Q. And whether it actually meets the needs of individuals,
10 for example, who have particular learning disabilities, 10:42
11 and what I'm asking about is whether or not steps have
12 been taken to evaluate those impacts in the course of
13 the work that has been done in the past and that is
14 ongoing in terms of improving the skills of the
15 profession? 10:42
16 A. Certainly the work that's ongoing at the minute is more
17 a look at numbers as opposed to quality and age
18 profiles. I mentioned earlier around age profile and
19 certain degree looking towards the future at what we
20 would need to put in place for learning disability 10:42
21 resources going forward. I'm not aware of any
22 qualitative assessment on how effective that has been.
23 77 Q. But perhaps am I right in saying that the work is
24 centred on the workforce rather than the individuals
25 who will be availing of the services? 10:43
26 A. This current review is in terms of the workforce
27 review, yes.
28 78 Q. Now, you then go on to refer to the work of the Nursing
29 and Midwifery Tasked Group at paragraphs 6.17 to 6.19,

1 and you provide the report of that group's work at
2 Exhibit 60. And that's, for the record, at page 3068.
3 I'm not going to go to that report. It was launched
4 relatively recently in March 2020. I mean that again
5 is a very high level report. Am I right in saying that 10:43
6 there is no specific reference to learning disability
7 or mental health in that report and it's
8 recommendations?
9 A. Well, all of the recommendations - the report, as you
10 say, the report was launched in 2020 and it was around 10:44
11 a future agenda. It does reflect the vision set out in
12 the Health and Well-Being Delivering Together Vision,
13 which I attached earlier at exhibit MMCG 5, but you're
14 right, it is a high level - again, I use the term
15 "roadmap", but it is a high level aspiration. 10:44
16 79 Q. The final point that I wanted to ask you about on this
17 topic relates to the professional alerts policy, and at
18 paragraph 6.20 on page 30, you say:
19
20 "The Department operated a professional alerts policy 10:45
21 for registered nursing staff that I have included
22 at..."
23
24 Sorry:
25 10:45
26 "...Exhibit 61. This policy was revoked in December
27 2022 and has not been replaced. I have included a copy
28 of the letters to all relevant health and social care
29 bodies confirming this at Exhibit 62."

1

2 And I just wanted to ask you about that policy. It's
3 at Exhibit 61 page 3166. If that could be brought up,
4 please? So that's the cover page and it's titled "The
5 Health and Social Care General Provisions No. 2 10:45
6 Direction Northern Ireland 2010", and this is
7 essentially a scheme for the issuing of alerts relating
8 to healthcare professionals in Northern Ireland, isn't
9 that correct?
10 A. That's correct. 10:46
11 80 Q. And it relates to nurses, midwives, and allied health
12 professionals?
13 A. That's my understanding, yes.
14 81 Q. And can we just look at page 3168, please? I just
15 wanted to look at the first couple of paragraphs. 10:46
16
17 "The issue of an alert is a way by which health and
18 social care bodies and professional organisations, as
19 listed in Appendix 1, can be made aware of a registered
20 healthcare professional whose performance or conduct 10:46
21 gives rise to concern that patients, staff or the
22 public may, in future, be at risk of harm either from
23 inadequate or unsafe clinical practice or from
24 inappropriate personal behaviour. It is also a means
25 of ensuring that health and social care organisations 10:46
26 are made aware of a healthcare professional that may
27 pose a threat to patients, staff or the public because
28 their conduct seriously compromises the effective
29 functions of a team or delivery of a service.

1
2 The alert system is intended to cover those situations
3 where a health and social care employer considers that
4 a member of their healthcare staff may pose a threat to
5 patient safety if they worked in that professional 10:47
6 capacity.
7
8 The alert system is not part of either the HSC
9 Employees Disciplinary Process or Statutory Regulatory
10 Framework. It is an integral part of the system for 10:47
11 preemployment checks. It is intended as a means of
12 alerting prospective employers to check that the
13 applicant's employment record is complete and
14 appropriate references are obtained and that
15 information relevant to safe employment is known in 10:47
16 advance of an appointment being made."
17
18 I wonder could we then just look at page 3169. It's
19 the next page. And I'm not going to read all of this
20 out, but just the paragraph beginning - paragraph 7, 10:48
21 triggering an alert.
22
23 "An alert may only be issued by the chef professional
24 officer, DH SSPS, and only where it considered that an
25 individual poses a significant risk of harm to 10:48
26 patients, staff or the public, and intends or may
27 intend to seek permanent or temporary work in the
28 NHS/HSC in that capacity and there is a pressing need
29 to issue an alert notice. Other bodies may also

1 request the issue of an alert (see paragraph 17 -18)."
2
3 Now, I'm not going to go through all of the document,
4 but you say that that policy was revoked very recently.
5 Isn't that correct? 10:48
6 A. Yes, in December 2022.
7 82 Q. December 2022. And you provide then a letter
8 explaining this and confirming this to all health and
9 social care bodies, and that is at page 3177. If that
10 could be brought up, please? And if we just scroll 10:49
11 down:
12
13 "Dear colleagues,
14 Revocation of scheme for issue of alert notices.
15 10:49
16 The Department of Health has completed an internal
17 review of the operation of the scheme for the issue of
18 alert notices for health and social care professionals
19 in Northern Ireland.
20 10:49
21 The scheme only applied to those in the applicable
22 professions in Northern Ireland and was not replicated
23 across the rest of the United Kingdom.
24
25 Following the conclusion of this review, Minister of 10:49
26 health, Robin Swan, has accepted the recommendation to
27 stand down the scheme.
28
29 The Department made a direction to that effect - The

1 Health and Social Care General Provisions No. 2
2 Revocation Directions Northern Ireland 2022 - today. A
3 copy is attached for your records."
4
5 And then the letter goes on to say: 10:50
6
7 "You will be aware that the scheme applied to the three
8 professional groups; nurses, midwives and allied health
9 professionals. These professions are governed by the
10 Nursing and Midwifery Council (NMC) and the Health and 10:50
11 Care Profession Council (HCPC) respectively. The key
12 duty of both regulators is to protect the public by
13 making sure all registrants are safe, meet the
14 standards of training and skills, and have up-to-date
15 knowledge of their practise and expected behaviours." 10:50
16
17 Then if you just scroll down, please? The letter goes
18 on to say:
19
20 "As a result of the decision to stand down the 10:50
21 professional alerts process, going forward all future
22 concerns regarding fitness to practise will not require
23 notification under the DOH professional alerts process
24 and should be referred directly to the appropriate
25 regulatory body. Employers should ensure that they 10:51
26 review their policies and remove any reference to
27 seeking the issue of an alert from these with immediate
28 effect."
29

1 Now, can you say anything more about the background to
2 that decision? Are you aware of what triggered the
3 internal review that's referred to in the letter?
4 A. I'm not, Mr. Doran. I am aware that the Chief Nursing
5 Officer, Maria McIlgorm had - I think it was previous 10:51
6 experience in Scotland before she came to Northern
7 Ireland, or it may have been elsewhere in England -
8 certainly it was in wider GB. So I am assuming, which
9 is potentially incorrect, that that experience she had
10 elsewhere in the jurisdictions, she brought that back 10:51
11 to Northern Ireland when she came here. As the letter
12 clearly says, it brings Northern Ireland in line with
13 the other GB jurisdictions in terms of those reporting
14 going directly to the oversight bodies as opposed to
15 coming into the Department. 10:52
16 83 Q. And that's the effect of this decision?
17 A. It is, yes.
18 84 Q. So the alert system now operates outside the Department
19 essentially?
20 A. It does. It brings it in line with the other parts of 10:52
21 the jurisdiction.
22 85 Q. And I wonder...(INTERJECTION)?
23 CHAIRPERSON: I think Dr. Maxwell may
24 just...(INTERJECTION)
25 DR. MAXWELL: Can I clarify this? So this system used 10:52
26 to work in the rest of the UK and it was challenged
27 from a legal basis that there were things that were not
28 on somebody's record. So it was certainly stopped in
29 England more than 10 years ago. And as this policy

1 says, if employers have concerns about somebody's
2 practice, they should refer to their regulator, and I
3 suspect Maria McIlgorm knows that Scotland stopped
4 doing it because of the legal challenge, and it was
5 probably on legal advice. Certainly it was more than 10:52
6 10 years ago it was stopped in England, but it was
7 across the whole of the UK at one point.
8 MR. DORAN: Yes. That's something we can certainly
9 explore perhaps. I wonder could a copy of the internal
10 review be brought to the attention of the Inquiry? 10:53
11 A. We'll certainly seek that and, if appropriate, we will
12 provide it to the Inquiry.
13 86 Q. Yes. That would certainly assist with getting to the
14 bottom of the rationale for taking this step in this
15 jurisdiction. 10:53
16 CHAIRPERSON: Can I also just check, in your paragraph
17 6.20, whether a minor amendment needs to be made?
18 Because you say:
19
20 "The Department operated a professional alerts policy 10:53
21 for registered nursing staff..."
22
23 But actually the alert letter covers allied health
24 professionals, which would cover, physios, OTs.
25 A. I'm happy to make that amendment, Chair. 10:53
26 CHAIRPERSON: Sure. We can do -- I mean it is now on
27 the transcript, but I think to be strictly accurate it
28 actually covers a wider section.
29 A. Apologies for that, Chair.

1 CHAIRPERSON: No, no, no. Not at all. Thank you.
2 87 Q. MR. DORAN: Just my next question actually also relates
3 to the wording of that paragraph, and you say that the
4 policy was revoked and has not been replaced. I take
5 it that there is no suggestion that it will be 10:54
6 replaced? That this is intended to be a permanent
7 development.
8 A. That would be my understanding, because it brings us in
9 line, as I say, with the other GB jurisdictions. And a
10 very helpful intervention from the Panel. 10:54
11 88 Q. Yes. Thank you. Now, the next topic, Topic 3(C),
12 relates to policies regarding restraint and/or
13 seclusion. Chair, Panel, do you wish to take a short
14 break at this stage?
15 CHAIRPERSON: Well, if we can keep going for say 15 10:54
16 minutes? I'm just aware that we're only going to take
17 one break this morning.
18 MR. DORAN: Yes.
19 CHAIRPERSON: It's 11:00 o'clock now. We've got a way
20 to go. Can you keep going for 10 or 15 minutes? 10:54
21 MR. DORAN: No problem with that at all. I'm just
22 conscious of the fact that we're referring to quite a
23 lot of documents in some detail and it requires focused
24 attention...
25 CHAIRPERSON: If the witness needs a break. Shall we 10:55
26 try and keep going for 10 minutes, to another section?
27 MR. DORAN: I'm more than happy to do that.
28 CHAIRPERSON: You don't mean that, Mr. Doran, but!
29 MR. DORAN: You can see me smile, Chair.

1 89 Q. Now, as I say Topic 3(C) relates to policies regarding
2 restraint and/or seclusion, and you deal with those at
3 paragraphs 7.1 to 7.10, and I have just a few questions
4 arising from this material.
5 10:55
6 You have provided at Exhibit 64 the 2005 Guidance that
7 was issued on these topics, and if I could just have
8 that brought up, please? It's at page 3181. I should
9 say this is a very detailed document. I'm not going to
10 be digging into it in any detail. So that's the 2005 10:56
11 Guidance on Restraint. And I just wanted to look at
12 page 3187, because that provides us with a list of who
13 should read the guidance. And if we just have a look.
14 I should say, Chair, I'm drawing attention to some of
15 this material for the assistance of the Panel and core 10:56
16 participants, not just to ask the witness questions.
17 CHAIRPERSON: Yes. Exactly. Thank you.
18 MR. DORAN: So that gives us the list of who the
19 guidance is intended to be used by, and it refers to:
20 10:56
21 "Service commissioners in the health and social care.
22 Managers of health and social care services.
23 Staff professionals working with children and adults
24 who may require to use restraint and/or seclusion.
25 Internal monitors of services and/or facilities. 10:57
26 Persons responsible for the operation of independent
27 sector services or homes.
28 Registration and inspection staff.
29 Trainers and training providers."

1
2 And then the document goes on to say:
3
4 "The information in this guidance may also be helpful
5 to: 10:57
6 Parents and those with parental responsibilities.
7 Health and Social Services councils.
8 The Mental Health Review Tribunal.
9 The Mental Health Commission.
10 Independent advocates. 10:57
11 Service users."
12
13 And then at - so it was intended to be used far and
14 wide really within the health and social care system,
15 isn't that correct? 10:57
16 A. I think that list covers just about everybody who would
17 be within the system, Mr. Doran.
18 90 Q. Yes. And the covering letter then is at page 3179 to
19 3180, and that's -- if that could be brought up,
20 please? 3179. And that's a letter from the Director 10:58
21 of Regional Strategy and Personal Safety. If we could
22 just scroll up a little bit again, please? So it's
23 directed to the Chief Executives of Health and Social
24 Care Trusts, and the Chief Executives of Health and
25 Social Services Boards. 10:58
26
27 Now just if you could just scroll down then the letter,
28 please. The letter reads:
29

1 "I am pleased to attach the document 'Guidance on
2 Restraint and Seclusion in Health and Personal Social
3 Services' produced by the Human Rights Working Group
4 which was formed to look at the issues from a human
5 rights perspective." 10:58
6
7 Now, if you could scroll down again, please, and again
8 just further down the letter I just wanted to draw
9 attention to one paragraph, and it's the paragraph
10 beginning: 10:58
11
12 "The guidance is entirely the product of the working
13 group established to look at the issues and does not
14 constitute formal guidance issued by the Department.
15 However, the guidance is commended to you as having a 10:59
16 useful contribution to make to the development of
17 operational policies and procedures on the use of
18 restraint and seclusion across HPSS to ensure both
19 service users' safety and the protection of staff."
20 10:59
21 Now, I just wanted to ask about that. Why was that not
22 - you may not be able to answer this personally, but I
23 wonder why was that not done by way of formal guidance
24 issued by the Department?
25 A. I think because this was guidance which was developed 10:59
26 externally to the Department. So the Department,
27 maybe, therefore wouldn't -- I think in the terminology
28 that has been used "The guidance is commended to you as
29 having a useful contribution", I think it goes slightly

1 further at paragraph 3190 where it says "The guidance
2 by providing a clear framework" -- sorry, if you could
3 maybe...
4 91 Q. Let's just bring 3190 up on the screen?
5 A. It is paragraph 1.6. 11:00
6 92 Q. Is this within the document itself?
7 A. It's the next exhibit. Apologies, Mr. Doran.
8 93 Q. No need to apologise. So this is the actual Guidance
9 itself I think, isn't it, Exhibit 64?
10 A. Yes. 11:00
11 94 Q. Yes.
12 A. So I think that's slightly clearer in terms of saying
13 that the Trust should use this guidance to inform the
14 production of policies and procedures on the use of
15 restraint and/or seclusion. So in commending the 11:00
16 Guidance to Trusts, basically my reading that of would
17 be at 1.6, it goes further than simply commending. But
18 the language, it's not language that I would use in a
19 guidance document today, but I can't speak to why it
20 was used at that stage, Mr. Doran. 11:01
21 95 Q. Yes, because the sentence to which you've drawn
22 reference of course appears in the document itself?
23 A. Yes. In the guidance document.
24 96 Q. Yes. But the covering letter which is coming from the
25 Department to the Heads of the Trusts is saying "This 11:01
26 is not formal instruction from the Department".
27 A. It's guidance.
28 97 Q. It's guidance from another source. So, I mean is there
29 a risk that that wording can cause a document to be

1 given somewhat less weight than it ought to be given?
2 A. I wouldn't like to speculate on that, Mr. Doran. As I
3 say, it wouldn't be language that I would use in a
4 guidance letter to Trusts today.
5 98 Q. Would you tend to use more directive language then? 11:01
6 A. It depends on the circumstances, but I wouldn't use
7 that language.
8 99 Q. Now, just going back to the statement at page 32,
9 paragraph 7.9. You refer to the Mental Health Action
10 Plan that was published by the Department on the 19th 11:02
11 May 2020 with the Action Plan subsequently being
12 superceded by the Mental Health Strategy 2021 - 2031,
13 published in June 2021, and you exhibit the action plan
14 at page 3312 - if that could be brought up, please? So
15 that's the cover page. And can we move then to page 11:02
16 3330? And if we could just hone in then on Action Plan
17 or Action 6.5? That refers to review, restraint and
18 seclusion:
19
20 "Review of restraint and seclusion. Final report to 11:03
21 contain regional policy on restrictive practices in
22 seclusion and regional operating procedures for
23 seclusion. Review to be completed by December 2020.
24 Outcomes to be implemented by April 2021. Intended
25 outcome is better patient care and safe practice." 11:03
26
27 And the indication is that the review will be completed
28 by December 2020, implementation by April 2021, and
29 there's a costing of up to £30,000 given in the report.

1
2 Now can I ask, were those targets met or has that
3 exercise been totally incorporated within the
4 consultation process to which you refer in paragraph
5 7.10? 11:04
6 A. My understanding is that the consultation process was
7 specifically in relation to the new policy. Now, I'm
8 not sure that those specific targets were met and they
9 were probably impacted significantly by the pandemic at
10 the time. That - the new policy on restraint and 11:04
11 seclusion has now been published and we're more than
12 happy to provide a copy of that to the Inquiry. It has
13 only been published in recent months, Mr. Doran.
14 100 Q. Since your statement was made?
15 A. Yes, it has. Yeah. We will provide a copy to the 11:04
16 Inquiry.
17 101 Q. No difficulty with providing that. Now, I just wanted
18 to ask on the issue of restraint and seclusion, did the
19 Department have any system in place for auditing the
20 use of restraint and seclusion at health care 11:04
21 facilities?
22 A. I'm not sure that would be a role of the Department.
23 To answer your question directly, I do not think we did
24 have a policy or a way of monitoring that in specific
25 establishments, but I would suggest it would not have 11:05
26 been a role for the Department to undertake.
27 102 Q. Who would that responsibility lie with?
28 A. Well I think the responsibility would lie with
29 individual Trusts to undertake - to record incidences.

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1 Let me may be clarify that. Seclusion and restraint
2 can be used in a wide variety of ways. It can be
3 simply for someone's safety. It could be a seatbelt on
4 a bus or it could be a seatbelt on a wheelchair for
5 someone's safety. It can also then be used in more 11:05
6 challenging circumstances in terms of seclusion where
7 someone may be held in a room on their own for specific
8 incidents or specific periods of challenging behaviour.
9 So there are normal everyday occurrences of the use of
10 seclusion and restraint, so I don't think they would be 11:06
11 routinely recorded, because it is just part of normal
12 practice and it would be part of someone's care plan as
13 such. So they wouldn't be recorded. Where there was
14 inappropriate use of seclusion and restraint, I would
15 expect that to be highlighted through Trusts and then 11:06
16 in through to the Board, but I can clarify that for
17 you.
18 103 Q. Well I was going to ask: What if there were a trend of
19 -- that showed -- or, sorry, a trend that showed an
20 increase in appropriate use of restraint and seclusion? 11:06
21 CHAIRPERSON: Sorry, do you mean "inappropriate"?
22 MR. DORAN: How would that
23 information...(INTERJECTION).
24 CHAIRPERSON: Inappropriate use.
25 104 Q. MR. DORAN: Sorry, inappropriate use of restraint and 11:06
26 seclusion, how would that filter it's way through to
27 the Department?
28 A. Well, we come later in the statement to the issue of
29 early alerts and serious adverse incidents. So if

1 there was a trend, if you like, or if there was an
2 inappropriate use nowadays, I would expect that to be
3 highlighted through an early alert to the Department.
4 105 Q. Sorry to interrupt you.
5 A. No, go ahead, Mr. Doran. 11:07
6 106 Q. Could that potentially be categorised as a serious
7 adverse incident?
8 A. I think the inappropriate use of restraint would be
9 clarified -- would be -- it depends on the severity of
10 it, because a serious adverse incident has, you know, 11:07
11 there is a threshold for a serious adverse incident.
12 So the inappropriate use of seclusion and restraint I
13 would suggest would be more in terms of an early alert
14 to the Department, and some -- even within my time in
15 the Department, some of those issues have been 11:07
16 escalated by way of early alert. So I don't think they
17 would necessarily meet the threshold of a serious
18 adverse incident, but they on occasions would meet the
19 threshold for an early alert to the Department.
20 107 Q. We'll deal with those matters later, as you say. But 11:07
21 you've helpfully pointed out the distinction between
22 serious adverse incidents and early alerts?
23 A. Yes.
24 108 Q. You're saying one can have early alerts in relation to
25 matters that aren't necessarily serious adverse 11:08
26 incidents?
27 A. They can.
28 109 Q. And an incident that is classified other than as
29 serious could end up being referred to the Department

1 by way of an early alert?
2 A. There's a number of set criteria that a clinician would
3 assess in terms of an early alert. I think there's six
4 criteria that they would examine any incident against
5 and alert that to the Department. 11:08
6 CHAIRPERSON: Could I just ask whether that has
7 changed, to your knowledge, since 2017? Is there
8 sensitivity to this because of what is said to have
9 happened at Muckamore?
10 A. I think we come to when the early alert system was 11:08
11 introduced, Chair. I don't have that detail at this
12 section of my statement, but we do come to it later.
13 So, apologies.
14 CHAIRPERSON: Okay.
15 MR. DORAN: We are going to be looking at that issue a 11:08
16 little bit later, Chair.
17 CHAIRPERSON: Yeah. All right. Would that be a
18 convenient moment, Mr. Doran?
19 MR. DORAN: Very much so.
20 CHAIRPERSON: All right. Okay. Well we'll take 15 11:09
21 minutes. We'll try and sit back at half past eleven.
22 Obviously if you need to speak to anybody you can, but
23 let Mr. Doran know. Thank you very much indeed.
24
25 SHORT ADJOURNMENT 11:11
26
27
28
29

1 THE HEARING RESUMED, AS FOLLOWS, AFTER THE SHORT
2 ADJOURNMENT
3
4 CHAIRPERSON: Thank you.
5 110 Q. MR. DORAN: So, Mr. McGuicken, we're going to be 11:29
6 looking now at safeguarding policies, that's Topic
7 3(D), and that begins at paragraph 8.1 of your
8 statement. Again you've exhibited a number of
9 documents, I'm not going to be examining these
10 documents in detail in oral evidence. It appears from 11:29
11 paragraph 8.5 that the first formal multiagency
12 protocol for joint investigation of alleged and
13 suspected cases of abuse of vulnerable adults was
14 published in December 2003?
15 A. That's correct. 11:29
16 111 Q. Is that right? And that involved, for the first time,
17 a formal arrangement between the Department, the PSNI,
18 the Health and Social Care Trusts, or the Boards and
19 the Trusts?
20 A. That's my understanding, yeah. 11:29
21 112 Q. And you refer also to guidance that was issued by the
22 Department in 1996 at paragraph 8.6, and you say you're
23 not able to locate that at the moment. Any success on
24 that front?
25 A. There hasn't been, Mr. Doran, apologies. We have done 11:30
26 an extensive search but we haven't been able to find
27 that guidance.
28 113 Q. That will obviously be a matter of interest as it
29 touches on the early years of the terms of reference?

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1 A. We will certainly continue to look, and if we find it
2 we will provide it to the Inquiry.
3 CHAIRPERSON: Can we just pause? My transcript, for
4 some reason -- I don't know if anybody else has got
5 problems? Sorry? Yeah, it has come up as a new 11:30
6 transcript, and I don't know why that is? But it means
7 the day is separated. We can't do anything about it.
8 Okay. Right. We are where we are. Sorry to interrupt
9 you.
10 114 Q. MR. DORAN: Thank you, Chair. And you indicate that 11:30
11 there have been three versions of the protocol; 2003,
12 2009 and 2016?
13 A. That's correct.
14 115 Q. Is 2016 the current?
15 A. That's my understanding. 11:31
16 116 Q. Yeah. Now, you also provide a number of documents
17 dating from 2006, 2010, and 2015 that set out Regional
18 and Policy Guidance on Safeguarding?
19 A. Yes, that's in the statement, yep.
20 117 Q. Yes. Now I just wonder from a lay perspective can you 11:31
21 explain how those two different documents work
22 alongside each other? On the one hand the protocol and
23 on the other hand the regional guidance.
24 A. My understanding is the protocol is a formal agreement
25 between the signed parties - as you say the Department 11:31
26 of Health or, sorry, the PSNI, the Board and the RQIA.
27 So that is a formal agreement. The guidance would, in
28 my understanding, would be in terms of the
29 operationalisation of that. The joint investigation

1 protocol is the protocol of how an investigation would
2 be undertaken by those parties, whereas the guidance is
3 a more generic document providing advice.
4 118 Q. And I suppose whereas the protocol is reactive in
5 nature, the guidance is in one sense seeking to be 11:32
6 preventative?
7 A. Yes, that would be correct.
8 119 Q. So it's seeking to suggest measures that might be
9 adopted to prevent risk?
10 A. Whereas the protocol is, as you say, more reactive. 11:32
11 Once something has happened then the protocol
12 investigation is invoked at that stage.
13 120 Q. Yes. Can I ask, who is responsible for ensuring that
14 staff are appropriately trained to work in accordance
15 with the protocol? 11:32
16 A. Could I ask, Mr. Doran, which specific exhibit that is,
17 just so that I can...
18 121 Q. Oh, yes, certainly. Let's look at the most recent
19 version of the protocol itself, which is at - let me
20 just have a look. The most recent version I think is? 11:33
21 CHAIRPERSON: Is it 2016?
22 MR. DORAN: It's the 2016 document?
23 CHAIRPERSON: It's paragraph 8.17.
24 122 Q. MR. DORAN: Oh, yeah, paragraph 8.17 on page 37, and
25 the exhibit is Exhibit 73, and that's at page 3716. If 11:33
26 that could be brought up, please? Thank you. And if
27 you can scroll down. Ask and let's look, for example,
28 at paragraph 1.6, if you could scroll down, please?
29 So, Roles and Responsibilities of Key Agencies. And

1 first of all you have the Health and Social Care
2 Trusts, and if you could scroll down, please? Then you
3 have the HSC Regional Emergency Social Work Service.
4 And scroll down further, please? PSNI. The PPS. The
5 RQIA. So within the health and social care sector 11:34
6 primary responsibility for operating the protocol
7 appears to be with the Trusts?
8 A. With the Trusts. And I think with the Board as well.
9 123 Q. Yes. So -- and that's now SPPG presumably?
10 A. SPPG, yeah. 11:35
11 124 Q. So...
12 A. So in effect the Department.
13 125 Q. Yes. And are you aware of any specific training that
14 is given in respect of the operation of the protocol?
15 A. I'm not, but we can check out and come back to the 11:35
16 Inquiry around any specific training.
17 126 Q. Yes. Now, I have a -- if we can go back to the
18 statement, please, at page 36, at paragraph 8.15.
19 Sorry 8.14 first of all. You say at 8.14:
20 11:35
21 "The RQIA's mental health and learning disability team
22 incorporated the theme of safeguarding into a planned
23 programme of inspections for 2011 to 2012. The report
24 of these inspections in 2013 summarised the findings
25 from 33 inspections carried out between December 2011 11:36
26 and July 2012 and contain two recommendations to ensure
27 the continued safeguarding and protection of children
28 and vulnerable adults. A follow-up report was
29 published in 2015."

1

2 So those are RQIA reports, isn't that right?

3 A. They are, Mr. Doran. And they're published on the RQIA

4 website.

5 127 Q. Yes. And, indeed, we'll be hearing evidence from RQIA 11:36

6 at a later stage.

7

8 You go on in paragraph 8.15 to say:

9

10 "The Northern Ireland executive identified safeguarding 11:36

11 adults at risk as a priority in their Program For

12 Government 2011 to 2015. In response the Department in

13 partnership with the Department of Justice developed

14 and published further guidance "Adult safeguarding -

15 Prevention and Protection" in partnership in July 11:37

16 2015."

17

18 And you attach that at Exhibit 72, and that replaced

19 the 2006 Guidance that you referred to earlier in the

20 statement. 11:37

21

22 Now, I just wanted to ask you about this. Presumably

23 those two matters you deal with in paragraphs 8.14 and

24 8.15 are linked. So, first of all, you have the RQIA

25 inspections and the report, and then you have the 11:37

26 executive identifying safeguarding adults at risk as a

27 priority in the Program For Government. Presumably

28 that was as a result of the RQIA reports?

29 A. I would surmise it is. But, again, I wasn't there at

1 the time, Mr. Doran, but it seems to flow naturally
2 from reports into the Program For Government the
3 following year.
4 128 Q. Yes. Well, what I was going to ask is whether there
5 was any risk assessment document or perhaps board 11:37
6 assurance framework document that sets out how
7 safeguarding was identified as a priority issue for the
8 executive at that time?
9 A. I'm not aware, but we will have a look and see what
10 there is available and provide it to the Inquiry. 11:38
11 129 Q. Yes. So presumably if it were the case that it was --
12 that the RQIA reports and the conclusions of those
13 reports caused the Executive to regard safeguarding as
14 a priority, there is likely to be some documentation
15 around that determination? 11:38
16 A. If that is the case there would be some correlation in
17 documentation, but we will have a look and provide
18 whatever there is to the Inquiry.
19 130 Q. Yes. And indeed any documentation that demonstrates
20 how and why safeguarding came to be a priority for the 11:38
21 executive at that point in time.
22 A. Yeah.
23 131 Q. And in paragraphs 8.19 to 8.21, you refer to the
24 proposed new legislation on safeguarding, and I just
25 want to read those paragraphs in actually. At 8.19 you 11:39
26 say:
27
28 "Following the widely publicised safeguarding failings
29 at Muckamore Abbey Hospital and Dunmurry Manor Care

1 Home, which highlighted the need to review and improve
2 adult safeguarding policy in Northern Ireland, the then
3 Minister For Health announced in 2020 the launch of a
4 public consultation on a range of legislative options
5 on safeguarding. The consultation closed in April 11:39
6 2021, and following analysis of the responses, the
7 Department is progressing work to introduce an Adult
8 Protection Bill which will provide a statutory
9 underpinning for safeguarding arrangements in Northern
10 Ireland. 11:40
11
12 It is worth noting that the Draft Adult Protection Bill
13 will need to be cleared by the Health Minister and then
14 by the Executive before being introduced to the
15 Northern Ireland Assembly. Therefore, the Draft Bill 11:40
16 cannot be introduced until an Executive is formed."
17
18 Is it right to say then that that legislative
19 initiative is in abeyance at the moment?
20 A. That is one of my other areas of responsibility, 11:40
21 Mr. Doran. So continue to draft the Bill. The Bill is
22 at a very advanced stage. We have engaged with the
23 Office of Legislative Council. So we would hope that
24 we would have a draft Bill ready to go if an Executive
25 is reformed. And, certainly, it already had -- the 11:40
26 legislative passage within the Assembly, it had to go
27 to the Executive to allow us to progress to this stage,
28 and the Executive were very supportive of the approach
29 being taken by the Department in terms of progressing

1 the Bill. So we would hope that we would have a Draft
2 Bill ready for an incoming Executive and an incoming
3 legislative programme, and we are at a very advanced
4 stage in drafting that Bill.
5 132 Q. But the Bill isn't yet fully formed, so to speak? 11:41
6 A. It's not fully formed at this stage, no.
7 133 Q. And following on from the issues at Muckamore and
8 Dunmurry that you mention at paragraph 8.19, has there
9 been any further guidance issued pending the new
10 legislation? 11:41
11 A. I'm not aware that there has been any further guidance
12 issued after the 2015 Guidance. If it had of been
13 issued we would have provided it to the Inquiry. So
14 the guidance at 8.15 would be the most up-to-date
15 guidance. 11:41
16 134 Q. In terms of the new legislation, might you be able to
17 assist with other documentation around that? For
18 example, any consultation response document or
19 submission to the Minister from DOH officials which,
20 you know, which will accompany the final draft policy 11:41
21 proposals?
22 A. We could certainly provide the consultation responses
23 and look into what other documentation we can provide.
24 We will provide that in terms of the addendum
25 statement, Mr. Doran. 11:42
26 135 Q. That's helpful.
27 CHAIRPERSON: And just -- sorry to interrupt,
28 Mr. Doran. Just on the question of timing. Once the
29 Executive comes back into existence, presumably there

1 is going to be a tremendous backlog.
2 A. There will. What they will do, they will look at a
3 legislative programme, Chair, and those Bills which are
4 ready to go would probably be the ones with -- and
5 depending on a programme for government, I suppose 11:42
6 coming from a new Executive there would be a
7 prioritisation exercise for legislation that is ready
8 to go. Certainly from a departmental perspective we
9 would see that as a priority piece of legislation from
10 the Department to push forward, but it would be part of 11:42
11 a wider executive legislative programme, and obviously
12 dependant on assembly time to progress the Bill. The
13 Bill would be considered a large Bill in terms of
14 Northern Ireland legislation, so it would take quite a
15 while to put through the Assembly process. 11:43
16 CHAIRPERSON: Are we talking about years?
17 A. We would hope to get it through within the first year
18 of a new Executive being formed, but it is all
19 dependant on getting its space on a legislative
20 programme. 11:43
21 CHAIRPERSON: Sure. Sorry. Thank you.
22 136 Q. MR. DORAN: I appreciate it may be difficult for you to
23 say, but can you give an indication as to how it is
24 hoped the new legislation will actually improve current
25 safeguarding arrangements? I appreciate that's a big 11:43
26 question?
27 A. It is a big question. I think it will put on a
28 statutory basis a number of things which are not
29 currently on a statutory basis. It will certainly

1 bring in an Adult Protection Board, which would be new
2 to this jurisdiction. So it does place, as I say, on a
3 statutory footing a number of issues which currently
4 aren't, but I'm more than happy to provide more detail
5 on that, Mr. Doran, in my amended statement. 11:43
6 137 Q. I really -- I don't want to invite speculation, but
7 what if you were asked to address the question from the
8 Department's perspective, how do you think this new law
9 might have made a difference to facilities such as
10 Dunmurry or Muckamore, if the legislation had been in 11:44
11 place at an earlier stage?
12 A. That would be purely speculative on my part, Mr. Doran,
13 and I don't think it would be appropriate to answer. I
14 wasn't in post at the time of Dunmurry Manor or of
15 Muckamore, so it would be very, very difficult for me 11:44
16 to answer that question with any, with any surety to
17 the Inquiry.
18 138 Q. Well I'm not going to push you on that point now,
19 you'll be glad to know, but we may wish to look at some
20 of the proposed new clauses in more detail in due 11:44
21 course.
22 A. I take that on board. Thank you.
23 139 Q. I move on now to Topic 3(E) which relates to policies
24 and procedures concerning medication and auditing of
25 medication. In paragraphs 9.1 to 9.24 you provide a 11:45
26 roadmap of the various statutes in place to ensure the
27 safe regulation of medicines, isn't that correct?
28 A. It is correct.
29 140 Q. And you also then provide guidelines, assurance and

1 standards documents on safe prescription, handling and
2 storage of medicines?
3 A. That's correct.
4 141 Q. Now, for Inquiry purposes it is not necessary for us to
5 examine those materials in detail in oral evidence 11:45
6 today, but I just have a couple of issues that I wanted
7 to raise with you. First of all, is it fair to say
8 that those statutes and guidelines apply right across
9 the health care system?
10 A. Yes. They wouldn't be specific to learning disability 11:45
11 or mental health. They are generic across the whole
12 system.
13 142 Q. My next question then is, it is a very large body of
14 materials, is there anything within the documents that
15 relates specifically to the use of medication to 11:45
16 control behaviour of learning disability patients?
17 A. The documentation provided I think would be more in
18 terms of the generic management and control of drugs
19 and prescribed drugs, as opposed to the clinical and
20 prescription of the drugs. This is largely the 11:46
21 overarching policies as you've said.
22 143 Q. Are you aware of any policy or guidelines within the
23 specific context of the use of medication and learning
24 disability patients?
25 A. Not specifically within these. There are a number of 11:46
26 issues around the safe management of controlled drugs
27 which may be more prevalent in learning disability
28 settings, but I wouldn't be able to point you directly
29 to anything within those exhibits which are specific to

1 LD.
2 DR. MAXWELL: Can I just ask? Do you get prescribing
3 trend data? So I know in England we can get reports on
4 individual GP practice, or individual hospitals for
5 prescription of certain classes of drugs, and obviously 11:47
6 Muckamore are interested in, in the drugs that are used
7 for psychological treatment. Does Northern Ireland
8 have that facility to look at the trend data for
9 prescribing certain drugs?
10 A. I think we may do, but could I come back to the Inquiry 11:47
11 on that and I will make inquiries and provide whatever
12 we have available?
13 DR. MAXWELL: Thank you.
14 144 Q. MR. DORAN: I wanted to pick up on what you say in the
15 concluding paragraph in this section, that's 9.24 on 11:47
16 page 43. So paragraph 9.24 you say:
17
18 "In respect of arrangements for audit, the Department
19 has not provided specific processes for auditing
20 medication use as professionals are already trained on 11:48
21 how to undertake audits as part of their professional
22 education and development, and so such direction from
23 the Department would be unnecessary. Trusts develop
24 their own processes for the circumstances for auditing
25 use of medicines in line with their own Medicines 11:48
26 Governance Codes and Practice."
27
28 So is the upshot of that then that there is no
29 overarching departmental policy on auditing medication

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1 use?
2 A. I think there would be overarching policies, but it
3 would not go down into specifics about how medicines
4 are audited at ward level or at establishment level,
5 would be my understanding of that part of the 11:48
6 statement. You will appreciate, Mr. Doran, we did seek
7 input from a wide range of professionals across the
8 Department in development of this statement, so that
9 would be my understanding of the process.
10 145 Q. It's just the wording that you use is to the effect 11:49
11 that the Department has not provided specific processes
12 for auditing medication use?
13 A. I think that would go to the point where processes
14 within individual wards and within individual
15 establishments would be the responsibility of the 11:49
16 Trusts and, therefore, the Department would not be
17 specific about how auditing of drugs and medication is
18 undertaken at that specific level of delivery at a ward
19 or a Trust level.
20 146 Q. Does it not seem somewhat out of step with other 11:49
21 policies and guidelines in the area of medication
22 though, given that the objective of so many of those
23 policies and guidelines is to ensure that practices
24 regarding medication are standardised?
25 A. I think that would be asking me to speculate on how 11:49
26 effective a policy is as opposed to what the policy is
27 set out to do. I can certainly come back on that,
28 Mr. Doran. I wouldn't have -- I don't have a strong
29 enough answer to your question, if I'm honest.

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1 147 Q. Well we can return to the matter, but I am just
2 wondering are you aware - has consideration ever been
3 given to whether departmental direction on the auditing
4 issue would be desirable?
5 A. I think we need to establish in terms of departmental 11:50
6 direction. Directions are issued by the Department in
7 terms of quite specific legislative provisions, so the
8 Department could issue guidance or a direction,
9 probably more relevant to issue guidance. But I think
10 this goes down to the structures which we've discussed 11:50
11 previously in terms of the Department setting an
12 overall overarching policy. The commissioning role
13 being undertaken by the Board and NASPPG now and the
14 delivery of that being delivered by individual Trusts.
15 So there is a large amount of autonomy in terms of how 11:51
16 individual policies and procedures are implemented on
17 the ground. So for the Department to set a direction,
18 as you've suggested Mr. Doran, in terms of how the
19 auditing of individual medicines and drugs are
20 undertaken at a Trust level or at a ward level, I think 11:51
21 would not be the role of the Department in that we're
22 there to sort of set strategic policy and direction as
23 opposed to micromanaging how things operate on the
24 ground.
25 148 Q. But I'm just thinking, for example, from a lay 11:51
26 perspective, one might expect there to be a requirement
27 of regular auditing of medication prescribed for
28 particularly vulnerable patients?
29 A. And I understand that does happen, but it wouldn't be

1 set -- I don't think it would be set by the Department
2 in terms of how that would be managed at a clinician
3 level. The prescribing and auditing of drugs,
4 certainly the prescribing of drugs would be on
5 clinician led basis on each individual patient, and 11:52
6 therefore the auditing of that would be the role and
7 the responsibility of the Trust, is my understanding.
8 DR. MAXWELL: Can I just ask? Is there a Chief
9 Pharmacist in Northern Ireland?
10 A. There is a Chief Pharmacist in Northern Ireland. 11:52
11 DR. MAXWELL: Who might be giving professional advice
12 on this?
13 A. The Chief Pharmacist is a member of the Senior
14 Management Group within the Department, and she would
15 provide advice, but I'm not sure whether she would 11:52
16 provide advice right down to the level of how
17 individual drugs are audited, but certainly I will come
18 back to the Inquiry on that.
19 DR. MAXWELL: But it might be more detailed in the
20 general direction of the policy, in the same way the 11:52
21 Chief Medical Officer and Chief Nursing Officer are
22 giving quite detailed professional advice.
23 A. Can I come back to the Inquiry on that?
24 149 Q. MR. DORAN: Yes, indeed. Just Topic 3(F) in Module 3
25 is "Policies Concerning Patients Property and Finance", 11:52
26 and I note that that isn't covered in the statement,
27 and I was just wondering is that an oversight or are
28 there no policies on those matters at departmental
29 level?

1 A. That may be an oversight on our part, Mr. Doran, but I
2 will come back and clarify that. Apologies.
3 150 Q. Thank you.
4 A. I will clarify it either way. If it's an oversight or
5 is there's not policies. 11:53
6 151 Q. Yes. Topic 3(G) then relates to policies and
7 procedures concerning psychological treatment, speech
8 and language therapy, occupational therapy and
9 physiotherapy, and at paragraph 10.3, your statement
10 suggests that the adoption of an overarching strategy 11:53
11 for allied health professionals is a relatively recent
12 development. Is that right? 2012?
13 A. What the statement says is that we were unable to
14 locate anything previously to that. Again we have
15 checked quite comprehensively across records and the 11:54
16 2012 to '17 is the earliest guidance we can find in the
17 records.
18 152 Q. I think you describe that as a high level - this is the
19 2012 document - as a high level roadmap for the
20 development of the AHP workforce? 11:54
21 A. Yes, Mr. Doran.
22 153 Q. And it doesn't seek to address in detail what services
23 are provided or how they are delivered?
24 A. No.
25 154 Q. And it's fair to say, isn't it, that the strategy 11:54
26 doesn't specifically address the role of allied health
27 professionals as regards learning disability patients?
28 A. Yes. As outlined in paragraph 10.5 of my statement, it
29 is -- it says "does not seek to address in detail the

1 specific services". So it would not go down right to
2 the level of individual programs of care.
3 155 Q. Now that strategy related to 2012 - 2017. Was it then
4 superceded by the UK-wide Strategic Framework that you
5 mention at paragraph 10.6? 11:55
6 A. Well, as noted, the Department was jointly involved in
7 the 2019 - 2024 Policy. I'm not sure that it
8 superceded it, because that was a UK-wide policy as
9 opposed to a Northern Ireland policy.
10 156 Q. So what about the strategy that you mentioned at 11:55
11 paragraph 10.3 then, may that still be operative?
12 A. I would need to check that Mr. Doran. Apologies.
13 157 Q. That's fine. I think I owe you an apology, because
14 apparently Topic 3(F) wasn't specifically referenced in
15 the letter from the Inquiry to the Department? 11:56
16 A. I should have known that as well, Mr. Doran. So,
17 apologies. But thank you for that clarity.
18 158 Q. Now...(INTERJECTION)?
19 CHAIRPERSON: Is 3(F) property?
20 MR. DORAN: 3(F), yes, is policies relating to 11:56
21 patient's property...(INTERJECTION)
22 CHAIRPERSON: For what its worth, I think we're getting
23 a lot of material tomorrow from the Belfast Trust.
24 There's a huge number of policies that going to be
25 seen. 11:56
26 159 Q. MR. DORAN: Yes. Yes. But, obviously, any issues from
27 a departmental perspective that can be addressed, that
28 can be dealt with in the follow-up statement.
29

1 Now, you refer then in paragraph 10.8 to the Department
2 strategy for the development of psychological services,
3 and that dates back to 2009, and it's exhibit - excuse
4 me - Exhibit 91 at page 4430. If that could be brought
5 up, please? So that's the cover page. Can we move on 11:57
6 then to page 4431, the next page, which contains the
7 Minister's foreword, and from the first paragraph one
8 can see that that strategy is linked to the Bamford
9 initiative, isn't that right?
10 A. Yes, it is. 11:57
11 160 Q. And I wonder is this document still operative?
12 A. I think it is still the one that would be in place,
13 Mr. Doran.
14 161 Q. I just -- I wanted to refer to a section of the
15 document that began at or begins at page 4465 and runs 11:57
16 through to 4466. So 4465. If one scrolls down,
17 please? Yes. You'll see the heading "A stepped care
18 model for people with a learning disability." So this
19 learning disability specific material.
20 11:58
21 The first paragraph:
22
23 "Learning disability is a life-long developmental
24 disorder and categorised into four levels: Mild,
25 moderate, severe and profound learning disability. 11:58
26
27 People with a learning disability have a high incidence
28 of epilepsy, autistic spectrum disorder, sensory
29 impairments and physical health conditions. They also

1 have a higher incidence of mental health needs than the
2 general population."
3
4 Just if you could scroll down then, please - I'm not
5 going to read all of this in. Paragraph 4.15: 11:58
6
7 "Simple adaptations to the implementation of
8 traditional psychological therapies are often required
9 when engaging with people with a learning disability.
10 The degree of adaptation will be commensurate with the 11:59
11 person's specific needs."
12
13 Can you scroll down, please? And further.
14
15 "The current policy to support people with a learning 11:59
16 disability in the community rather than a hospital
17 setting will shape the development of psychological
18 therapy services and the training needs of staff
19 delivering therapies. An adapted stepped care model
20 will be required and an example will be provided 11:59
21 below."
22
23 And can you just scroll then to the next page, 4467.
24 Now this is the example of the stepped care approach to
25 learning disability within the field of psychological 11:59
26 services. Now, I'm not -- it's not the easiest
27 document to navigate, that may be the understatement of
28 the day, but if one scrolls down one can see Step 1,
29 Step 2, Step 3, and it is quite -- it is actually quite

1 a detailed document obviously.
2 A. Yes.
3 162 Q. And I don't expect you to be able to answer questions
4 about the detail of services offered within the field
5 of psychology, but I am interested in this issue of 12:00
6 whether or not - or the Inquiry is interested in this
7 issue of whether or not this document is still
8 operative and still informs the practice of psychology
9 today vis a vis learning disability patients?
10 A. I think the principles remain the same today in that, 12:00
11 you know, that no one should live in a hospital and
12 call that hospital their home. So it is around that
13 reablement and betterment between the community and
14 community services, as the document notes there, around
15 day opportunities and trying to ensure that those 12:00
16 services are provided within a community setting rather
17 than a hospital setting.
18 163 Q. Yes. Are you aware, is there any other policy document
19 that touches upon the number of psychologists required
20 to deal with learning disability patients or the actual 12:01
21 deployment of psychologists in the field of learning
22 disability?
23 A. I am not aware of anything, Mr. Doran, but we can
24 certainly check.
25 164 Q. Now, in the next section then, Topic 3(H), you deal 12:01
26 with resettlement policies and the provision of
27 monitoring of resettlement, and you trace the policy,
28 the overarching policy direction of the Department
29 towards resettlement of long stay residential patients

1 with a learning disability to the early 1990s?
2 A. Yeah, to the People First.
3 165 Q. I just wanted to ask you about that actually, because
4 I'm going back to counsel's opening to the Inquiry, and
5 obviously there was some research conducted prior to 12:02
6 that and, what I said at the opening was:
7
8 "1987 - 2007 resettlement of long stay patients and the
9 move to a core hospital.
10 12:02
11 In 1987 the regional strategy for Northern Ireland 1987
12 - 1992 was published. It sought to move patients away
13 from long stay hospitals towards community care and to
14 implement an extensive programme of resettlement and it
15 set a target of 20% reduction in the number of long 12:02
16 stay hospital beds in the period 1987 - 1992. A
17 particular emphasis was placed on reducing the numbers
18 of people with learning disabilities in hospitals. The
19 early years of this resettlement programme saw patient
20 numbers at Muckamore Abbey Hospital fall to 558 by 12:03
21 1993."
22
23 Now, just, I'm referring that to your attention just to
24 ask, I mean was the policy in fact in place even prior
25 to the early 1990s? 12:03
26 A. I think that was always a direction of travel to ensure
27 that where people could be resettled they were
28 resettled. Obviously it has been a considerable length
29 of time to finalise that journey and we're still within

1 the process of that with the remaining patients to be
2 resettled from Muckamore. But I think it has always
3 been the focus that where they could -- where patients
4 could be treated within the community, they should be
5 treated within the community. 12:03
6 166 Q. But I suppose are you citing People First as a sort of
7 pivotal document in the development of that policy?
8 A. Yes. Yes, I am. Yes.
9 167 Q. Now, I wanted to ask about paragraphs 11.4 and 11.5.
10 If we can go back to page 46, please. 12:04
11
12 "In or around 1995, the Department took a decision that
13 it would seek to resettle all long stay patients from
14 the three learning disability hospitals in Northern
15 Ireland within accommodation offering a better life for 12:04
16 the patient.
17
18 The defining principle was that resettlement should be
19 offered where it is clinically appropriate, meets the
20 patient needs, has the potential to better the life of 12:04
21 the patient and is in line with the wishes of the
22 patient and their family, where this is appropriate.
23 These criteria are addressed under the heading of
24 "Betterment".
25 12:04
26 The term "betterment" emerged in the mid 1990s when
27 conflict arose between those charged with delivering
28 the resettlement programme at the time and families who
29 sometimes felt that their family member would be better

1 off in hospital.
2
3 In 1995 the Northern Ireland Minister of Health at the
4 time gave a public assurance to families that a member
5 of their family living in hospital would only be 12:05
6 resettled into the community if there was clear
7 evidence of betterment for the patient and provided
8 that it was not against their wishes. This commitment
9 has been restated by successive ministers and remains
10 in place and was a key principle underpinning the 12:05
11 Bamford Vision."
12
13 So you say that that commitment remains in place today?
14 A. Well, the commitment remains in place, although we have
15 undertaken a consultation, as you're aware, we've 12:05
16 discussed earlier, Mr. Doran, in terms of the future of
17 the hospital. So whilst the hospital remains open,
18 that commitment would still be in place. If the
19 hospital no longer remained open, obviously, you know,
20 if someone wished to remain in the hospital they could 12:05
21 not if the hospital was not open.
22 168 Q. Yes. Now, I do want to flag up some material for the
23 benefit of the Panel and core participants, and its
24 derived from the document that you referred to at
25 paragraph 11.6, and that is the document that was 12:06
26 called "Health and well-being into the next millennium
27 - setting out a five year regional strategy for
28 health", and it's exhibited at Exhibit 93, and that's
29 at page 4558, please, if that could be brought up on

1 screen. And if one then goes down to page 4636, and
2 just, just looking at the first paragraph, 10.1:
3
4 "There are over 8,000 people with a learning disability
5 in Northern Ireland. The report of a comprehensive 12:07
6 review of policy for people with a learning disability
7 was published in 1995. The Department fully endorses
8 the reviews' conclusions which identify policy aims
9 appropriate to the end of the 20th Century and its
10 recommendations which address the key issues for policy 12:07
11 into the next Century.
12
13 The review highlighted the importance of including
14 people with a learning disability in society. Access
15 to mainstream services can broaden their horizons and 12:07
16 social circle, widen experience, offer opportunities
17 and challenges and stimulate achievement."
18
19 If you could scroll down on the page, please? I just
20 wanted to look at paragraph 10.4, which sets out the 12:07
21 objective:
22
23 "To provide the individual with a choice of living
24 accommodation and day activities appropriate to assess
25 needs. The Department, Boards and Trusts should 12:07
26 develop links which promote interagency co-operation.
27 These links should be with other departments, agencies
28 and organisations responsible for housing, further
29 education, training for and support in employment and

1 leisure activities."
2
3 Then:
4
5 "Targets: 12:08
6 Each Board and Trust should develop a comprehensive
7 range of supportive services for people with a learning
8 disability and their carers. The overall objective is
9 that by 2002 long-term institutional should no longer
10 be provided in traditional specialist hospital 12:08
11 environments."
12
13 Chair, Panel, I'm flagging up this page, and indeed
14 right up to page 4638, because they provide a very
15 helpful snapshot, I think, of the direction of travel 12:08
16 in policy right at the outset, or before, just before
17 the outset of the terms of reference of the Inquiry.
18 I'm not going to go right through the policy history,
19 I'm not going to ask you, Mr. McGuicken, to comment on
20 those paragraphs. I just wanted to flag up something 12:09
21 else at Exhibit 96 at page 4798, and that's mentioned
22 in paragraph 11.13 of the statement. And this was the
23 publication by the Minister in 2007 of an Action Plan
24 for Learning Disability Hospitals.
25 12:09
26 So this represented ministerial thinking as of 2007. I
27 just wanted to -- if you scroll down, please. If we
28 could just look at bullet point -- well, one can see at
29 the outset that there is a specific reference there to

1 the hospital.
2
3 "Health Minister Paul Goggins has announced an action
4 plan to discharge all patients from learning disability
5 hospitals, including Muckamore, and key elements of the 12:10
6 plan include..."
7
8 And at the fourth bullet point, sorry the fifth bullet
9 point:
10 12:10
11 "By 2014 no learning disabled patient will have a
12 hospital as a permanent address."
13
14 Now, as I say, I'm not expecting you to comment
15 specifically on the contents of those documents, but it 12:10
16 is fair to say that the aspirations of some years ago
17 have not yet quite been achieved, isn't that right?
18 A. That's accurate.
19 CHAIRPERSON: Sorry, just so that I get the timing
20 right. The first document you referred to, was that 12:10
21 1997?
22 MR. DORAN: That was from 1996. It was
23 a...(INTERJECTION)
24 CHAIRPERSON: '96.
25 MR. DORAN: Yeah. "Strategy for health going into the 12:10
26 Millennium", and that's Exhibit 93 at page 4558 for the
27 record. It's dealt with in paragraph 11.6 of the
28 statement.
29 CHAIRPERSON: Yes. Thank you.

1 MR. DORAN: So they're helpful documents, Chair, in my
2 view, in that they give a useful snapshot of policy
3 thinking at those relevant times?
4 CHAIRPERSON: Pre-Bamford.
5 MR. DORAN: Pre-Bamford, pre-terms of -- shortly 12:11
6 pre-terms of reference and then the 2007 ministerial
7 statement which we've just, which we've just looked at.
8 Now, again, you've obviously accepted that the target
9 hasn't quite been met. Would you be able to comment
10 from a departmental perspective on what you regard as 12:11
11 the reasons as to why the target hasn't been met after
12 all these years?
13 A. I can comment on the current resettlement programme,
14 Mr. Doran. I couldn't comment on that before I was in
15 post. In terms of the current resettlement programme 12:12
16 there are 29 patients remaining in Muckamore, and if I
17 could possibly correct the record. I was asked
18 previously when I was here whether there are three
19 patients under assessment and treatment, and I said
20 there weren't. Actually there are three patients 12:12
21 currently under assessment and treatment. So I
22 apologise that I was incorrect in my last appearance.
23 Now that will change on a daily basis, to be honest,
24 depending on the circumstances of those patients, but
25 there are three patients under active assessment and 12:12
26 treatment. So those remaining 29 patients, 26, if you
27 like, would be fit for resettlement today. There's a
28 programme of resettlement ongoing. There are
29 considerable pressures across learning disability in

1 terms of getting resettlements into community provision
2 and into hospital provision. We work very closely with
3 the independent sector and third sector to make or
4 deliver bespoke placements for a lot of the individual
5 patients are currently left within Muckamore. So I 12:13
6 don't think the challenges are new today. The
7 challenges today are around ensuring that the right
8 placement is there for each individual patient and
9 meets those individual patient's needs. Those
10 resettlements are expensive, but that has never been an 12:13
11 impediment to moving the resettlement on.
12 169 Q. So you say cost isn't an impediment?
13 A. Certainly in my time within the Department cost has
14 never been an impediment, and I'm not sure there's any
15 evidence that cost has ever been an impediment to 12:13
16 resettlement. The resettlement of the remaining
17 patients within Muckamore is - I suppose use the term
18 "hugely expensive" in terms of individual patients and
19 the needs of those individuals patients, but the
20 resettlement programme at the minute has not been in 12:14
21 any way delayed by funding, despite the financial
22 position the Department faces in the coming years.
23 Funding has been there to resettle. In the last six
24 months I think it is seven patients that have been
25 resettled from Muckamore, and there is a programme now 12:14
26 which hopefully will start to pick up some pace in
27 terms of the resettlement of the remaining 29 patients
28 from Muckamore.
29 CHAIRPERSON: We heard yesterday, didn't we, that one

Gwen Malone Stenography Services Ltd.

1 of the primary problems is workforce as opposed to
2 funding.
3 A. It is, yeah. It is. The workforce in the independent
4 sector, not just in terms of learning disability,
5 Chair, but in terms of even domiciliary care, the wider 12:14
6 domiciliary care workforce is a problem across the
7 piste in the independent sector.
8 DR. MAXWELL: The independent review of resettlement
9 was published last year, identified at that time that
10 there were 10 patients who had been resident since 12:14
11 2007. Do we know what the particular problems around
12 those 10 patients were and whether you've been able to
13 overcome them?
14 A. I don't know which specific patients have - the
15 independent review referred to. I suppose I've had 12:15
16 discussions with a number of the patients within
17 Muckamore as part of the work of the resettlement, we
18 have on occasions engaged, particularly around the
19 consultation and the closure I've engaged directly with
20 a number of the patients. A number of the patients 12:15
21 would class Muckamore as their home and they have said
22 that, that they...(INTERJECTION)
23 DR. MAXWELL: So they don't want to go.
24 A. Yes. So they wouldn't want to go. So until a decision
25 is taken on the future of the hospital, some of those 12:15
26 resettlements are difficult because the patients simply
27 don't want to leave, or their families don't want them
28 to leave. I spoke to one patient who has been there 37
29 years, another patient who has been there 27 years. So

1 that's basically all they've known is Muckamore as
2 their home. Clearly the Policy Directive is that
3 nobody should call a hospital their home, but that's a
4 very challenging circumstance where an individual
5 believes - or considers, sorry doesn't believe - they 12:16
6 consider the hospital setting to be their home. So
7 that may be some of the impediments to resettlement.
8 170 Q. MR. DORAN: The Inquiry may, obviously, or will
9 continue to probe issues around the history of the
10 resettlement issue, but essentially are you saying your 12:16
11 evidence on this issue is confined to your experience
12 since you've been in post and relates to the current
13 programme?
14 A. Well, the statement obviously covers quite a bit before
15 my time, Mr. Doran, but my -- anything I can say in 12:16
16 terms of my experience is purely within the last 20
17 months or so.
18 171 Q. Yes. Now, one other document that you refer to at
19 paragraph 11.23 is the Permanent Secretary's apology to
20 Muckamore families following on from the revelations 12:16
21 about the hospital. And if we could go back then to
22 page 50, please? Paragraph 11.23. So there you say:
23
24 "In December 2018 in response to the findings of the A
25 Way to Go Report, the Department's then Permanent 12:17
26 Secretary made two further commitments on resettlement.
27 The first of these was that he expected completion of
28 the Bamford Resettlement Programme by December 2019
29 and, secondly, that no one should call a hospital their

1 home in the future."
2
3 And:
4
5 "I attach a copy of the Permanent Secretary's statement 12:17
6 at Exhibit 59."
7
8 Can we just look at Exhibit 59 then? It's on page
9 4829?
10 CHAIRPERSON: Sorry, Exhibit 99. 12:17
11 MR. DORAN: 4829. Oh, Exhibit 99, yes. Now, the
12 heading is: "Permanent Secretary Apologises to
13 Muckamore Families", and as you say, that was
14 essentially in response to the A Way to Go Report, is
15 that right? 12:18
16 A. It was, yeah.
17 172 Q. And just scrolling down:
18
19 "The Department of Health Permanent Secretary Richard
20 Pengelly, today apologised to families of Muckamore 12:18
21 Abbey Hospital patients at a meeting with them at the
22 Co. Antrim facility. Mr. Pengelly also made a series
23 of firm commitments to the families as regards future
24 care provision."
25 12:18
26 And I wonder if you could just scroll down, please?
27
28 "He was accompanied at the meeting by Chief Social
29 Worker Sean Holland and Chief Nursing Officer Charlotte

1 McArdle. Commenting after the meeting Mr. Pengelly
2 said:
3 "It was important to me to apologise to families
4 face-to-face for what happened to their loved ones
5 while in the care of Muckamore Abbey hospital rather 12:19
6 than through a press statement. I am both appalled and
7 angered that vulnerable people were let down. At the
8 same time action is urgently needed by the HSC system
9 as a whole in response to the recommendations of the
10 Serious Adverse Incident (SAI) review. I fully endorse 12:19
11 the review of the SAI panel that no one should have to
12 call Muckamore their home in future when there are
13 better options for their care. I am now confirming to
14 the families that this will be the case. That means
15 Muckamore returns to being a hospital providing acute 12:19
16 care and not simply a residential facility. To make
17 that happen will require and investment in both
18 specialised accommodation and staff training to meet
19 the complex needs of people who no longer need to be in
20 hospital"." 12:19
21
22 And then we have a further statement about expecting
23 the resettlement process to be completed by the end of
24 2019.
25 12:19
26 I wonder if you could just continue to scroll down,
27 please? And further, please. Yes, I just wanted to
28 pick up on the paragraph beginning:
29

1 "Mr. Pengelly also took the opportunity to update the
2 families on plans for a new model of acute care for
3 people with learning disability through the
4 transformation agenda saying:
5 "This work will now be prioritised as part of a wider 12:20
6 project already initiated to transform learning
7 disability services and will take account of the
8 findings of the SAI report which states very clearly
9 that the current model is not working. We need
10 urgently to find pragmatic solutions to the issues laid 12:20
11 out in stark terms in this report"."
12
13 So can you just set that paragraph in the context of
14 the various reports and initiatives that you have dealt
15 with in your statement? 12:20
16 A. Well, that comes out of, as it says, out of the SAI
17 Report following the allegations of abuse at the
18 Hospital. The out-workings of that are the MDAG Action
19 Plan. MDAG was set up then as a delivery mechanism to
20 take forward the actions coming out of the SAI Report, 12:21
21 and we continue to carry those actions forward today.
22 Now, as you've clearly highlighted, Mr. Doran, there
23 was a commitment the resettlement programmeme would be
24 completed by 2019, and as I've noted previously, we
25 still have an ongoing resettlement programmeme today. 12:21
26 So we have not met that commitment.
27 173 Q. Yes. But the reference to the new model of acute care,
28 that relates to the strategy that is currently being
29 developed?

1 A. It does, yes. And it is -- one of the questions in the
2 consultation document on the future of the hospital
3 was: Do you believe this, you know, the closure of the
4 hospital would be in keeping with the strategic
5 direction? And about a future direction for the sort 12:21
6 of acute care. And we continue to work with all Trusts
7 around what that future model would look like, but the
8 Learning Disability Strategic Plan specifically is
9 taking that work forward at this stage.
10 174 Q. Yes. Just if scroll down towards the end of the 12:22
11 letter. The Minister:
12
13 "Finally, Mr. Pengelly stated that it was his intention
14 to have regular meetings with the families to keep them
15 updated on developments and to listen to any new 12:22
16 concerns that they may have."
17
18 Now can I ask, did those meetings take place or have
19 they been subsumed within the MDAG process?"
20 A. They have largely been subsumed within MDAG. We have a 12:22
21 number of family representatives who are members of
22 MDAG. We also have patient client council as members
23 of MDAG as well. So I can't comment on how many
24 meetings Mr. Pengelly may have had with family
25 representatives. Certainly I meet with family 12:23
26 representatives on a number of occasions. I have met
27 with family representatives on a number of occasions
28 since taking up post, but there are three family
29 representatives, from memory, on MDAG.

1 175 Q. Then going back to the statement at page 50, please.
2 At the bottom of the page, paragraph 11.25, you refer
3 there to a further group:
4
5 "The Regional Learning Disability Operational Delivery 12:23
6 Group, which was established in 2019 as part of the
7 response to the Muckamore Abbey Hospital HSC action
8 plan to provide the Department with assurance regarding
9 the HSC's actions following A Way to Go, to provide
10 oversight of the Permanent Secretary's commitments on 12:23
11 resettlement made in December 2018, and to ensure that
12 the development of enhanced and regionally consistent
13 community services for people with a learning
14 disability and their carers are designed to support and
15 sustain people in their communities and avoid the need 12:24
16 for inappropriate in-patient admission."
17
18 Now can you tell the Panel something about the
19 membership of that group and how it has operated?
20 A. That group was established by the Board, as it was 12:24
21 then, Mr. Doran. I understand the membership comes
22 largely from health and social care Trusts, but I can
23 confirm the exact membership in my addendum statement.
24 What I would say is that that group as well was
25 reporting into MDAG. So the overall accountability for 12:24
26 delivering the actions coming out of the SAI was --
27 responsibility was the Department's and, therefore, was
28 MDAG. So the acronym for that group is RLDODG. So you
29 may see that referenced in the Board's statement when

1 they come to give their evidence. So that group was
2 there and it reported into MDAG.
3
4 Now, it says in paragraph 11.26 about the group was
5 established in 2019. That group has largely been in 12:25
6 abeyance since the work that we brought Ian Sutherland
7 and Bria Mongan in to do, the Review Group, so that has
8 largely been in abeyance, and my understanding is that
9 group does not meet at present, because the work on
10 resettlement is now taken forward by the group chaired 12:25
11 by Patricia Donnelly, the oversight group.
12
13 So there were a number of structures put in place at
14 that time - that being one of them. Now MDAG continues
15 to manage the overall delivery of the action plan 12:25
16 coming out of the SAI, but the work of that group has
17 been superceded then by the Resettlement Oversight
18 Board, chaired by Patricia Donnelly.
19 176 Q. Something we could also perhaps with SPPG. But are
20 there reports or minutes associated with that 12:26
21 particular group?
22 A. I'm sure there would be, Mr. Doran, but it would be for
23 SPPG to answer that one.
24 177 Q. Yes. You say then that that group was actually
25 replaced in October 2022 by a new regional resettlement 12:26
26 task force?
27 A. It was, yes.
28 178 Q. And that was as a result of last year's resettlement
29 report?

1 A. It was, yes. That was one of the recommendations, that
2 an oversight board be set up, and that was accepted and
3 implemented immediately.
4 179 Q. Can you say whether the task force's terms of reference
5 are different from those of the earlier group? 12:26
6 A. I'm not sure, but we could provide both. Or SPPG may
7 well have provided the terms of reference in their
8 statement, but if not we can provide both to the
9 Inquiry.
10 180 Q. Yes. That's very helpful. And we can pick up with 12:26
11 SPPG as well. But I think you say in your statement
12 that the new task force reports to the Department
13 specifically?
14 A. It does. Because the Board are now part of the
15 Department under SPPG. 12:27
16 181 Q. Yes.
17 A. So it reports directly via the Deputy Secretary of SPPG
18 into the Departmental Board.
19 182 Q. So that is properly a matter to pursue with SPPG?
20 A. Yes. 12:27
21 183 Q. Now, you refer then to topic 3(I) at paragraph 12.1 of
22 your statement and subsequent paragraphs, and this
23 topic is "Complaints and whistleblowing policies and
24 procedures", and you begin by speaking in general terms
25 about complaint handling and the raising of concerns, 12:27
26 and I just wanted to read in the comment that you make
27 at 12.2 where you say:
28
29 "Similarly, encouraging staff to openly raise concerns

1 in the public interest, or whistleblowing, as part of
2 normal day-to-day practice is an important part of
3 improving the quality of services and patient safety."
4
5 Now that's, I take it that's not actually derived from 12:28
6 a particular document but an important general
7 statement of principle on your part?
8 A. It would be, yeah.
9 184 Q. And looking back at the various documents that you do
10 exhibit, that principle has clearly been openly 12:28
11 acknowledged and accepted for a long time, isn't that
12 right?
13 A. It has, Mr. Doran.
14 185 Q. I just want to take one document by way of example that
15 actually predates the terms of reference, and it's a 12:28
16 circular that you mention at paragraph 12.5, which was
17 issued in February 1996, and that's a document called
18 "Guidance for staff on relations with the public and
19 the media", at Exhibit 108, and it appears at page
20 4977. If we could bring that page up, please? And if 12:29
21 we can scroll down to paragraph 2? Sorry, just scroll
22 up again a little bit for me, please? That's dated the
23 12th February 1996. It is issued to General Manager
24 Chief Executive of each Health and Social Services
25 Board, the Chief Executive of each Trust, the Chief 12:29
26 Executive each special agency, and the Human Resources
27 Director of each HSS Board, Trust and agency. So,
28 again, wide-ranging circulation?
29 A. Yes.

1 186 Q. And if you go down -- if we go down then to paragraph
2 2:
3
4 "It is important that we encourage a climate of
5 openness and dialogue within the HPSS where free 12:30
6 expression by staff of their concerns are welcomed by
7 their managers as a contribution towards improving
8 services. However, this must be done reasonably and
9 with proper regard to principles of confidentiality
10 which the guidance explains. The guidance provides a 12:30
11 framework within which local procedures to resolve
12 differences can be developed. It is important that
13 managers are able to address these issues locally and
14 develop mechanisms for dealing with staff concerns
15 appropriate to local circumstances." 12:30
16
17 So really that principle of openness to which you've
18 referred, applied before the beginning of the terms of
19 reference and continues to apply today?
20 A. And continues -- yeah, it does. Yeah. 12:30
21 187 Q. You set out then the history of complaints procedures
22 in paragraph 12.3 to 12.15 and, again, it's correct to
23 say, isn't it, that those procedures apply right across
24 the health and social care system?
25 A. Yes, they're not specific to learning disability and 12:31
26 mental health, they're generic across the system.
27 188 Q. And I wonder can you say how patients and their
28 families would have been made aware of complaints
29 procedures?

1 A. I can't, Mr. Doran, if I'm honest. I think that would
2 have been a matter for Trusts to ensure that those
3 matters are brought to the attention of patients. Now,
4 in current days there are reports published on a yearly
5 basis by Trusts on compliments and complaints, so, you 12:31
6 know, there is probably more openness and transparency
7 nowadays around the complaints process than there may
8 have been. I'm not suggesting that there was any,
9 there was any closure around complaints processes in
10 those days, but obviously, you know, with things being 12:32
11 available on websites, et cetera, now, it's a lot
12 easier to navigate those procedures and policies.
13 189 Q. You referred to the publication now of documents
14 setting out details of complaints and statistics on
15 complaints, I imagine 12:32
16 A. Yes, there is. There's a yearly report published by
17 each Trust around the number of -- it's called a
18 compliments and complaints report. So it's published
19 on a yearly basis. And we can provide those to the
20 Inquiry, if that's helpful, or a snapshot of them. 12:32
21 190 Q. Yes. Well, I'm wondering who has primary
22 responsibility for monitoring complaints or complaint
23 trends? I mean let's say, let's say complaints about a
24 particular facility were on the rise, how would that be
25 detected by the health authorities? 12:32
26 A. Well, those complaints, my understanding is that those
27 complaints would be a regular item on a Trust Board,
28 and Board minutes would come to the Department. So
29 there is a way there of that escalating into the

1 Department. There's also the structure of governance
2 and accountability meetings with the Department and
3 with the Permanent Secretary. So my understanding is
4 the complaints would be a standing agenda item, but I
5 will clarify that for you. 12:33
6 191 Q. But you're feeling is that it's first level the Trust?
7 A. Absolutely, yeah.
8 192 Q. But ultimate responsibility and accountability with the
9 Department?
10 A. Accountability for individual complaints, and the sort 12:33
11 of -- the investigation of individual complaints would
12 rest with the Trust. Now obviously if a complainant
13 isn't satisfied about that, they may raise it with the
14 Department or with the Northern Ireland Public Service
15 Ombudsman to investigate a complaint further. So there 12:33
16 are structures that it would go through a process at
17 Trust level and then it would be escalated potentially
18 to the Department or to the Ombudsman.
19 193 Q. I'm not going to take you through the full history of
20 the different complaints documents that were issued 12:34
21 through the years, but I note from paragraph 12.15 that
22 the 2019 Guidance was amended and reissued in 2022 to
23 reflect the transfer of Board functions. Again, could
24 that be furnished to the Inquiry by way of
25 completeness? 12:34
26 A. It could, yes. It may well have been provided by SPPG,
27 but if it hasn't, we can provide it, Mr. Doran.
28 194 Q. Yes. Yes, indeed. Now, you then go on in paragraph
29 12.16 to deal with the specific issue of

1 whistleblowing, and you refer to the legislation, the
2 Public Interest Disclosure Northern Ireland Order 1998,
3 and that legislation obviously governs practice and
4 procedure in this area?
5 A. It does. 12:35
6 195 Q. And you refer then to a circular issued by the
7 Department in January 2000 to HSSB and the Trusts, and
8 that is Exhibit 113 and it appears at page 5289. If
9 that could be brought on screen, please?
10 12:35
11 Now that's dated the 14th of January 2000. And, again,
12 could you just scroll up again, briefly? I just wanted
13 to look at the addressees. The general manager. Chief
14 Executive of each Health and Social Services Board.
15 Check Executive of the Central Services Agency. Chief 12:35
16 Executive of each HSS Trust, and the Chief Executive of
17 each special agency. And then:
18
19 "For information to..."
20 12:35
21 -- the Human Resources Director of each HSS Board.
22 Trust. The Central Services Agency and Special Agency.
23 So, again, very wide circulation?
24 A. Wide-ranging.
25 196 Q. And the letter is headed -- sorry, the circular is 12:36
26 headed:
27
28 "The Public Interest Disclosure Northern Ireland Order
29 1998 - Whistleblowing in the HPSS."

1
2 And effectively the circular required HPSS
3 organisations to have local policies and procedures in
4 place to ensure compliance with the legislation. Is
5 that right? 12:36
6 A. It is.
7 197 Q. And can we look then at paragraph 5 at page 5290, and
8 reflecting the terms of the order, paragraph 5 says:
9
10 "The order does not require organisations to set up a 12:36
11 whistleblowing policy but provide strong reasons why
12 they should. HSS Boards, HSS Trusts and agencies
13 should have such policies already in place, but local
14 policies will need to be reviewed and updated as
15 necessary to ensure that they comply with the new 12:37
16 statutory protection for employees."
17
18 So really the message is going out that you need to
19 have your policies and procedures in place to reflect
20 the requirements of the legislation? 12:37
21 A. Yes. I think it's clear that the legislation did not
22 require whistleblowing policy, but the Department was
23 going slightly further to say there should be policies
24 in place that should be updated to reflect the
25 legislation. 12:37
26 198 Q. Let's look then at page 5291 and paragraph 11
27 specifically. So, paragraph 11 then reads:
28
29 "Every HPSS Trust, Board and Agency should have in

1 place local policies and procedures which comply with
2 the provisions of the 1998 Order. The minimum
3 requirements of local policies should include..."
4
5 And then it goes out and sets out a number of 12:38
6 requirements.
7
8 "1. The designation of a senior manager with specific
9 responsibilities for addressing concerns raised in
10 confidence which need to be handled outside the usual 12:38
11 line management chain.
12 2. Guidance to help staff who have concerns about
13 malpractice to do so reasonably and responsibly with
14 the right people.
15 3. A clear commitment that staff concerns would be 12:38
16 taken seriously and investigated.
17 4. An unequivocal guarantee that staff who raise
18 concerns responsibly and reasonably will be protected
19 against victimisation and should prohibit..."
20 12:38
21 -- and then if we scroll down:
22
23 "5. Should prohibit confidentiality gagging clauses in
24 contracts of employment and compromise agreements which
25 seek to prevent the disclosure of information in the 12:39
26 public interest. Ensure that all their staff are aware
27 of local policies and procedures and their own
28 responsibilities for raising genuine concerns in a
29 reasonable and responsible way."

1
2 So I mean think it's right to say, isn't it, that the
3 approach then adopted by the Department at that stage,
4 a couple of decades ago, was to provide guidance and --
5 or, sorry, to impose minimum requirements on local - 12:39
6 for policies on the Trusts?
7 A. Yes, I think that circular is quite directive to Trusts
8 and what they should do, because it was the
9 introduction of the Order. So it's probably setting
10 out the stall from the very start around what the 12:39
11 expectations of the Department were from various Boards
12 and Trusts at that stage.
13 199 Q. But with responsibility devolved to local level to
14 promote local policies?
15 A. To local level. 12:40
16 200 Q. And it seems to be then in 2009 the approach was
17 changed somewhat, and you set out the further circular
18 that was issued, and you refer to this in paragraph
19 12.18, Exhibit 114. And that's at page 5295 if that
20 could be brought on screen, please? 12:40
21 CHAIRPERSON: Before we move off this page can I just
22 ask, the idea that confidentiality gagging clauses and
23 compromised agreements should be prohibited, do you
24 know if that actually happened in any Trust? Because I
25 can tell you in England that is a continuing problem in 12:40
26 the NHS.
27 A. I'm not sure, Chair, but we can look into that and see
28 if there's any background evidence for that. I'm not
29 aware of it.

1 CHAIRPERSON: Well if you've managed to do that, you've
2 done rather better in Northern Ireland.
3 A. I will see what there is available.
4 201 Q. MR. DORAN: Now, there's a further circular then in
5 2009 that I've referred to, and that's at page 5295. 12:41
6 And if we can scroll down, please? The date is 17th
7 February 2009. And just pausing there, please.
8
9 "For information to all DH SSPS staff, Chief Executive
10 and Director of Finance of each HSC Board, HSC Trust, 12:41
11 special agency and MDPB."
12
13 And then helpfully there's a summary of the contents:
14
15 "The purpose of this circular to encourage HSC bodies 12:41
16 to ensure they have whistleblowing procedures in place
17 and make accounting officers aware of a template which
18 has been drawn up for use in developing organisational
19 specific arrangements."
20 12:42
21 So, is it right to say then that the approach changed
22 in 2009 to setting out minimum requirements to actually
23 providing a model template for a whistleblowing policy
24 to the Trusts, the Board and other relevant
25 organisations? 12:42
26 A. That would seem so from the circular issued.
27 202 Q. And the responsibility then lay with the Trust to
28 formulate it's own policy?
29 A. Well, I think even the previous circulars still, the

1 responsibility still laid with the Trust. From my
2 reading of this, this would bring more uniformity to
3 the policies and provide that template for usage across
4 all Trusts.
5 203 Q. Yes. Perhaps a more directive approach? 12:42
6 A. Potentially.
7 204 Q. But still one would expect then that each Trust would
8 have their own separate whistleblowing policy?
9 A. Yes. Absolutely.
10 205 Q. And you then refer in paragraph 12.20 and 12.21 to the 12:42
11 Minister For Health's letter of March 2012, and that's
12 at page -- that is at page 5304. If that could be
13 brought up, please? Now that's dated, as one can see,
14 the 22nd March 2012, and it's sent for action to Chief
15 Executives of HSC bodies, Chief Fire Officer and for 12:43
16 information to the Director of Human Resources of each
17 body, and it's a message from Edwin Poots, who I think
18 was the Minister at the time, isn't that right?
19 A. He was.
20 206 Q. And it begins: 12:43
21
22 "Please bring the contents of this letter to the
23 attention of all your employees and make available with
24 it your whistleblowing policy."
25 12:44
26 So that really was an exhortation to management at all
27 levels to ensure that all staff were aware of the
28 whistleblowing policy. Is that right?
29 A. That's my reading of it, Mr. Doran, yes.

1 207 Q. And just scrolling down a little bit, the letter refers
2 to the right to whistleblow and sets out the Minister's
3 commitment that:
4
5 "...the highest possible standards of conduct, 12:44
6 openness, honesty and accountability in our services."
7
8 In line with that the letter says:
9
10 "I expect staff to act on any genuine concerns they 12:44
11 might have about any aspect of an organisation's work
12 or colleagues in the knowledge that such action has
13 support from the highest level."
14
15 I'm not going to read the letter in detail, but again 12:44
16 the key point is that this was to be brought to the
17 attention of all staff?
18 A. It was, yes. I think it goes on, just above paragraph
19 3, it takes it further in that it's not just your right
20 it's your duty as well to -- where you believe 12:45
21 something is inappropriate -- to report that. So it's
22 probably the strongest, as you suggested exhortation to
23 staff by that stage, around their right -- their duty
24 and their right.
25 208 Q. So there has been a sort of incremental process, I 12:45
26 suppose, from the legislation, then the initial
27 circular, and now the model template, followed by
28 advice directly from the Minister that the
29 whistleblowing policy should brought to the

1 attention...(INTERJECTION)
2 A. Of all the staff, yeah.
3 209 Q. Now, then in paragraph 12.23 and 12.24, you say that:
4
5 "In August 2015 the Department commissioned RQIA to 12:45
6 undertake a review of the operation of HSC
7 whistleblowing arrangements. The review was published
8 in September 2016 and made eleven recommendations to
9 strengthen the arrangements for raising concerns within
10 HSC organisations. In response the Department 12:46
11 developed a HSC Whistleblowing Framework and Model
12 Policy."
13
14 And you provide a copy of the policy at Exhibit 116.
15 And you go on to say then: 12:46
16
17 "The aim of the framework and model policy was to
18 ensure that under the terms of the Public Interest
19 Disclosure Northern Ireland Order 1998, a member of
20 staff was able to raise legitimate concerns when they 12:46
21 believe that a person's health may be endangered or
22 have concerns about systematic failure, malpractice,
23 misconduct or illegal practice, without fear of
24 retribution and/or detriment. It was intended to
25 improve accountability and good governance within 12:46
26 organisations by assuring the workforce that it is safe
27 to raise their concerns."
28
29 Now, again, I'm not going to go into these documents in

1 detail, Chair. For the record, the model -- the
2 framework document is at page 5307. The model policy
3 is at 5322. And there's a flowchart then at 5341.
4 Again, I'm not going to touch on these directly in oral
5 evidence. But I suppose this is another step forward 12:47
6 then, Framework and Model Policy. Now, I just wanted
7 to ask you this: given that the approach adopted in all
8 of these documents is to delegate responsibility for
9 the policy to individual trusts, is there a mechanism
10 in place for ensuring that the actual policies adopted 12:47
11 are fully compliant with the Department's guidance?
12 A. I'm not aware of a specific policy that we would "QA"
13 if you like each individual's Trusts whistleblowing
14 policy. Each Trust Executive is the accounting officer
15 for their Trust and, therefore, that responsibility 12:48
16 would lie with the accounting officer of each
17 individual Trust. Now, as I have noted previously,
18 there are governance and accountability meetings. I'm
19 not aware whether the governance and accountability
20 meetings would go into the level of detail that say "Do 12:48
21 you have a whistleblowing policy in place?". But I can
22 certainly look into that, Mr. Doran, and come back.
23 210 Q. But it would, obviously, be a matter of concern,
24 wouldn't it, if the individual policies weren't fully
25 compliant with the Department's template? I'm not 12:48
26 saying that that's the case by the way, but obviously
27 the question of whether or not there was full
28 compliance is a matter that the Department would be
29 interested in?

1 A. Interested and concerned, I would suggest, if it wasn't
2 in place. Now, I would suggest there are flexibilities
3 around what a policy would look like. As you've
4 suggested we've put a model policy and we've put a
5 template in place, but there would be flexibilities at 12:49
6 each Trust level as to how -- the flowchart you've
7 mentioned -- how that would work at each individual
8 Trust level. But the overarching policy should be
9 followed by each Trust.
10 211 Q. Yes. I'm just wondering about the Minister's direction 12:49
11 that the letter and the policy be brought to the
12 attention of all staff, who would be responsible for
13 monitoring whether that had actually been done?
14 A. Oh, I think a letter like that from the Minister going
15 to Trust Chief Executives, it would be the 12:49
16 responsibility of the Chief Executive to ensure that
17 ministerial -- whilst it is not a direction, it was a
18 very -- a very, very strong steer from the minister at
19 the time to the Trust Chief Executives. So it would be
20 the responsibility as a Trust chief Executive, as the 12:50
21 accounting officer, to ensure that that was brought to
22 all staff attention.
23 212 Q. Just as I asked you about complaints. Who is
24 responsible for monitoring whistleblowing and trends?
25 A. I am not sure who would be responsible within each 12:50
26 Trust. We have a governance unit within the Department
27 that would look at complaints that are brought to the
28 Department's door, if you like. But, again, I can come
29 back, Mr. Doran, on where responsibility would lie

1 within each Trust around that monitoring of complaints.
2 My assumption would be - and I will correct this if I'm
3 wrong - that there would be a complaints section, if
4 you like, or a complaints and governance section within
5 each Trust who have responsibility for monitoring and 12:50
6 responding to complaints. That's how it operates
7 within the Department, so that's why I am making an
8 assumption that it would work like that in each Trust
9 as well.
10 213 Q. Yes. I'm just wondering who would be expected to pick 12:50
11 up on whether there had been an increase in
12 whistleblowing reports, for example, from a particular
13 facility? Who would be expected to pick up that kind
14 of information?
15 A. That would be trust level responsibility. 12:51
16 214 Q. Chair, I am almost finished this section, but I am also
17 conscious that we're very close to lunchtime. I'm
18 inevitably going to go into the afternoon. So...
19 CHAIRPERSON: Go over. Have you got much to do on
20 whistleblowing? 12:51
21 MR. DORAN: No, I think I can deal with this within the
22 next few minutes actually.
23 CHAIRPERSON: Shall we try and do that?
24 MR. DORAN: So I'll finish this topic just before
25 lunch. 12:51
26 215 Q. Yes, I just wanted to ask you then about the group that
27 you refer to in paragraph 2.26, that's the Regional
28 Whistleblowing Working Group?
29 CHAIRPERSON: 12.26.

1 216 Q. MR. DORAN: 12.26, yes. Oh, apologies. Yes. 12.26:
2
3 "The Regional Whistleblowing Working Group headed up by
4 Trusts and with departmental involvement has recently
5 conducted work in re-drafting the HSC Whistleblowing 12:51
6 Framework and Model Policy to ensure it is in
7 compliance with recent good practice guidance. Public
8 consultation in relation to this document finished in
9 September 2022 and the framework and policy is
10 currently being finalised." 12:52
11
12 Just, can you say something more about the composition
13 and working arrangements of that group?
14 A. I don't have that detail, Mr. Doran, apologies, but I
15 will come back on that. I don't have the details of 12:52
16 who sat on that group or the current status of the
17 report, but I will provide that in the addendum
18 statement.
19 217 Q. Yes. I was going to ask actually whether there was any
20 update on the report, and presumably that can be 12:52
21 furnished to the Inquiry?
22 A. Absolutely.
23 218 Q. Just a final query in this section. Has consideration
24 ever been given in Northern Ireland to an initiative
25 such as the National Guardian's Office and the Freedom 12:52
26 to Speak Up Guardians? I'm not sure if you're aware of
27 that initiative in England and Wales? It was
28 introduced certainly in England a number of years ago.
29 A. I'm not aware of it, and I wouldn't have detail as to

1 whether that had been considered in Northern Ireland or
2 not.
3 219 Q. Just it followed on from a report by Sir Robert Francis
4 in 2015, and basically his recommendations were made on
5 the basis that the culture within the health service in 12:53
6 England didn't always encourage or support workers to
7 speak up, and there was a system then of guardians or
8 independent support persons introduced to promote
9 speaking up within the workplace?
10 A. I think one of the -- I suppose one of the elements of 12:53
11 the framework we've mentioned at my Exhibit 116, it
12 does contain there on page 5329 a list of who
13 complaints can be raised with within individual Trusts,
14 et cetera, who they could go to.
15 220 Q. Can we bring up 5329, please? 12:53
16 A. I think it was 5329. So that would give a list of who
17 you could raise -- an individual could raise a
18 complaint with. I'm not sure whether that is similar
19 to the guardian...(INTERJECTION).
20 CHAIRPERSON: No. I mean what that is, that's just 12:54
21 following the public interest disclosure order, isn't
22 it? I mean, this may be of some importance - to what
23 extent does somebody in your department look at what's
24 happening in England and the learning from reports such
25 as Sir Robert Francis and think 'oh, we had better have 12:54
26 a look at that and see if it is worthwhile to do in
27 Northern Ireland?'. Does that happen?
28 A. We would regularly look at what's happening in other
29 parts of the jurisdiction, Chair. As I've noted on a

1 number of occasions, with an integrated care system it
2 isn't always that we can read across what happens in
3 England and with locally accountable ministers. We
4 always like to look at what is specific for Northern
5 Ireland's circumstances. But where there is learning, 12:54
6 we would regularly -- for example, any new policy which
7 I have developed not only in the Department of Health
8 but in the Department of Justice where I used to work,
9 we would regularly say, and this is what happens in
10 England and Wales and the Republic of Ireland -- so 12:55
11 there is - we would regularly look at what is happening
12 in other parts of the jurisdiction to see what learning
13 can be brought into Northern Ireland.
14 CHAIRPERSON: So who in your department would be
15 looking at things like the National Guardians Office? 12:55
16 A. We have a central governance unit within the Department
17 who would deal with complaints and who would deal with
18 freedom of information requests, subject access
19 requests, et cetera. I'm not sure
20 whether...(INTERJECTION) 12:55
21 CHAIRPERSON: But in terms of policy, I mean, rather
22 than...
23 A. They would also deal with policy. There's a central
24 unit within the Department who would look at policies.
25 In terms of Civil Service wide whistleblowing or 12:55
26 complaints policies, they would be the responsibility
27 of the Department of Finance, and they would
28 disseminate policies across the Northern Ireland Civil
29 Service.

1 CHAIRPERSON: Right. And I mention this with some
2 sensitivity, but out of interest, do you know if the
3 fit and proper person test as applied in the NHS is
4 under consideration in Northern Ireland?
5 A. I am not aware, Chair, but we will look into that and I 12:56
6 can come back.
7 CHAIRPERSON: Now. Okay. Thank you.
8 MR. DORAN: That completes my coverage of that topic,
9 Chair. So I think that's a suitable moment to break?
10 CHAIRPERSON: How long do you think... 12:56
11 MR. DORAN: Certainly less than an hour, Chair?
12 CHAIRPERSON: Right. Okay. Mr. McGuicken, thank you
13 very much indeed. We'll see you later.
14 A. Thank you, Chair.
15 MR. DORAN: Two o'clock, Chair? 12:56
16 CHAIRPERSON: Yes. Sorry, two o'clock.
17 MS. ANYADIKE-DANES: Just before you rise. Firstly to
18 apologise. I am not able to be here this afternoon
19 because I have a matter that I just simply cannot get
20 out of, so I apologise for that. My junior will be 12:56
21 here.
22
23 But I just wanted to raise one matter that you I think
24 yourself raised at the end of the evidence of Elizabeth
25 Brady yesterday, which is throughout this witness' 12:57
26 evidence there have been a number of occasions in which
27 he has said "I'll check on that" or "I'll come back on
28 that", and your suggestion last time was could all
29 those be collated so that there's one shopping list of

1 all the things that are going to be checked, otherwise
2 it is possible for something to be lost.
3 MR. DORAN: Chair, this is a matter that will be dealt
4 with by your representatives.
5 CHAIRPERSON: All right. 12:57
6 MS. ANYADIKE-DANES: Well, I'm very grateful.
7 MR. DORAN: What I will say, Chair, is that this
8 witness is fully represented, obviously.
9 CHAIRPERSON: Yes.
10 MR. DORAN: And I am aware that careful note is being 12:57
11 taken of the various outstanding matters that are
12 arising in the course of evidence. So all of that
13 matter is being fully looked after by your team.
14 CHAIRPERSON: Sure. What I raised yesterday was
15 obviously the importance of a focus for the witness to 12:57
16 know what the Inquiry is specifically interested in,
17 and we may be able to assist.
18 MR. DORAN: We will assist in every way that we can.
19 CHAIRPERSON: Yes. All right. Well, thank you very
20 much indeed. All right. Thank you. Two o'clock, 12:58
21 please.
22
23 LUNCHEON ADJOURNMENT
24
25
26
27
28
29

Gwen Malone Stenography Services Ltd.

1 THE HEARING RESUMED, AS FOLLOWS, AFTER THE LUNCHEON
2 ADJOURNMENT
3
4 CHAIRPERSON: Thank you.
5 MR. DORAN: Good afternoon. Mr. McGuicken, we're 13:59
6 moving on now to consider Topic 3(J) and that's:
7
8 "Overview of mechanisms for identifying and responding
9 to concerns."
10 14:00
11 CHAIRPERSON: Sorry, Mr. Doran, I should have said.
12 Just so that everybody knows, they may already have
13 been told, unfortunately we had to split the transcript
14 up today into three. There have been technical reasons
15 for that. It won't happen again, I'm assured, and 14:00
16 there will be a synchronized complete transcript for
17 today. But at the moment, if you want to keep the
18 transcript you've got to save them. Apologies.
19 MR. DORAN: Thank you, Chair. So it's Topic 3(J):
20 14:00
21 "Overview of mechanisms for identifying and responding
22 to concerns."
23
24 And you provide a detailed history of mechanisms for
25 identifying concerns at paragraphs 13.1 to 13.21 of the 14:00
26 statement.
27 A. Yes.
28 221 Q. Again, I'm not going to proceed through the finer
29 details of this material in oral evidence. The Inquiry

1 will of course be hearing further about the RQIA and
2 its predecessor in due course. But I just wanted to
3 highlight perhaps some key milestones in the timeframe
4 of the terms of reference in the area of regulation and
5 improvement. 14:01
6
7 The first is in 2001, and you deal with this in
8 paragraph 13.2 with the publication of the Best
9 Practice and Best Care Report and that appears at
10 Exhibit 117 at page 5342. Can we go to page 5342, 14:01
11 please? And just scrolling down to page 5373. I think
12 it's fair to say the essential recommendation in this
13 report was for a body called the Health and Social
14 Services Improvement Authority. Isn't that right?
15 A. It is, yeah. 14:02
16 222 Q. And was that then the genesis of the RQIA?
17 A. It is. That was the forerunner for the RQIA.
18 223 Q. Yes. And the RQIA was eventually formed in 2005?
19 A. Yes.
20 224 Q. I think you deal with that in paragraph 13.8. I think 14:02
21 it is right to say that there never was a body actually
22 called the Health and Social Services Improvement
23 Authority? That in fact when it was introduced it was
24 called the RQIA?
25 A. I'm not sure, Mr. Doran, to be fair. I'll check that. 14:02
26 I'll take your word for it.
27 225 Q. It's something that we can check ourselves. But the
28 RQIA in any case eventually formed in 2005, and then in
29 paragraph 13.15 you refer to the RQIA taking on the

1 functions of the old Mental Health Commission, and that
2 occurred in 2009?
3 A. That's correct.
4 226 Q. Now, I just want to go back briefly to 2004, and you
5 refer in paragraph 13.5 to a circular that provided a 14:03
6 definition of serious adverse incident, and you say at
7 13.5:
8
9 "In 2004, the Department issued a circular providing
10 interim guidance on the need for the Department to be 14:03
11 informed immediately about incidences regarded as
12 serious, provided a definition of what constitutes a
13 serious adverse incident and advised that the
14 Department would collate information on incidents
15 reported to it and provide relevant analysis to the 14:03
16 Health and Personal Social Services organisations and
17 agencies."
18
19 And the circular is attached at Exhibit 119. And I
20 wonder can we just have a look at the circular? It 14:03
21 appears at page 5408. And then again, it's directed at
22 a wide range of addressees, as one can see. I'm not
23 going to go through them again. But if we can scroll
24 down, please, to the next page, 5409, and this is
25 Guidance on Serious Adverse Incidents, and paragraph 2 14:04
26 provides that:
27
28 "The Department is to be informed immediately. This
29 interim guidance highlights in particular the need for

1 the Department to be informed immediately about
2 incidents which are regarded as serious enough for
3 regional action to be taken to ensure improved care or
4 safety for patients, clients, or staff."
5 14:04
6 And:
7
8 "It also draws attention to the need for the Department
9 to be informed, or a Trust Board or Special Agency
10 considers that an event is of such seriousness that it 14:04
11 is likely to be of public concern."
12
13 And then can we scroll down to page 5410, and that
14 provides then a definition of serious adverse
15 incidents, and at paragraph 8 one sees the definition: 14:05
16
17 "In line with this, the action required by this
18 circular, the Department considers that a serious
19 adverse incident should be defined as any event or
20 circumstances arising during the course of the business 14:05
21 of a HSS organisation, special agency or commission
22 service, that led or could have lead to serious
23 unintended or unexpected harm, loss or damage. This
24 may be because it involves a large number of patients,
25 there is a question of poor clinical or management 14:05
26 judgment, a service or a piece of equipment has failed,
27 a patient has died under unusual circumstances or there
28 is the possibility or perception that any of these
29 might have occurred."

1
2 And then some examples are given, and also in Annex A
3 of that document, which we'll not go on to.
4
5 14:06
6 Just to ask, does that definition of serious adverse
7 incident remain valid today?
8 A. I think that would be the same general example or the
9 same general criteria as we use today.
10 227 Q. Yes. So certainly looking through the documentation 14:06
11 there doesn't appear to an updated version of that.
12 Who actually decides whether a serious adverse incident
13 has occurred or may have occurred?
14 A. That would be each individual trust using that criteria
15 would decide whether it reaches a threshold of an SAI, 14:06
16 is my understanding.
17 228 Q. So, again, it's a matter of, in the first instance, for
18 the Trust to identify?
19 A. Yes.
20 229 Q. And I wanted to ask you then about the change of 14:06
21 practice that occurred in or around 2010. In fact in
22 2010. And you deal with this at paragraph 13.16, and
23 paragraph 13.17. If we just go back, please, to page
24 61. So you say there in paragraph 13.16:
25 14:07
26 "A further departmental circular issued on 30th April
27 2010 on revised arrangements for severe adverse
28 incident advised that HSC organisations were to cease
29 routinely reporting SAIs to the Department from the 1st

1 of May 2010, and in line with operational guidance
2 issued by the HSC BPHA reporting of all incidents
3 meeting the SAI criteria should be from the HSCB from
4 the 1st of May 2010."
5 14:07
6 And you attach a copy of the circular then at Exhibit
7 133. Then:
8
9 "On the 28th May 2010, the Department issued the
10 circular establishment of an early alert system which 14:08
11 provided guidance on the operation of a new early alert
12 system intended to ensure that the Department was made
13 aware in a timely fashion of significant events
14 occurring within HSC organisations."
15 14:08
16 And again you attach a copy. Now, that seemed then to
17 mark a change of practice whereby reporting of serious
18 adverse incidents would be to the Board in the first
19 instance rather than to the Department?
20 A. Yes, that's correct. 14:08
21 230 Q. And there's then the new system for reporting serious
22 adverse incidents, or the new early alert system for
23 reporting incidents that we discussed in brief earlier
24 on?
25 A. Yes. Yes. 14:08
26 231 Q. Can you explain, if possible, the rationale for those
27 changes at the time?
28 A. I can't necessarily explain the rationale, Mr. Doran,
29 but in terms of the early alert system, I think when

1 the SAIs were reported to the Department it meant the
2 Department was seeing everything and then SAIs were
3 reported directly to the Board. So there wasn't that
4 direct line of sight between an incident happening in a
5 Trust, or in an establishment, if it was an SAI, 14:09
6 because that was going to the Board. The early alert
7 system was then brought in to allow that reporting
8 mechanism. The early alert system has, I think it's
9 around six criteria, that a Trust would assess whether
10 the Department needed to be made aware of an early 14:09
11 alert happening. Certainly in my time in the
12 Department a number of early -- quite a few early
13 alerts have been notified to the Department depending
14 that they meet the criteria, whether it be in relation
15 to a reduction in services, or care packages not being 14:09
16 able to be delivered, or delays in hospital discharge,
17 et cetera, some of those issues would be sent up to the
18 Department as an early alert so the minister is aware
19 of an emerging issue.
20 232 Q. But did it mean that a serious adverse incident 14:10
21 wouldn't necessarily be brought directly to the
22 attention of the Department itself?
23 A. Yes, because it was reported to the Board at that
24 stage.
25 233 Q. The Board would be expected to progress the matter 14:10
26 then?
27 A. The Board would be expected -- yes, yes.
28 234 Q. And, I suppose, that has changed now, has it, with the
29 introduction of S...(INTERJECTION)

1 A. SPP, yes.
2 235 Q. Yes. So the system would be referral of SAI to
3 SPP...(INTERJECTION)?
4 A. Yes.
5 236 Q. In the first instance. 14:10
6 A. Which is, in essence, the Department.
7 237 Q. But in terms of the overall responsibility to address
8 serious adverse incidents, presumably that resides
9 still with the Department?
10 A. It does, yeah. 14:10
11 238 Q. I then wanted to ask you to explain a point that you
12 make about the strategy that was launched in 2011 to
13 protect and improve quality and health in social care
14 in Northern Ireland, and you deal with this at
15 paragraph 13.18, that's on the next page, page 62. And 14:11
16 you say there:
17
18 "In November 2011 the Department launched Quality 2020,
19 a 10-year strategy to protect and improve quality in
20 health and social care in Northern Ireland. 14:11
21
22 As part of the strategy Objective 1 set out that as
23 part of an increased emphasis on high quality services,
24 a key element to gauge the success would be an increase
25 in the number of adverse incidents and near misses 14:11
26 being reported as the outworking of a stronger
27 reporting and learning culture, with a related decline
28 in the number of serious adverse incidents."
29

1 And you attach a copy of the strategy then at Exhibit
2 135. I wonder could you just possibly explain what
3 you're getting at in that paragraph 13.18?
4 A. I think when you introduce anything new in terms of a
5 reporting mechanism you would expect to see an increase 14:12
6 in reports, and that's what it reflects in terms of
7 that we would expect to see an increase in the
8 reporting of SAIs, because it was a revised structure
9 and a revised process in place for that reporting
10 mechanism. So you would automatically expect to see an 14:12
11 increase in the number of SAIs reported because it was
12 based on a revised structure. Now, that tailed off. I
13 think the SAI figures are in an earlier exhibit, so it
14 does show - I think it's page 5610 and 5611 shows the
15 number of SAIs reported, so you do see a slight peak in 14:12
16 that and then they fall off again after that.
17 239 Q. So procedures change slightly, then there's an upturn
18 in reports, but that falls away?
19 A. Yeah. Once it's embedded. And I don't think it would
20 be reflective of - again, I'm trying to look back in 14:13
21 history - I don't think it would be reflective of an
22 increase in incidents. It would purely be reflective
23 of an increase in the reporting of those incidents.
24 240 Q. But is that matter capable of being analysed?
25 Presumably it would cause concern if there was an 14:13
26 increase in reports?
27 A. I think, as I've set out there, we did expect to see an
28 increase because of the new structures in place and
29 then a decline once those structures had been embedded

1 in.
2 CHAIRPERSON: But the decline, the concept is that the
3 decline comes from the learning.
4 A. Yes.
5 CHAIRPERSON: From the increased number of reports. 14:13
6 Therefore, there should be a fewer number of incidents
7 but not a fewer number of reports relating to
8 incidents.
9 A. Yes. Yes. Sorry, Chair.
10 241 Q. MR. DORAN: And that obviously was a strategy devised 14:13
11 for the forthcoming decade.
12 A. Yes.
13 242 Q. Was that kept under review?
14 A. Well, it was. It was a 10-year strategy, as is
15 highlighted in that report. I'm not aware of the 14:14
16 reporting or the review mechanisms of that, Mr. Doran,
17 but we can check to see if there was any review
18 mechanisms in place.
19 243 Q. Now, finally in this section you deal with the
20 Department's process for dealing with early alerts, and 14:14
21 that is covered in paragraphs 13.20 and 13.21. I'm not
22 going to go into this in detail. You refer to guidance
23 in paragraph 13.21 that was issued in March 2020, I
24 think, and that's exhibited at 141. Is that the most
25 up-to-date guidance on the early alert? 14:14
26 A. It is, Mr. Doran, yeah.
27 244 Q. Now, in Topic 3(K) then you deal with Risk Assessments
28 and Planning Regarding Changes of Policy, and in
29 paragraphs 14.1 to 14.13 you refer to very high level

1 policy documents on risk and risk management?
2 A. That's correct.
3 245 Q. And as indicated earlier, these are materials that the
4 Panel needs to have but the Inquiry doesn't necessarily
5 need to explore in oral evidence for the purpose of 14:15
6 addressing the terms of reference. But there's just
7 one question arising from what you say at 14.12, where
8 you mention the equality screening process, and you say
9 at 14.12 - that's page 65 - you say:
10 14:15
11 "All new policies or proposals to change existing
12 policies are required to undergo a screening process to
13 identify any potential adverse impacts on the groups
14 specified in Section 75."
15 14:16
16 And that's Section 75 of the Northern Ireland Act 1998.
17
18 "Impacts on and the protection of human rights are also
19 assessed."
20 14:16
21 I just wanted to ask you a question about that process.
22 What about other kinds of risks, such as impact on
23 staffing? You know, for example, are there enough
24 staff to ensure that a particular policy can be
25 implemented effectively, or will the change of policy 14:16
26 lead to staff being diverted from other dedicated tasks
27 or even, you know, what about the impact of a change of
28 policy on say patient safety. Is there any mechanism
29 for considering risks of that kind as opposed to those

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1 you've identified in the statement?
2 A. The policy statement there in terms of 14.12 is around
3 each departmental or each government Department's
4 responsibilities in terms of the Northern Ireland Act,
5 and it looks at a number of - we need to do a number of 14:17
6 assessments for new policies, and there'd be human
7 rights, there'd be equality, there would be rural
8 impact assessments, et cetera. So they are governed by
9 what we have to do in terms of the Northern Ireland
10 Act, and they are Civil Service wide policies. That's 14:17
11 what that specific paragraph relates to.
12 246 Q. That's essentially to reflect the statutory
13 requirement?
14 A. It is, Mr. Doran, yes.
15 247 Q. What I'm asking about is, for example, other risks that 14:17
16 might be occasioned by developing a new policy, such as
17 impact, you know, the impact of a change on patient
18 safety?
19 A. Yeah.
20 248 Q. What about considerations such as that? How do they 14:17
21 factor in to the assessment process prior to an
22 anticipated change of policy?
23 A. There is no formal legislative requirement to carry out
24 that assessment, is my understanding. Now in terms of
25 if we were bringing in a new policy we would need to 14:18
26 look at how that would be delivered and how Trusts
27 would deliver that. So part of that impact assessment
28 - as I say there is no formal impact assessment on the
29 impact on patients or the impact on patient safety, to

1 my knowledge, but it would be part of the consideration
2 we would give to a policy in development.
3 249 Q. And when you say "we" do you mean the Department or do
4 you mean a specific policy branch within the
5 Department? 14:18
6 A. It would be -- depending on each individual policy. As
7 we've noted previously, my area covers learning - or
8 disability in older people. So if we were implementing
9 a new policy I would have to have cognisance of the
10 impact of that specific to my area of policy 14:18
11 responsibility and others would have do similar within
12 their areas.
13 DR. MAXWELL: Can I ask a specific question around
14 that? So we've heard of frequent ambitions to close
15 Muckamore completely, which haven't come to fruition. 14:18
16 When looking at resettlement policies, have people
17 thought about the consequences of moving the resources
18 to that on the remaining service at Muckamore?
19 A. Certainly in terms of the current resettlement agenda
20 being overseen by Patricia Donnelly, we have not 14:19
21 withdrawn any of the current funding from Muckamore in
22 terms of doing those resettlements. So, eventually if
23 a decision is taken to close Muckamore as a hospital
24 setting in its current setting we will have to then
25 look at... 14:19
26 DR. MAXWELL: But it's more than just financial. So
27 we've heard from actually families that they're aware
28 that staff became very anxious about their job security
29 from as early as 2012, and that contributed to the

1 staffing difficulties, which may have contributed to
2 the incidents we are looking at. Are those unintended
3 consequences considered?
4 A. They are. Certainly we have, as part of the process
5 before we went to public consultation, Belfast Trust 14:20
6 did engage with the staff to inform them of the
7 consultation on the future of the hospital, and we will
8 engage or we will ask the Trust again to engage when a
9 decision is taken before that decision is made public.
10 Equally we engaged with families and carers before the 14:20
11 public consultation went live. So we are aware of the
12 implications of the impact of staff.
13
14 A number of staff within Muckamore are already taking
15 other opportunities in other learning disabilities 14:20
16 establishments. There is a number of new beds being
17 opened in the Northern Trust, and some of the staff
18 from Muckamore have applied for those posts and have
19 been successful in those posts in other Trust areas.
20 So there is an impact on the staff in Muckamore. 14:20
21 DR. MAXWELL: With consequent impact on the patients,
22 because we've already heard, I think from you, that
23 they're running 80% agency at the moment. The more
24 staff move out, the more that -- so there are
25 consequences of policies other than financial. 14:21
26 A. There are. As staff move out, staff will -- the
27 staffing levels will be commensurate to the amount of
28 patients who are still within Muckamore. We have had,
29 as I say, I think it is seven have been resettled from

1 Muckamore in the past five or six months. We have not
2 reduce the staffing levels at all within Muckamore in
3 that time period. So it will be commensurate to the
4 risk of the patients and the level of clinical need of
5 those patients. 14:21
6 DR. MAXWELL: I am sorry to labour this. But agency
7 staff present more of a risk than substantive staff.
8 So there is still is risk.
9 A. A lot of the agency staff who are currently within the
10 hospital have been there for a considerable period of 14:21
11 time, but I do accept that there is a higher risk with
12 agency staff than substantive staff.
13 250 Q. MR. DORAN: You then move on to deal with Topic 3(L),
14 and that's "Procedures to Provide Assurance Regarding
15 Adherence to Policies", and you deal with this in 14:22
16 paragraphs 15.1 to 15.18. Now, you mention the
17 overarching framework document at paragraph 15.2, and
18 also then the learning disability service framework
19 document at 15.7, and we addressed those documents in
20 the first evidence session, and we'll be returning to 14:22
21 deal with the Learning Disability Framework when you
22 have made your follow-up statement.
23 A. That's fine, Mr. Doran.
24 251 Q. The other documents addressed in this section again are
25 for the most part very high level materials. I just 14:22
26 want to focus on a couple of specific matters.
27
28 At paragraph 15.9 you say that:
29

1 "The Department holds assurance and accountability
2 meetings with each HSC body twice yearly at mid and
3 end-year."
4
5 And you go on to give details of those, and I think 14:23
6 then you give an example in your exhibits from the
7 2010/2011 end-year. Can you say in what year those
8 meetings started?
9 A. I'm not -- I don't have that detail, but I can come
10 back, Mr. Doran. I don't know exactly when they 14:23
11 started.
12 252 Q. Now this is a matter that might require some further
13 research, but are you aware of any of those meetings in
14 which there was a discussion of issues relating
15 specifically to learning disability or to the facility 14:23
16 at Muckamore?
17 A. I understand there were specific meetings with Belfast
18 Trust, which would have considered Muckamore, but we
19 will provide specific details of those minutes to the
20 Inquiry. 14:23
21 253 Q. Yes. Yes. It may well be that those minutes have been
22 provided through another route, but that's obviously a
23 matter in which the Inquiry will be interested.
24
25 Now, you refer in paragraphs 15.14 to 15.18 to 14:24
26 delegated statutory functions, and in the first
27 evidence session we dealt with the purchaser/provider
28 split and the primary responsibility for provision
29 being with the Trust, isn't that right?

1 A. Yes.
2 254 Q. And you then go on to describe the mechanisms that are
3 in place for the oversight of delegated statutory
4 functions, and it's fair to say overall responsibility
5 lies with the Department? 14:24
6 A. It does.
7 255 Q. I think you refer to the Office of Social Services. Is
8 that an office within the Department of Health?
9 A. That is. That is another directorate within -- it sits
10 within the same policy area as my directorate does. So 14:24
11 its responsibility is with the Chief Social Work
12 Officer within the Department.
13 256 Q. Now, I just want to look briefly at two documents in
14 this context. The first is Exhibit 160. You say in
15 paragraph 15.15 that you've included -- sorry, you 14:25
16 refer to the requirement for an unbroken line of
17 professional oversight of the discharge of delegated
18 statutory functions from the Trusts to the Board and:
19
20 "...it's predecessors to the Department has been in 14:25
21 place since then, as set out in circular HSS 1 2006
22 that I've included at MMCG 160."
23
24 And can we just turn to that? It's on page 6506. Just
25 my query about this is that it seems to relate to 14:25
26 children only, the welfare of children only. Is that
27 just given as an example of this kind of document?
28 A. It is, Mr. Doran. It's purely an example.
29 257 Q. Yes. No, that's fine. The next document I think is of

1 more general application, and that's Exhibit 161 at
2 page 6519. I wonder if we could move to that one,
3 please? And that is a circular headed:
4
5 "Roles and Responsibilities of the Department of 14:26
6 Health, Social Services and Public Safety, the Health
7 and Social Care Board and the Health and Social Care
8 Trusts for the professional oversight of the discharge
9 of delegated statutory functions."
10 14:26
11 And I just want to highlight one paragraph in this
12 document, more for attention than the putting of
13 questions, and it's at paragraph 3.1 on page 6520.
14 That's it. It's paragraph 3.1, "Accountability".
15 14:26
16 "Accountability is a key element in the discharge of
17 delegated statutory functions. The Department as the
18 parent sponsor body of the HSCB and Trusts carries
19 ultimate responsibility for the performance of these
20 organisations, including the discharge of DSFs within a 14:27
21 system of delegation. This responsibility is not
22 transferable to any other body."
23
24 Presumably that is a succinct and accurate statement of
25 the Department's overarching responsibility in this? 14:27
26 A. It is, Mr. Doran, yeah.
27 258 Q. And you say then, if we go back to the statement at
28 page 70, in paragraph 15.8 - sorry 15.18 you say:
29

1 "In terms of reporting, professional oversight is an
2 ongoing process and takes place throughout the year
3 with arrangements in place for any issues raised to be
4 dealt with."
5 14:27
6 Can you be a bit more specific about those arrangements
7 and how they work?
8 A. Well that would be part -- I've noted previously around
9 -- paragraphs 15.19 -- around the accountability
10 meetings and the insurance meetings that are held twice 14:28
11 yearly, and I described as well in my initial statement
12 around those governance and accountability structures
13 within the Department. So they would be taken forward
14 through there. If there were any issues which were
15 identified in a year, or there was an ongoing issue - 14:28
16 specifically in this one - in terms of social work, the
17 Chief Social Work Officer would engage with Trusts and
18 engage with the social work officers within the Trusts
19 to clarify any ongoing issues. So it wouldn't
20 necessarily be left to those, those formal meetings. 14:28
21 If there's an issue throughout any given period in the
22 year they would be addressed by the Chief Social Work
23 Officer with the social work leads within the Trusts.
24 259 Q. And you give an example there of the Department's
25 advice to the chief social worker. Is that just by way 14:28
26 of example? Presumably the advice could be to someone
27 else, if appropriate.
28 A. Again, it is purely by way of example, Mr. Doran.
29 260 Q. Yes. Now, you mention the annual report that the

1 Department receives from the Board, now SPPG,
2 presumably?
3 A. Yes, that's correct.
4 261 Q. And you give a sample report from 2016/2017 at Exhibit
5 162. Can we turn to that? It's on page 6543. And the 14:29
6 report is titled "Delegated Statutory Functions -
7 Composite Corporate Parenting Report". Presumably
8 corporate parenting is a technical term? This isn't
9 related to actual parenting?
10 A. No, it's a technical term. 14:29
11 262 Q. Yes. In this report actually, if one turns to 6574,
12 there is actually a section on mental health and
13 learning disability. If you scroll down to -- could we
14 scroll down to 6576, please, where the specific area of
15 learning disability is addressed. And I think -- so 14:30
16 there's a reference there to risk, governance issues
17 and service pressures, and could we scroll down a
18 little bit, please? There's a -- yeah, there's a
19 reference to professional and workforce issues.
20 14:30
21 "HSCB has led a regional drive to invest in crisis
22 response services for people with learning disability
23 in each Trust area. In the Belfast Trust there is a
24 reported lack of demand for this service. However, it
25 is noted that there are an increasing number of 14:30
26 inappropriate readmissions to Muckamore linked to
27 behaviour challenges as opposed to an identified
28 treatment requirement."
29

1 Now, that's a specific reference to Muckamore in this
2 report and that was for 2016 to 2017. I wonder, have
3 you checked the following year's report to see if the
4 revelations of Muckamore were specifically addressed in
5 this forum? 14:31
6 A. I haven't personally, Mr. Doran, but I can do that and
7 come back as part of my addendum statement.
8 263 Q. It would be a matter of interest to the Inquiry as to
9 whether there was specific consideration of the issues
10 in the context of a delegated statutory functions 14:31
11 report of this kind?
12 A. Again, this was only provided by way of an example. So
13 we can look at the subsequent years.
14 264 Q. Thank you. Now the final topic then in this module is
15 3(M), and you deal in paragraph 16.1 to 16.16 with a 14:31
16 number of very high level documents concerning
17 workforce training and development across the health
18 and social care system in Northern Ireland. Again,
19 very helpful for the panel to have the documents
20 collated in this way, but I don't need to go through 14:32
21 them in detail in oral evidence with you today.
22
23 I just had one question arising from paragraph 16.5.
24 You refer to the fact that the vast majority of staff
25 in the health and social care system are employed under 14:32
26 agenda for change, terms and conditions. And then
27 later in that paragraph -- sorry we're back at page 71.
28 My apologies. And it's paragraph 16.5.
29

1 Yes. So you say:
2
3 "The vast majority of staff are employed under agenda
4 for change."
5 14:32
6 And then later you say:
7
8 "As part of the agenda for change agreement introduced
9 in Northern Ireland in 2004, knowledge and skills
10 framework was developed as a tool for describing the 14:33
11 knowledge and skills staff need to apply at work in
12 order to deliver high quality services."
13
14 And you attach then a copy of the NHS Knowledge and
15 Skills Framework. My query is simply this; is the NHS 14:33
16 Knowledge and Skills Framework directly applicable in
17 Northern Ireland or is there a Northern Ireland
18 specific version of that document?
19 A. I could only read what's been provided, and it says:
20 14:33
21 "As part of the agenda for change introduced in
22 Northern Ireland the skills framework was developed as
23 part of..."
24
25 -- as that tool. So I'm assuming it is relevant to 14:33
26 Northern Ireland in that context. But, again,
27 Mr. Doran, I can clarify that.
28 265 Q. It's something that can be...
29 DR. MAXWELL: I think it's UK-wide.

1 MR. DORAN: It is UK-wide. Well, that answers my
2 question, and in fact that answers my final question
3 for today's evidence session. Thank you.
4 Mr. McGuicken, those are all the questions that I have,
5 but it may be that the Panel will want to pick up on a 14:33
6 few issues before we close.
7 CHAIRPERSON: I think we picked up on everything as
8 we've gone along. Mr. McGuicken is coming back in any
9 event.
10 MR. DORAN: Yes. I wanted to say something about that, 14:34
11 Chair. If one looks at the schedule for next week.
12 The inquiry is not sitting on -- well, the indication
13 is given that on Monday, 24th April, time has been
14 reserved for evidence if required, and on Tuesday, 25th
15 April, Mr. McGuicken is due to return in the afternoon 14:34
16 at 2:00p.m.. Now, the reason Monday doesn't have a
17 specific witness at the moment, and indeed Tuesday
18 morning, is that the Inquiry was to hear from a Trust
19 witness, Ms. Shaw.
20 CHAIRPERSON: Yes. 14:35
21 MR. DORAN: The statement in relation to her evidence
22 and exhibits, which are fairly voluminous, was received
23 relatively recently, and it was felt that some further
24 time would be needed, both for your representatives,
25 core participants and, indeed, the Panel to consider 14:35
26 that material. So Ms. Shaw's evidence has been
27 deferred until the 1st of June.
28
29 Now, I reflect -- I think I indicated earlier that

1 Mr. McGuicken may wish to come back in the morning
2 rather than the afternoon next Tuesday, but I've had a
3 radical rethink of that plan, Chair, and the reason is
4 this: when one looks at Mr. McGuicken's statement, we
5 have already been through substantial parts of it. He 14:35
6 was only asked to address Topic A in Module 4, which
7 relates to Workforce Plans For Disability Care 1999 -
8 2021, and that part of the statement runs to about four
9 pages, or less than four pages. Now, as we know,
10 Mr. McGuicken is going to be furnishing the Inquiry 14:36
11 with a further statement.
12 CHAIRPERSON: So paragraph 17.1 onwards.
13 MR. DORAN: 17.1 through to 17.14.
14 CHAIRPERSON: Yeah. So, just a few pages.
15 MR. DORAN: Just a few pages. So we know that 14:36
16 Mr. McGuicken is going to be providing a further
17 statement. There are a number of issues to be picked
18 up on, particularly in relation to the earlier issues
19 that I dealt with on the last occasion. There is in
20 fact some overlap with those issues and the matters 14:36
21 that are dealt with under Module 4A. So it seems to me
22 that it may be preferable, rather than having
23 Mr. McGuicken back for a short session next Tuesday, to
24 hear all of the remainder of his evidence at a later
25 date, on which occasion we would have the benefit of 14:37
26 the further statement.
27 CHAIRPERSON: And there may be some matters picked up
28 from today, indeed.
29 MR. DORAN: Absolutely. Yes.

1 CHAIRPERSON: Well, there's no point, frankly, in
2 simply inconveniencing the witness, because the rest of
3 this statement is going to take less than an hour,
4 isn't it?
5 MR. DORAN: Oh, yes. Definitely. 14:37
6 CHAIRPERSON: When can Mr. McGuicken come back for that
7 final session?
8 MR. DORAN: Yes. To allow time, obviously, for the new
9 statement to be produced and for that to be processed
10 for disclosure and to be considered. 14:37
11 CHAIRPERSON: Yeah. We're looking at June?
12 MR. DORAN: We're looking at early June. Probably the
13 second week in June.
14 A. Just to flag, Chair, I have an immovable commitment
15 with my daughter being married at the end of May. So, 14:37
16 it would probably be towards the latter half of June
17 for my availability. Apologies.
18 CHAIRPERSON: Right.
19 A. The third week in June.
20 CHAIRPERSON: Well, I'm going to leave that. We are 14:38
21 sitting in the third week of June, so. It doesn't make
22 sense, frankly, to bring you back next week for half an
23 hour or an hour. That's stupid. So let's avoid doing
24 that. It does mean we're not sitting on Tuesday then.
25 MR. DORAN: It does. It means we're not sitting on 14:38
26 Monday or Tuesday of next week. We do have evidence on
27 the Wednesday and Thursday of next week.
28 CHAIRPERSON: Wednesday and Thursday. All right.
29 Rather than try and sort out your availability now in

1 public, I think it's better if we leave that to be
2 discussed between those representing you, and counsel
3 and Secretary to the Inquiry.
4 MR. DORAN: Yes. Chair, the witness can rest assured
5 that we'll make all efforts to accommodate him. 14:38
6 CHAIRPERSON: Yeah. Yeah. But it's obviously sensible
7 that we try and round up everything together in one
8 session, and we might need a couple of hours.
9 MR. DORAN: Yes, I would say we'd need either a morning
10 or an afternoon session. 14:39
11 CHAIRPERSON: Yeah. All right. Okay. All right.
12 Well, look, can I thank you in the meantime -- I think
13 that's what we'll do.
14 A. Thank you, Chair.
15 CHAIRPERSON: Can I thank you for the very 14:39
16 straightforward way that you've answered those
17 questions that you can answer. There's obviously quite
18 a lot that you haven't been able to deal with. But
19 thank you for the care that you've taken and for the
20 preparation that you've obviously done, as I said last 14:39
21 time I think you were here, and I'll leave you to speak
22 with those representing you and the Inquiry team to
23 organisation when you can return.
24 A. Thank you, Chair.
25 CHAIRPERSON: All right. So, we do have a full day 14:39
26 tomorrow?
27 MR. DORAN: Yes, we do, Chair. We have the evidence of
28 Mr. Hagan tomorrow commencing at 10:00 o'clock.
29 CHAIRPERSON: Yeah. Okay. All right. Well, thank you

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1 very much indeed. Then 10:00 o'clock tomorrow, please.
2 Thank you.
3
4 THE HEARING WAS THEN ADJOURNED UNTIL 10.00AM ON
5 THURSDAY, 20TH APRIL 2023 14:40
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