MUCKAMORE ABBEY HOSPITAL INQUIRY

SITTING AT CORN EXCHANGE, CATHEDRAL QUARTER, BELFAST

HEARD BEFORE THE INQUIRY PANEL

ON WEDNESDAY, 24TH MAY 2023 - DAY 43

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1 THE INQUIRY RESUMED AS FOLLOWS ON WEDNESDAY, 24TH MAY
2 2024
3
4 CHAIRPERSON: Good morning everybody. Just before we
5 start can I just mention tomorrow, where we've got Dr. 10:01
6 Margaret Flynn coming to give evidence, first of all
7 just to remind everybody it's a 9:30 start, that's to
8 assist Dr. Flynn. That is in the schedule, but it's
9 easy to miss, so it's a 9:30 start. There is likely to
10 be an application for a restriction order in relation 10:01
11 to some part of Dr. Flynn's evidence, which I will
12 consider tomorrow morning. Can I just say this: My
13 attitude, as you will know by now, is that as far as
14 possible all hearings should be public and the public
15 should see and hear as much of the Inquiry as 10:01
16 conceivably possible and so if there is a restriction
17 order, I would ask that it is, first of all, if there
18 is an application for a restriction order, it will be
19 in relation to a limited part of Dr. Flynn's evidence
20 and I will only, as it were, order a restriction in 10:02
21 respect of a very limited part of Dr. Flynn's evidence.
22 The great majority of it will be in public, so that
23 people can hear and see what she says, and I will only
24 order a restriction order, obviously, if it is
25 necessary to comply with my undertaking under the MOU. 10:02
26
27 Okay, are we ready for our next two witnesses?
28 MR. McEVOY: Yes. Good morning, Chair, good morning
29 panel.

1 CHAIRPERSON: Good morning.
2 MR. McEVOY: The Inquiry will hear today from
3 Ms. Vivian McConvey and Ms. Meadbha Monaghan on
4 behalf of the Patient and Client Council. Ms. McConvey
5 is the principle witness. There is an arrangement 10:03
6 where Ms. Monaghan, who is the current Chief Executive,
7 is going to join her in the witness box in case there
8 are any issues of currency which she can contribute
9 upon.
10 10:03
11 I should say, just for everyone's clarity, of course,
12 we are now looking, once again, at module 5 in relation
13 to the history, statutory remit objectives and
14 methodology, roles and responsibilities of PCC as it
15 relates to Muckamore. If the witness could be called 10:03
16 please.
17 CHAIRPERSON: So the main witness is going to be in the
18 big chair, as it were?
19 MR. McEVOY: The main witness is going to be in the big
20 chair I anticipate. 10:03
21
22 MS. VIVIAN MCCONVEY, HAVING AFFIRMED, WAS EXAMINED BY
23 MR. McEVOY AS FOLLOWS
24
25 MS. MEADBHA MONAGHAN, HAVING AFFIRMED, WAS EXAMINED BY 10:04
26 MR. McEVOY AS FOLLOWS
27
28 CHAIRPERSON: Can we have your names please?
29 MS. McCONVEY: Vivian McConvey.

1 CHAIRPERSON: And you took the affirmation first.
2 MS. McCONVEY: Yes.
3 MS. MONAGHAN: And Meadbha Monaghan, and I took it
4 second.
5 CHAIRPERSON: Can I welcome you both to the Inquiry and 10:04
6 thank you for your statement. I think the principal
7 writer was Ms. McConvey but thank you both. This
8 practice of, as it's called, buddying up witnesses or
9 having two witnesses in the box is quite unusual, as
10 you may know, but inquiries are allowed to do it, and 10:04
11 it has worked so far in the Inquiry and I'm sure it
12 will work this morning. But, Ms. McConvey, if we treat
13 you, please, as the principal witness and if at any
14 stage you need to confer with Ms. Monaghan or if,
15 Ms. Monaghan, you need to say anything can you just 10:05
16 make it clear that it is you speaking so that when we
17 eventually look at the transcript we know who has given
18 what evidence?
19 MS. MONAGHAN: No problem.
20 CHAIRPERSON: Thank you very much. 10:05
21 1 Q. MR. McEVOY: Thank you, Chair. So, Ms. McConvey,
22 hopefully before you, I think you have it in paper form
23 and also on the screen you will see a statement in your
24 name?
25 A. Yes. 10:05
26 2 Q. That's it. The statement is 59 pages in length. And if
27 you go to the last of those pages, page 59, do you see
28 there your signature?
29 A. Yes, I do.

1 3 Q. And a date then of 30th January 2023?
2 A. Yes.
3 4 Q. And do you wish to adopt that statement and the two, I
4 beg your pardon, the four exhibits as the basis of your
5 evidence to the Inquiry? 10:06
6 A. Yes, I do.
7 5 Q. So, Ms. McConvey, you have helpfully indicated just at
8 the outset of the statement, if we can go back to the
9 very first page, your professional background and your
10 involvement with the PCC. And at the time of 10:06
11 completing the statement you tell us then that you were
12 the Chief Executive Officer of the PCC. What's the
13 current position with regard to your role?
14 A. Currently I am in the process of retiring from the PCC,
15 I will finish up on 7th June. I'm currently on leave 10:06
16 from 13th March 2023. My colleague, Meadbha Monaghan,
17 took over as the Chief Executive and also as the
18 Accounting Officer responsible for the Patient Client
19 Council. This has enabled us through that period of
20 time to do a hand over and also I'm just using my leave 10:07
21 that I didn't get for the last two years.
22 6 Q. Okay. Lucky you, some might say. And in terms of
23 Ms. Monaghan's role then, what is her, and what has
24 been, if there has been one, the working relationship
25 between the two of you? 10:07
26 A. Ms. Monaghan joined the PCC in May 2020 as the Head of
27 Operations. As the Head of Operations in the PCC she
28 would have been deputy to myself as Chief Executive.
29 Therefore in the organisational review change in

1 operations Ms. Monaghan would have had the lead role.
2 7 Q. Okay. So you indicate then at the outset of your
3 statement on the first page, and indeed just at the end
4 of the first main paragraph:
5 10:07
6 "Prior to my appointment as Chief Executive officer I
7 was Chief Executive officer of Voice of Young People in
8 Care or VOYPIC from September 2002 until April 2019."
9 A. (Witness Nods).
10 8 Q. So that is a voluntary or a third sector organisation, 10:08
11 is that right?
12 A. That is correct. Predominantly, throughout my entire
13 career I have worked in the third sector. And I came
14 into VOYPIC, as it's known, Voice of Young People in
15 Care, in 2002, left in April 2019. It was a charity 10:08
16 that worked specifically with children who were in care
17 or leaving care aged up to 25. And predominantly the
18 role there was how to engage with young people in
19 systems and processes providing advocacy and ensuring
20 they were involved in decision-making processes related 10:08
21 to their life.
22 9 Q. Okay. And in that connection had you any involvement
23 with regard to children and young people who were in
24 the care of Muckamore, or the authorities responsible
25 for Muckamore? 10:09
26 A. No, not to my knowledge.
27 10 Q. Okay. Now, you have begun by giving in your statement
28 a history by way of an introduction of the statutory
29 functions and statutory objectives and a chronology of

1 the PCC and its structure. Could I ask you, please,
2 just to turn to, within that section, it's page six in
3 fact, if you can turn it up please. I suppose starting
4 towards the end first, if you can help the Inquiry to
5 understand just where you come into the picture in 10:09
6 terms of what you're able to speak about from your own
7 personal experience.
8 A. Yes.
9 11 Q. That is, from 2019 on, as you've told us. You indicate
10 at paragraph 8 that, under a heading of: 10:10
11
12 "Post 2019 organisational review" that prior to 2019
13 PCC had experienced a number of years of leadership
14 instability with year-on-year decreases in its funding.
15 Now, the Inquiry will come back to look at maybe the 10:10
16 reasons behind that in due course but can you give us
17 an indication, if you can, of what your perception was
18 in joining the PCC of how that instability had impacted
19 upon the PCC and in particular its statutory functions?
20 A. Just prior to joining the PCC I attended a couple of 10:10
21 meetings. I met with the outgoing chair and I met
22 with, at that time, their senior leadership team for a
23 couple of hours in the afternoon in their senior
24 leadership team meeting. I also took time to meet with
25 the interim Chief Executive, who had been holding the 10:11
26 post for I think it was six to nine months before I had
27 come in. And during that time, as a new Chief
28 Executive coming in, what you wanted to try to do was
29 to understand what was the landscape of the

1 organisation as you were coming into it.
2
3 This had been actually the first job that I had held in
4 health and social services. So most of my life, I
5 started off my career quite some time ago in 1987 in 10:11
6 which I worked with children who were in conflict with
7 the law in the justice end. Then I'd worked
8 predominantly throughout the voluntary sector and the
9 third sector. So I needed to have some understanding
10 coming in at this moment as a Chief Executive where was 10:11
11 the organisation, what were the key issues, what did I
12 need to focus on first?
13
14 So, trying to glean, it was an organisation that I had
15 seen and what I put in the statement was my perception 10:12
16 of what I'd seen at that time.
17
18 So I came in first and I had a look at the funding end
19 of it. So I came into a budget of about 1.4 million.
20 And actually in that first year I had to take a 2% cut, 10:12
21 so then I lost another £28,000. So it was important
22 for me to understand, first of all, what were the
23 resources of the organisation, what are you working
24 with. I had about 28 staff at the time. Then I needed
25 to understand what were the issues, how were the staff 10:12
26 experiencing.
27
28 So the Chief Executive had left, the Head of Operations
29 had been on long-term sick and there was a changeover

1 in the chair. Our Council at that time there were
2 issues in relation to recruitment, which is not in the
3 control of the PCC, as you know, it's a public
4 appointments process. And then there had been a change
5 at the head of development of corporate services and an 10:13
6 interim chief executive had been placed in. So what
7 you had there for a couple of years you could see
8 within an organisation that coming in it was timely for
9 a new chief executive, timely for a new chair. But if
10 you imagine at the top you would have this situation, 10:13
11 therefore that would roll down through into the rest of
12 the organisation, how the organisation would feel.
13
14 So I tried in those discussions to find out what was
15 happening, some of the messages I was getting was, one 10:13
16 was financial and the resource. Because when the PCC
17 had first started in 2009 it had a budget of about £1.8
18 million. Now, if you took that in relation to what you
19 would expect an organisation with inflation and going
20 up it was about a 40% drop in funding. So before I 10:13
21 even got to understanding our statutory functions and
22 how well we can act with our statutory functions and
23 what they are you need to understand as the Chief
24 Executive the staffing resource you have, how healthy
25 they are with that, where's the vision of the 10:14
26 organisation, how is it operating within the sector,
27 how is it operating on behalf of the public and what
28 are your key things. So they normally call that, for a
29 new Chief Executive, like the golden moment, where you

1 are those fresh eyes and ears, and that's what I was.
2 In listening to that some of the messages that I was
3 hearing from the senior staff at that time. And in my
4 first year I had a full turn over of the leadership
5 team as well. So by the time Ms. Monaghan joined me in 10:14
6 2020 we practically had a full turn over of the
7 leadership team. Both of us, I need to say as well,
8 had not worked in health and social services, we had
9 come from the third sector.
10 10:14
11 So what I set about then was a series of reviews. And
12 some of those reviews as well were in relation to going
13 back to basics of the function and role of the PCC and
14 looking at -- because also, you know, if legislation
15 comes in in 2009 its already been in action for about 10:15
16 three/four years before. We were now at 2019 so it was
17 timely to look at the organisation in that sense as
18 well. So went on a journey of reviewing the
19 organisation, looking at our statutory functions and
20 looking toward future proofing the organisation. 10:15
21 MR. McEVOY: Okay.
22 CHAIRPERSON: Could I just ask, in relation to funding
23 does your funding come direct from the DOH?
24 A. Yes, there's only one. Under the legislation for the
25 PCC there's only one source that we can actually 10:15
26 receive funding and that allows us to maintain a level
27 of independence. So as an organisation it comes
28 directly from the Department of Health.
29 CHAIRPERSON: And do you, because you've referred to

1 the cut in funding, and it's in your statement as well
2 --
3 A. Yes.
4 CHAIRPERSON: -- do you know if that was a cut in
5 funding across the board within the DOH or were you 10:16
6 sort of singled out for particular attention?
7 A. I don't believe we were singled out. Where I would be
8 giving you a reflection on this, as being a Chief
9 Executive in the third sector you would have had some
10 understanding of some of the cuts and the changes that 10:16
11 would have been made and it may have been there, but I
12 couldn't give you the absolute detail of how that was.
13 CHAIRPERSON: That's fine. Okay, thank you. Sorry
14 Mr. McEvoy.
15 12 Q. MR. McEVOY: In terms of the teams that you had 10:16
16 succeeded, the senior leadership teams that you had
17 succeeded do you know whether they were drawn from a
18 third sector background, such as yourself and
19 Ms. Monaghan, or were they drawn from trust management
20 team leadership? 10:16
21 A. I'll have to think. Some of the staff who were in the
22 leadership team had actually transferred over because
23 the PCC came into being --
24 13 Q. From where, sorry, when you say transferred over?
25 A. The PCC came into place in 2009 under new legislation. 10:16
26 14 Q. Yeah.
27 A. Prior to that there would have been four health and
28 social care councils.
29 15 Q. Yes.

1 A. Now from the four health and social care councils a
2 number of staff transferred into the PCC. And to my
3 knowledge at a management level, when I came in, there
4 were at least two people who had been in, say, the
5 health and social care council, into the PCC and would 10:17
6 have had tenure up to about 20/25 years - because I can
7 remember one member of staff hitting that point in
8 relation to HR.
9 16 Q. And those staff, without naming names, but were those
10 staff members leadership or where were they based 10:17
11 within the organisation?
12 A. Those two that I'm speaking about would have been
13 leadership.
14 17 Q. Okay.
15 A. One at leadership level and one that would have been at 10:17
16 executive leadership level.
17 18 Q. Okay. The instability then, again, as I indicated, you
18 know it is something we'll come back to look at in more
19 depth when you've given a description certainly of the
20 financial circumstance and how it was a good time to do 10:18
21 a review. The instability that you discovered in 2019
22 also coincided with a conclusion, I think, that you
23 indicate at paragraph 13, where you tell us that there
24 was no, in a sense, no, effectively no specific focus
25 on Muckamore Abbey between 2009 and 2019 by the PCC. 10:18
26 A. Yes. When I looked at the records previous to myself
27 what you can see is an evidential base around 2009/2010
28 of contact in relation to the council having met with
29 TILII, visited Muckamore, also having met with the

1 Friends and Society of Muckamore and all of that would
2 have been around looking at resettlement. And the
3 issues that would have presented there around
4 resettlement would have been access to advocacy, family
5 engagement, placements being available. Also, there 10:19
6 was some in relation to some families wishing for their
7 loved ones to stay within Muckamore. I could see that
8 in the evidence that we presented to the Inquiry.
9 19 Q. Yeah.
10 A. Also when we looked at all of the casework under your 10:19
11 terms of reference we found about 236 cases. And when
12 we narrowed that all down it came out as 33 cases that
13 we had supported families. And within that there was
14 about, I think, 15 post my time and then from, really
15 you're taking about from 2012, because the PCC had then 10:20
16 introduced in 2012 a digital system for their case
17 management, and so that's what I'd be referring to.
18 So previous to that what you're talking about is
19 probably 15 to 17 cases over a ten-year period that we
20 could find evidence of in relation to Muckamore in the 10:20
21 tenure of the PCC from 2009.
22 20 Q. So if it's not no involvement would it be fair to say
23 it's negligible involvement over that period of time in
24 terms of the numbers?
25 A. Yes, in direct casework. 10:20
26 21 Q. Yes.
27 A. Now, there would have been other work that was being
28 undertaken and we've put in some evidence of that in
29 around the Bamford Monitoring Group.

1 22 Q. I think you indicated that in the body of your
2 statement, so that patients and families, you say,
3 would have been included in generic activity and would
4 have featured within the general work and activity of
5 the Bamford Monitoring Group? 10:21
6 A. Yes.
7 23 Q. All right, okay. Well, look, you do say at paragraph
8 13 that actions and activity from the PCC has focused
9 specifically on Muckamore Abbey since 2019, which
10 coincides, of course, with you assuming the reigns as 10:21
11 Chief Executive, but, as we know, allegations of abuse
12 and neglect which triggered the Inquiry came to light
13 in 2017. So there were certainly two years from, say,
14 the second half of 2017 conservatively until then you
15 come into post. What was being done in that time? 10:21
16 Could you see whether there was any work at all to
17 reach out on the part of the PCC and assist patients
18 and their families?
19 A. Not that I could find a strong evidential base. And I
20 also did take the opportunity in preparing for our 10:22
21 witness statement to speak to the colleagues, several
22 colleagues who had left the PCC and to ask them
23 specifically could they identify for me anywhere that I
24 would go because I was trying to find in a system that
25 I didn't really know really where was the best place to 10:22
26 start and what information was there and did not
27 receive a clear direction or information that would
28 have told me that there was, in any way, a strong focus
29 of work there.

1 24 Q. Okay. And you may have noted from the media, and maybe
2 from your own engagement with the work of the Inquiry
3 and maybe even viewing some of the sessions of evidence
4 that the Inquiry has heard from patients and their
5 families about the raising of safeguarding concerns 10:22
6 over a long period.
7 A. Yes.
8 25 Q. What is your view of that at this remove?
9 A. I think in particular, for me, it is that the entire
10 system failed all these families, that they had reached 10:23
11 out on a number of levels in a number of ways to quite
12 a wide range of people and somehow, some why they
13 weren't being specifically heard.
14
15 My thing as well around it, in thinking about it and 10:23
16 our experience of looking at things is in the first
17 stage families raise an issue of complaint and
18 complaint can then get confused with what is a
19 complaint and what is a safeguarding issue. So at that
20 first stage of somebody giving you information in which 10:23
21 you nearly need to listen when people are in distress,
22 with your head, your heart and your hands, where you're
23 trying to work out what is the issue here and if
24 someone is driven down through a complaints process you
25 can then see that something gets missed in a 10:24
26 safeguarding. And from that I would say in relation to
27 adult safeguarding and working with families in the
28 system understanding that things got missed, families
29 were failed.

1 26 Q. Okay. At paragraph 17, which appears on page ten,
2 then, under the heading of: "Membership of the
3 Muckamore Departmental Assurance Group" or "MDAG" - and
4 the Inquiry has heard quite a bit about this group thus
5 far but we can see then that you recall attending a 10:24
6 meeting of that group on 30th October and you were
7 introduced then to two family representatives from the
8 Society of the Parents and Friends of Muckamore. Then
9 after that you attended a meeting on 4th November 2019.
10 You've indicated, helpfully, the agenda. Just at point 10:24
11 two of the agenda you've included mention of a
12 presentation from the Patient and Client Council and
13 how they can assist relatives and carers.
14 A. Hmm.
15 27 Q. So this is a meeting in late 2019. 10:25
16 A. (Witness Nods).
17 28 Q. And obviously we have touched on interaction or absence
18 of it hitherto. Can you recall what your impression
19 was of that meeting in terms of what you were able to
20 articulate to those families and their understanding of 10:25
21 what the PCC was able to do or not do for them as the
22 case might be?
23 A. Yeah. The approach that I took when I first came in as
24 Chief Executive, not just for the families at
25 Muckamore, but any families that I met with, was, first 10:25
26 of all, to sit and listen to them and to try and
27 understand what was going on for them and then how best
28 to assist. So I wasn't coming in to say: Here's the
29 PCC and this is what we could do.

1
2 This was a new area for me. That was my first
3 introduction. From that, knowing that there was an
4 MDAG group, at that point I wasn't a member of MDAG, so
5 when I went along to there, what I was hearing - and 10:26
6 you could see that on point 18 where the families
7 discussed different things that were happening there,
8 for them: Lack of reliable information, communication
9 with the trusts, a range of issues, concerns about
10 community -- 10:26
11 CHAIRPERSON: Slow down a little bit.
12 A. Apologies.
13 CHAIRPERSON: Even our stenographer may not be able to
14 keep up with you.
15 A. I'm sorry. 10:26
16 MR. McEVOY: You're not alone, don't worry.
17 A. So for me at the meeting I was explaining that I wasn't
18 here to say: This is what we'll do. What I was here
19 to say is: Can I hear what's going on and then try and
20 work out what can we do? 10:27
21
22 So from that it was laid out what the issues were and
23 that developed a relationship in which PCC, for me in
24 my tenure, was connected with talking to families.
25 What I was hearing from them was about issues of 10:27
26 communication, issues of advocacy and support required.
27 And so from there what I went back to the organisation
28 to do was then, as an organisation I then requested our
29 complaints services manager to have dedicated time to

1 start to look and scope out -- because the other thing
2 that I was aware of at the time as well, and did not
3 want to duplicate, confuse or come over the top of was
4 that there were other advocacy organisations engaged
5 and involved. So I was never going to take an approach 10:28
6 which would be that I would just jump in there and
7 start with the PCC. Because there's a difference.
8 29 Q. Just on that point it might be helpful for you to
9 explain, I mean the PCC has specific statutory
10 functions which encompass advocacy, but as we know, 10:28
11 there are lots of third sector providers out there who
12 are in a position to offer advocacy and it might be
13 helpful for you to explain, maybe even at this
14 juncture, what the interrelationship, if there is one,
15 is between your statutory role and then those third 10:28
16 sector providers, if you can do that, if you're able
17 to?
18 A. Absolutely. So the PCC, first of all, in understanding
19 who does the PCC represent? So the PCC represents all
20 people across Northern Ireland. So it is the one 10:28
21 organisation that has a complete regional remit across
22 all peoples, all issues, all health and social care.
23 Now, as you can imagine, that's huge. When I first
24 came into the PCC there were six client support
25 complaints officers and they worked right across the 10:29
26 piece for everything. Now even in my previous job I
27 was Chief Executive of a specialist organisation that
28 provided advocacy for looked after children and those
29 leaving care. Across the community and voluntary sector

1 there are organisations, charities who are either
2 directly commissioned by the trusts to undertake
3 advocacy in different areas. So within Muckamore each
4 one of those trusts would have commissioned in an
5 advocacy service. 10:29
6
7 The PCC's role would have been right across regionally
8 and we were not commissioned by anybody because in that
9 sense we were completely independent. But the role and
10 function of the organisation - and you've got to 10:30
11 remember, at that point there was six complaints
12 officers and a small organisation going right across,
13 whereas Muckamore had dedicated time.
14
15 Now, from looking back on the records I could see pre 10:30
16 my time that PCC would have had connected in with those
17 organisations and would have had a relationship with
18 those organisations. So when I came in and met with the
19 families, the first thing, a bit like I did with the
20 PCC, I needed to understand the landscape of what was 10:30
21 happening in Muckamore and the advocacy services that
22 were there. So our client support manager went in and
23 did some work and had a conversation with those
24 organisations. On the basis of that and the request
25 from families and -- 10:30
26 30 Q. Those organisations being the other, the third sector
27 organisations?
28 A. Yes. There would have been a number, Bryson House
29 being the main one, for both Belfast Trust and the

1 Southeastern Trust. Mencap would have been in the
2 Northern Trust. Disability Action the Southern Trust.
3 The Western Trust, our understanding was that it was an
4 ad hoc relationship with Bryson House. Also what you
5 would have had in Muckamore at that time as well, 10:31
6 because the PCC and research or anything it would have
7 done would have connected in with ARC and TILII for
8 assistance and guidance around --
9 CHAIRPERSON: TILII being, Tell It Like It Is?
10 A. Tell It Like It Is. And given their core focus, you 10:31
11 know, what you would be doing in the PCC is we'd be
12 ensuring that we'd be using their skills to keep us
13 correct in those things. So as an organisation, they
14 were -- or, sorry, apologies, PCC we're right across
15 Northern Ireland with a remit for 1.9 million people, 10:31
16 but also you have these other organisations, not just
17 in Muckamore, but in others. So most recently there
18 what we've been trying to do in our new model of
19 practice in the PCC is we have set up what we're
20 calling a network of networks. So we had an event 10:32
21 there on 19th April in which we're developing a
22 relationship with other advocacy organisations or
23 organisations that support people in the public because
24 there's no way we can cover all issues. But if we
25 collectively work together we are able to receive 10:32
26 referrals from them for us to refer on appropriately
27 people to make sure that they don't slip true through
28 the cracks.
29 31 Q. MR. McEVOY: And that is the understanding that you

1 have been able to gain and use to put in place for a, I
2 suppose, dispensation in the post 2019 period?
3 A. Yeah.
4 32 Q. But can you offer a view about whether that degree of
5 understanding was in place in the period from 2009 to 10:32
6 2019 --
7 A. My understanding --
8 33 Q. -- on the part of the PCC in terms of that
9 understanding of the relationship with third sector
10 organisations? 10:33
11 A. We tried to get as extensive records, but what I could
12 see from our Client Support Manager is he would have
13 had connections with those other advocacy
14 organisations. The other thing that did happen as well
15 was there was a development, because I know that from 10:33
16 my previous job, of an advocacy network in
17 Northern Ireland and so some organisations would have
18 connected together.
19
20 Advocacy is one of those services, or it's not a 10:33
21 service it's a model of practice in which you assist
22 people to be heard that's been developing over the last
23 ten years and I was aware that within the PCC prior
24 some cases or people who came to the PCC they would
25 have had referred through to Bryson House. 10:33
26 MS. MONAGHAN: Do you mind if I just add to that?
27 Ms. Monaghan speaking.
28 CHAIRPERSON: Thanks.
29 MS. MONAGHAN: From the review of casework that we were

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1 able to look at of those from the Alemba cases, there
2 would have been evidence of work between the PCC or a
3 connection between the PCC and some of those other
4 advocacy services. But the extent and the nature of
5 that relationship is not necessarily clear. And I 10:34
6 think it's important to note that advocacy, as Vivian
7 has mentioned, is a model of practice and one we have
8 developed quite differently post 2019 and I think it's
9 fair to say that the PCC's role with respect to that
10 function previously, from what we can see, may have 10:34
11 been more administratively focused --
12 MR. McEVOY: Yes.
13 MS. MONAGHAN: -- in their connection with some of
14 those organisations, rather than it being a necessarily
15 advocacy role in that regard. 10:34
16 34 Q. MR. McEVOY: And I know that Ms. McConvey in her
17 statement makes that point and I'm going to ask her a
18 little bit more about it. So that's helpful. Thank
19 you.
20 10:35
21 So what you were able to do then, I think, in the
22 period then post your engagement with some of the
23 families and friends and after contact, I think then
24 you tell us, with the Client Support Manager, was to
25 make it a priority to secure funding to the Department 10:35
26 to secure the appointment of a dedicated independent
27 advocate. So I'm looking at paragraph 22 now on the
28 bottom of page 12.
29 A. MS. McCONVEY: Yes.

1 35 Q. What was the -- at that particular time in terms of
2 Muckamore and your assessment built on the information
3 gathering from patients and families and those
4 organisations, what was your understanding of what was
5 present as an existing advocacy resource at Muckamore 10:35
6 at that point in time?
7 A. I'd requested our clients --
8 36 Q. This is late 2019, I should be clear.
9 A. Yeah, late 2019. In the autumn of 2019 I had requested
10 our Client Support Manager to reach out and really do 10:36
11 an environmental scan of the services that were there.
12 37 Q. Okay. What does that mean for the uninitiated?
13 A. Sorry.
14 38 Q. What is an environmental scan?
15 A. It's just probably a fancy word to say could you go in 10:36
16 there, could you talk to as many people as possible,
17 could you find out what was happening, what's the
18 degree of service they're providing, also what would be
19 the relationship. Because what I was absolutely clear
20 about, and have been in my career, is not to duplicate 10:36
21 with anybody, but to work in partnership. And also the
22 primary focus has to be that when somebody is looking
23 for that help they know who to go to and it has that
24 clarity.
25 10:37
26 So what we found out at that time was - and I went back
27 through our records to check and put it in the
28 statement - that it would seem that there were 50 hours
29 per week in total coming in from Bryson House and that

1 was for a range of staff being there, 25 hours per week
2 for Mencap. And from that I had requested our Client
3 Support Manager to contact the organisations, see how
4 we could actually all work together in a way that you
5 would offer support. 10:37
6 39 Q. So was that a total of 75 hours then into - just
7 correct me if I'm wrong - is it a total of 75 hours
8 into Muckamore across the entire patient quotient in
9 the hospital?
10 A. As what I understood at the time as presented to me, 10:37
11 yes, that's what was presented.
12 40 Q. And in your view and the view of the PCC in late 2019,
13 coming in as a new Chief Executive, was 75 hours
14 adequate?
15 A. That's a very interesting question because I was trying 10:38
16 to understand what was the level of support for the
17 families that are required. And at that point I think
18 there were well over 40 people living there. And
19 that's quite a significant caseload if you are
20 providing particularly the direction travel of 10:38
21 resettlement because that's a huge amount in relation
22 to meetings with families and the process, which is
23 quite complex, with people with challenging needs, to
24 make sure that the community is ready. Also, you would
25 have to have in that a service for families, not just 10:38
26 in Muckamore, it needed to go into the community, you
27 needed to follow with the families, particularly if
28 there would have been a family breakdown. So in
29 relation to that, you know, if somebody was holding a

1 caseload at that level of intensity into single figures
2 would be quite a high caseload. So when looking at
3 that it was important to be sure that we were offering
4 a service or adding to that service, but adding value
5 to that service and allowing people to make a choice. 10:39
6 Because the other thing about advocacy is, you know, if
7 you have a range of services people need to have a
8 choice of the type of advocacy they want and how that
9 is provided. And there are also a range of things that
10 we had like, say, for example, maybe a difference in 10:39
11 relation to dealing with SAIs.
12
13 So I think it would be best to have a conversation with
14 each one of those advocacy organisations to understand
15 the work that they were undertaking, I wouldn't have 10:39
16 that in-depth.
17 41 Q. But clearly you identified a gap --
18 A. Yes.
19 42 Q. -- in terms of the range of advocacy services?
20 A. (Witness Nods). 10:40
21 43 Q. If not, if I understand you correctly, the volume, in
22 terms of hours?
23 A. Yeah.
24 44 Q. Is that...
25 A. Well, I think one of the things when I was looking at 10:40
26 it at that time it felt like, to me, from the outside
27 coming in, that the services were commissioned
28 individually by each one of the trusts. Therefore that
29 meant, when I was looking at it, that a family or

1 someone who lived within Muckamore their option for
2 advocacy at that point was with that trust and that
3 service that was being provided there. When I was
4 looking at it, if you're asking for an opinion?
5 45 Q. Mm-hmm. 10:40
6 A. It felt like there were very individualised services by
7 the individual trusts. Trying to understand how that
8 map came together was really important. But that was
9 also identified, as you're aware, in the leadership and
10 governance report. 10:41
11 46 Q. I'm going to come on to look at that. So just in terms
12 then of what you managed to secure in terms of this
13 advocacy resource, if you like, you have described it
14 in paragraph 22 as a dedicated independent advocate.
15 A. Yeah. 10:41
16 47 Q. But by whom, essentially, was that advocate then
17 employed? Where did their contract of employment, if
18 you like, lie? Were they a PCC staff member?
19 A. What we were looking to do was to have within the PCC a
20 staff member who would provide advocacy support and 10:41
21 also advocacy/engagement because we have advocacy which
22 is direct casework.
23 48 Q. Yes.
24 A. But you also have advocacy which would be on a policy
25 decision-making process. And that's in our new model 10:41
26 of practice in which, you know, it's not just about
27 when someone has an issue of concern or complaint, what
28 you're also trying do is promote the engagement of
29 people in the decision-making around the services.

1 There was a lot of change that was happening in
2 Muckamore at this point, so really what was required
3 there, I was thinking --
4 49 Q. Sorry, if I can maybe just ask it in this way then: Was
5 that person's role dedicated towards the sort of, if 10:42
6 you like, the hard edge of casework on a day-to-day
7 basis with patients and families or was their role to
8 work at a higher, as you say, sort of more policy level
9 influencing, engagement with policy?
10 A. Both. 10:42
11 50 Q. Both?
12 A. Their role was to work with both.
13 51 Q. Okay. And was there any, when you put that person into
14 place then - I appreciate this is comparatively a
15 recent development - was there any way of ensuring that 10:42
16 both bases were adequately covered, if you like, that
17 there wouldn't be a bias towards neglecting one form of
18 advocacy at the expense of the other? Do you follow me?
19 A. Absolutely. And it's also, once again, an interesting
20 question because one of the things in relation to 10:43
21 trying to work out are you doing one or the other. So,
22 first of all, someone has to reach in and request
23 support.
24 52 Q. Yes.
25 A. So, in relation to that, are you providing advocacy 10:43
26 service, it's making yourself available, people
27 understanding that the service is available there for
28 them and then it's not that you're appointed to every
29 family, it is that someone would chose, or a person

1 within, a resident of Muckamore, that they would choose
2 to be there.
3
4 The other thing about it as well, and it's hard to
5 answer that question, because the role for that person 10:43
6 was to be there with families and respond to the
7 requests that they would have had. So, for example,
8 there was a family group set up through the
9 Belfast Trust, she would have attended that. She
10 attended family liaison meetings. She would have went 10:44
11 to safeguarding. A lot of the work that comes in
12 relation to advocacy, what you're trying to do is that
13 you're trying to do -- the job or work of an advocate
14 is really set by the people who are using the service.
15 So it's hard for me to say in that bit there, what we 10:44
16 felt we were doing was monitoring and managing what was
17 happening.
18
19 The other part of that as well is it wasn't just that
20 one person, you know, in relation to doing it. We got 10:44
21 a dedicated person, I mean both myself, Ms. Monaghan
22 and other managers as well would act as advocates
23 because there would be different parts of work that
24 would be at different levels. So it wasn't just that
25 everything was directed through to this one role. 10:44
26 MS. MONAGHAN: Chair, if I could just add to that,
27 would you mind?
28 MR. McEVOY: This is Ms. Monaghan speaking.
29 MS. MONAGHAN: The nature of the work that that advocate

1 undertook by the time they came into post and were
2 permanently appointed was dictated by the needs of
3 families and what we were hearing at that time but also
4 the work that we were asked to undertake in relation to
5 the engagement on the terms of reference for the 10:45
6 Inquiry. And much of the work then came out of that
7 both with respect to direct casework as we engaged with
8 people and issues arose, or we became knowledgeable
9 about some of the casework, but also facilitating that
10 engagement process as part of that piece of work. 10:45
11 So in terms of the balance it was very much dictated by
12 what arose and the needs of families both reaching in
13 as part of that process, but also trying to facilitate
14 a direct reach out as well, if that's helpful.
15 53 Q. MR. McEVOY: The resource was, I think you say at the 10:45
16 top of page 13, the same paragraph, was non-recurrent
17 for 2019/2020.
18 MS. McCONVEY: (Witness Nods).
19 54 Q. Did that worry you, that it was for one year, if that's
20 to be understood correctly? 10:46
21 A. Absolutely. And coming into the health service at that
22 time what you would have seen across the health service
23 there was only a yearly budget that was set, and so
24 that has only changed in the last couple of years. So
25 the complication of that one is how do you retain 10:46
26 staff? You're not offering permanent posts. We had to
27 use agency to go through it because we were unable to
28 do that. So for a Chief Executive you'll take anything
29 and where it comes from and you'll creatively work with

1 it but there wasn't anything I could do to change a
2 system of finance within the Department of Health.
3 55 Q. Okay. Then you say at the bottom of page 23, it's the
4 final, sorry, I beg your pardon, paragraph 23, the last
5 sentence: 10:46
6
7 "In November 2020 PCC employed a full-time dedicated
8 advocate to provide a service for residents and
9 families at Muckamore Abbey Hospital."
10 10:47
11 Is that role still, is that resource and that role
12 still there?
13 A. The reason we were able to do that is in the in between
14 we also had some money that came from Bamford
15 Monitoring Group and that was equating to about 10:47
16 £114,000. When I came in I looked at that money to see
17 how best to use it. So where I had non-recurrent money
18 knowing that there needed to be something in the
19 organisation of advocacy in relation to learning
20 disability, and we had a dedicated post, it has 10:47
21 evolved, if I can explain where it is at now?
22 56 Q. Mm-hmm.
23 A. So I was able to because of the changes that were
24 happening in mental health and learning disability in
25 Bamford to reconfigure. And in the reconfiguration of 10:47
26 that we moved to take in that £114,000 and turn it into
27 three full-time posts, sorry two full-time posts and a
28 part-time post. One of those posts is a learning
29 disability champion, someone who has been within the

1 organisation throughout. The other is, sorry, an
2 advocate, and they deal with mental health and learning
3 disability, and that is a permanent post. And the
4 other is someone who deals with mental health, learning
5 disability and the focus is on engagement and the 10:48
6 policy advocacy. So we separated them out.
7 57 Q. Okay. And that learning disability champion, sorry,
8 which organisation, when you say organisation?
9 A. PCC.
10 58 Q. I know you've described the constrictions and the 10:48
11 imperative to work within circumstances where funding
12 was year-on-year but I suppose I asked you because you
13 were engaging with the Department in trying to secure
14 the service against the backdrop of what had come to
15 light and in the knowledge, I think, subsequently that 10:49
16 there was going to be a public Inquiry. Did you get
17 the sense that the Department was aware of the need to
18 ensure, or the possible need to ensure that advocacy
19 services were going to need to be provided for by PCC
20 going forward? 10:49
21 A. Yes, I did. The PCC is an arm's length body.
22 59 Q. Yeah.
23 A. We report to a sponsor branch. I would have had
24 conversations with our sponsor branch in relation to a
25 business case specifically knowing the work that was 10:49
26 ongoing at this point and how we would then move to
27 support people that we needed a bespoke direct funding,
28 because that was the first time, apart from the Bamford
29 Monitoring Group, that money came in. I had found them

1 very supportive in relation to trying to find that
2 money for us.
3 60 Q. Okay. You had mentioned, if I can take you on then to
4 page 15 and paragraph 27 at the top, it's the
5 subheading around the leadership and governance review, 10:50
6 which I think you've mentioned, and I indicated to you
7 I was going to take you on to it. In terms of the
8 inception of the leadership and governance review, and
9 the Inquiry hasn't yet formally heard about the review
10 from its authors yet, but what was the PCC's stance 10:50
11 around the decision that such a review should be
12 conducted?
13 A. I was only introduced to the leadership and governance
14 review through the MDAG group, Muckamore Departmental
15 Assurance Group, and had not been aware of it 10:50
16 beforehand. So my role coming in at that point having
17 been asked by the Department and Minister to facilitate
18 the feedback to families the night before, or the night
19 of the publication of the actual report.
20 61 Q. Yeah, I suppose my question was beyond simply sort of - 10:51
21 and without wishing to sort of downplay it - hosting
22 the briefing, did you have a stance, did you have a
23 position, were you supportive of such a review on
24 behalf of families and patients? Did you have a view
25 about whether or not such a review should be conducted? 10:51
26 A. Absolutely. And I mean on the evening of, it was an
27 extremely emotive evening where the reviewers directly
28 met with the families in relation to bringing their
29 findings to there and what they had attempted to do in

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1 relation to look directly at the systemic failures --
2 62 Q. Yeah.
3 A. -- in the system.
4 63 Q. Okay, we'll move on a little bit then to page 22.
5 Sorry, I beg your pardon, 21, and it's paragraph 48 at 10:52
6 21. We had touched earlier on the budget, you had
7 begun to describe the size of it and the strictures,
8 some of the strictures that you had noted on coming
9 into the role. On paragraph 48 you describe a
10 reduction over a seven-year period from a little bit 10:52
11 over 1.8 million in 2012/13 to 1.4, or just a bit over
12 1.4 in 2019/20. And then you go on to indicate that
13 that was a reduction of £368,000 over that seven-year
14 time period without taking into consideration
15 inflationary costs. 10:53
16 A. (Witness Nods).
17 64 Q. The expected increases in line with inflation were
18 about 2% each year. In net terms the expected PCC
19 budget allocation. In 2019/20, which would have been
20 your first complete year in the role of 10:53
21 Chief Executive, was worth 40% less than the 2012/13
22 allocation. Then you go on to describe what that means
23 in terms of requirements around prudence?
24 A. (Witness Nods).
25 65 Q. Was that a disappointment to you, that reduction in 10:53
26 2019/20?
27 A. I have to say when I came in and as a new
28 Chief Executive when you look at what you've got that's
29 what you've got. But when you look at the history it's

1 quite concerning then because what you would say to
2 yourself is: Really, I should probably be at 2.2
3 million. And trying to understand what the impact is.
4 You asked me earlier about statutory functions. One of
5 the issues about statutory functions, which are really 10:54
6 good, when you have those, your ability to carry out
7 your statutory functions one of those issues has got to
8 be about resource because what you have to do in your
9 resource each time is you need to think about: What
10 are your priorities? What is the evidential basis you 10:54
11 have? Where do you take a very finite resource and
12 where do you position it into?
13
14 What I have to say is our current budget now, and
15 Ms. Monaghan can speak to where she is moving in to 10:54
16 this year, but when I left the budget was at £1.9
17 million. So over the four-year period we had been able
18 to secure additional funding.
19 66 Q. So the budget was cut and cut and cut and cut and it
20 was cut in 2017 and presumably cut again in 2018 and 10:55
21 that was against the backdrop where the Department knew
22 about the revelations in relation to what had happened
23 at Muckamore?
24 A. (Witness Nods).
25 67 Q. And it was cutting money from a body, a statutory body 10:55
26 designed to advocate and articulate patient concerns
27 and complaints.
28 A. (Witness Nods).
29 68 Q. Was that a concern for you? And if it was, did you

1 convey that to the Department when you came into role?
2 A. Yes, I did convey it and I think the evidence of having
3 increased the budget from 1.4 when I came in up to 1.9
4 tells you where the direction of travel for the
5 organisation is. Health and social services will have 10:55
6 to, at times, take cuts. The question and the
7 conversation that I would have with the Department is
8 that that's not an equal playing field for everybody.
9 So if there are places where you have to exercise cuts
10 that has to be open to the public having a conversation 10:56
11 about it. But where you may cut some services there
12 are other services, like advocacy services, etc., which
13 actually will require an increase in budget. So it's
14 not one of those things that when you look at budgeting
15 you just salami slice from the top, you need to really 10:56
16 understand the profiling. So, for example, there was a
17 requested cut there in the Department for all
18 organisations of potentially 3% to 5%. Our
19 conversation with the Department in relation to that
20 was to discuss what we would offer up as a 3% or 5% cut 10:56
21 going into this year and actually, we were deemed at
22 the PCC to be high risk, so the PCC going into the cuts
23 that other arm's length bodies would have had to take
24 did not take a cut in budget this year. Sorry, to that
25 point, but I would like to bring in Ms. Monaghan 10:57
26 because I am aware that something has happened just us
27 going into the beginning of the year.
28 69 Q. You can't speak to Ms. Monaghan. (To Ms. Monaghan) Can
29 you speak to this issue?

1 MS. MONAGHAN: Yes, I am happy to just clarify that
2 point. So in the financial year 2023/24 Vivian is
3 correct in saying that we have not, at this point,
4 sustained a 3% or 5% cut because it was deemed high
5 impact to the organisation. We have been requested to 10:57
6 make savings based on the NIO budget coming to
7 Northern Ireland and from the Department, so we do have
8 savings to be made of circa 63,000 at this stage, some
9 recurrent, some non-recurrent. And the position
10 regarding the in year funding may change based on the 10:57
11 overall Department of Health's budget with respect to
12 the high impact cuts. But at this stage we have not
13 been asked to make those 3% or 5% at this stage.
14 70 Q. And the fact that they have been deemed high impact is
15 any of that, is the fact that they have been deemed 10:58
16 high impact driven at all by the situation with regard
17 to the ongoing, this Inquiry and the revelations that
18 they're looking at?
19 A. My understanding is that they were deemed high impact
20 as a result of the conversation that Vivian, as the 10:58
21 former Chief Executive, had with regard to the already
22 quite rigorous process that the PCC had undertaken with
23 regard to our resource. So we --
24 71 Q. So it's a general assessment?
25 A. It is a general assessment, yes. 10:58
26 72 Q. Okay, thank you. Moving on then to page 22, and it's
27 paragraph 51. Again, just looking at a heading of the
28 organisation's accountability arrangements and at 51
29 you say that an annual report and accounts are produced

1 and then submitted to the Department and then laid
2 before the assembly
3 A. (Witness Nods).
4 73 Q. You participate in mid and end-year meetings with the
5 Department, organise the Department's sponsor branch 10:59
6 for the PCC, which is of course the Department of
7 Health?
8 A. Yes.
9 74 Q. Annual report summarises the PCC's main achievements
10 and work undertaken in the previous year. You then 10:59
11 tell us:
12
13 "It would also describe control issues, which are
14 issues which have arisen and for which additional steps
15 need to be taken. There is no evidence in PCC annual 10:59
16 reports or in other governance documentation of control
17 issues having arisen specifically in relation to
18 Muckamore."
19
20 Now on its face that's a neutral statement but can you 10:59
21 tell us what the implication of that is? Would you have
22 expected there to have been reference to control issues
23 at any time before your tenure?
24 A. If I explain where I was thinking about control issues
25 and some that came up for me and diverges and that. 11:00
26 75 Q. Yeah.
27 A. I did bring up in relation to our annual report and
28 that our level of staffing, our ability to meet the
29 demand coming forward from the public in relation to

1 that work. And so if something was coming up that was
2 a major issue around there I would have expected that
3 if it was on the agenda you would put it into your
4 annual report because then that makes it clear as an
5 organisation going forward what are the major issues 11:00
6 that you would be dealing with.
7 76 Q. You would have, I suppose my working of that is that
8 you would have expected, therefore, in the reports for
9 2017 and 2018 to have seen some reference to the
10 revelations around abuse and neglect at Muckamore to be 11:00
11 indicated then?
12 A. What I'm saying there as a neutral statement there
13 wasn't anything because what I was asked to do was to
14 look around all documentation to see for the
15 organisation was this matter from 2017, or actually all 11:01
16 the way through was it on the agenda. I'm not sure, if
17 you just give me a moment because what I'm trying to
18 think about this is... Muckamore became very public in
19 2017, so it was a conversation that was there. I can't
20 get into the head of the people who were there before 11:01
21 me and say whether they were thinking: Well, this is
22 out as a public inquiry, or not a public inquiry at
23 that point, but in relation to coming out as public
24 outrage, which rightly it was, that it was being dealt
25 with in different areas and whether they were making a 11:01
26 decision that someone else had it. I think, in truth,
27 that I would ask you to put that question to someone
28 else.
29 77 Q. We'll follow it up with them, but I suppose, and maybe

1 that's as far as you're prepared to go, but with your
2 eyes and ears and clean approach, clean desk approach,
3 if you like, coming in in 2019/20 there must have been
4 some surprise on your part not to have seen reference
5 to it in the 2017 and 2018 reports? 11:02
6 A. Yes, there was some surprise because there was other
7 things that came in when, for example, some other stuff
8 that would have happened through COPNI and Dunmurry,
9 and that became a priority for me because they were big
10 issues around advocacy. Similar issues around people 11:02
11 falling through the gaps. So in that sense I might
12 have expected that it would have been there all right.
13 CHAIRPERSON: Could I just ask on that. Sorry
14 Mr. McEvoy.
15 MR. McEVOY: Yes, of course 11:03
16 CHAIRPERSON: There is one thing looking at the PCC
17 system and what the PCC reaction was in 2017 but I
18 suppose there might also have been a clamouring for
19 assistance coming into the PCC following the 2017
20 revelations, now would those have been recorded within 11:03
21 the PCC somewhere?
22 A. Yes. And pre my tenure, saying from 2012 through to
23 2022, when we went through our Alemba, which is a
24 digital system for casework, we found 33 cases relevant
25 to the Inquiry. And of that 15 of those cases were 11:03
26 post 2019. So if you're looking at that, no, there
27 weren't a big amount of people coming through, probably
28 I think it was, and again I'd need to defer and come
29 back to you on that one, two or three of that year.

1 MS. MONAGHAN: If I could just add to that. Of the 33
2 cases during that time period 15 of those, from the
3 2019 period onwards, 50% of those came in during the
4 time when we had the dedicated advocate. So it's fair
5 to say that at the time when the PCC put a dedicated 11:04
6 resource in and began to engage around the advocacy and
7 the engagement that there was an uptake in cases at
8 that stage.
9 CHAIRPERSON: That's from 2019 onwards. What I'm asking
10 is in 2017, do your records show that there was a 11:04
11 clamouring for assistance?
12 A. MS. McCONVEY: Not to my knowledge, no, because there
13 only would have been 15 cases. And what I am aware of
14 some of those would have been 12, 13, 14, 15, but we
15 did not see a surge coming in at 2017. 11:04
16 PROF. MURPHY: And did you conclude that that was
17 because families weren't aware of the PCC and its role?
18 A. Well, in relation to that, first of all, the families
19 of Muckamore may have had more access to the dedicated
20 advocacy services in-house. 11:05
21 PROF. MURPHY: Hmm.
22 A. Secondly, to be aware, the PCC as well for someone who
23 is coming, because when things go wrong for families it
24 usually comes left field and they are in distress, so
25 what has to happen is the person that's closest to 11:05
26 them, those that are the service providers, need to
27 provide the information for them.
28 PROF. MURPHY: Hmm
29 A. So where they would have had an introduction to the PCC

1 is in, say, the formal complaints process. So if they
2 were raising a concern it might not have come up
3 because you may have went for local resolution. If it
4 went for a formal complaint it is incumbent on the
5 organisation that is providing the service to inform 11:05
6 people about the complaints procedures. In the
7 regional complaints procedures there is there
8 information about directing the person to the PCC. So
9 we don't investigate complaints, we are there to
10 support people. But there's a real important role here 11:05
11 that you need to think about, about the passporting to
12 the PCC, particularly in times of distress for
13 somebody, over to our services.
14 PROF. MURPHY: Thank you.
15 78 Q. MR. McEVOY: Picking up on that maybe at this juncture, 11:06
16 the period from 2009 to 2019 is one that we have heard
17 about where there wasn't much engagement at Muckamore
18 on the part of the PCC. Have you, or did you, conduct
19 an assessment of measures taken by the PCC to reach out
20 and make its services available to patients and their 11:06
21 families?
22 A. That was completed by our Client Support Manager in the
23 autumn of 2019 when he joined in. But also what I'm
24 aware of is the same person would have connected with
25 those organisations and passported people who came 11:07
26 through earlier between 2009 and 2019 through. So they
27 would have been well aware of the advocacy
28 organisations within Muckamore.
29 79 Q. And just in terms of the PCC itself, there was, can we

1 take it just from that last answer, that there was some
2 sort of analysis of what the PCC had done in the period
3 from its inception in 2009 to 2019?
4 A. Yes.
5 80 Q. There was some sort of analysis of what had been done 11:07
6 to make itself visible --
7 A. Mm-hmm.
8 81 Q. -- to those who might need to use its services most at
9 Muckamore?
10 A. From 2009 to 2019 particularly PCC would have done 11:07
11 quite extensive roadshows and workshops and conferences
12 and leafletting and a web site and different things
13 that would have been set out.
14 82 Q. Okay. And was that the outcome, what you've just
15 described there was that a summary of what the analysis 11:08
16 found?
17 A. Well in relation to asking what was happening and doing
18 that work in Muckamore I have to say I was very much
19 focused not on the past, I was focused when I came in
20 on what is the here and now, what do we need to provide 11:08
21 here and now and what's the action we're going to take
22 going forward. I apologise, I wasn't having a backward
23 look at that point.
24 83 Q. Although I suppose the general principle, one might
25 say, is that the best way to remedy a problem is to 11:08
26 have an assessment of what has gone wrong in order to
27 fix it.
28 A. Sometimes. But sometimes it's best to sit down with
29 people right here, right now and understand the

1 landscape of what you're doing. The past will give you
2 have some indication and knowledge of things that you
3 can learn from that but I had come into quite a complex
4 situation in relation to, it was an immediacy and
5 actually the immediacy then had increased again, where 11:08
6 we then had the support for families and the leadership
7 and governance, where then it had come through in to
8 being the Inquiry. So we had to be an ever-changing
9 organisation at that point in evolving and developing
10 the service that families had received. 11:09
11 84 Q. Yeah. I suppose the reason I'm asking you those
12 questions and the Inquiry is interested to know is
13 because you're the gatekeepers in terms of the
14 information, although you only came into office, as we
15 know, into position, as we know, in 2019, you are the 11:09
16 gatekeepers in terms of the information from the period
17 2009 to 2019?
18 A. (Witness Nods).
19 85 Q. So in terms of being able to give us an impression of
20 what was being done and what was being offered we rely 11:09
21 on you. Is the answer really, essentially, that there
22 were roadshows, there was leafletting, as you've
23 indicated?
24 A. Yeah.
25 86 Q. And was there a sort of a, if not, obviously your 11:09
26 priorities were self-evident, as you have explained,
27 was it Client Services Manager, the Client Support
28 Manager?
29 A. Client Support Manager. In the PCC there would have

1 been at that point a complaint service and also what
2 would be called personal and public involvement.
3 87 Q. Yeah.
4 A. In the area of the personal and public involvement,
5 which I think I discuss in more detail as we go along, 11:10
6 there would have been work undertaken in relation to
7 learning disability services and mental health
8 services.
9 88 Q. Just --
10 A. So at the minute where we're focusing on that advocacy 11:10
11 it's the client support advocacy role that I have been
12 talking to.
13 89 Q. Okay. So he would have been able to give you an
14 assessment of where the Council hadn't, where the PCC
15 hadn't maybe been as prominent as it might have been in 11:10
16 terms of making its services known to those who need
17 them?
18 A. Yes, that is correct. And also he would have given me
19 an assessment because he had quite a tenure from the
20 PCC in 2009 to 2019, but also having worked in the 11:10
21 Eastern Board Health and Social Care Council and being
22 connected to those other advocacy organisations
23 throughout that period of time.
24 90 Q. Okay. Then just looking at page 25 and paragraph 58,
25 you have provided a section entitled: 11:11
26
27 "Statutory functions, learning disabilities and mental
28 health." And you consider it:
29 "Helpful for the Inquiry to understand how the PCC

1 executes its statutory functions in practice with
2 respect to learning disabilities, mental health and
3 Muckamore Abbey Hospital, specifically, where
4 appropriate. It should be stressed that the PCC work
5 in the area of learning disabilities was often also 11:11
6 equally applicable to mental health and it is not
7 always practical to separate out these two as separate
8 work streams. Services provided to patients and
9 families at Muckamore or with A connection to Muckamore
10 formed A part of this larger work stream flowing from 11:11
11 our work in the area of mental health and learning
12 disability more generally."
13
14 Can you just explain what that means in layman's terms
15 so that, you know, those families and patients who are 11:11
16 watching can understand what you mean by that?
17 A. Well what we mean is that across the piece in all of
18 the work of the PCC, any family, any person can be
19 engaged and involved within that, so therefore there is
20 the possibility that some families from Muckamore might 11:12
21 have been involved in some of the other areas of work
22 that were undertaken, say in pieces of research around
23 that, around those issues, and that at times where you
24 might have someone who may have an issue of learning
25 disability there may also be mental health issues as 11:12
26 well. So you can't very easily separate both and it
27 would have come under both. And that's why currently,
28 going forward we have people dedicated to both
29 elements, they cover both mental health and learning

1 disability.
2 91 Q. Okay, thank you. Then at paragraph 59 then:
3
4 "Consistent with its role and functions the PCC had
5 from its establishment in April 2009 engaged 11:13
6 extensively with stakeholders on both how PCC should
7 best discharge its functions and in reviewing or
8 evaluating how well the PCC has discharged its
9 functions."
10 11:13
11 What did that extensive engagement look like?
12 A. If you go to service, like, we try to detail that then
13 in paragraph 62 onwards.
14 92 Q. Okay.
15 A. Where we're talking about we were able to go back into 11:13
16 the records and look at August 2010: Are You Being
17 Heard workshop? August 2010, a focus group on the
18 membership seek the views on developing. So we've
19 tried to lay out for you here in those following
20 paragraphs, that's what that relates to, to give you 11:13
21 some understanding of how the organisation would have
22 dipped in to understanding how well it was functioning.
23 93 Q. Okay, that's helpful. Then the next sentence is:
24
25 "PCC has also undertaken research to try to establish 11:14
26 how effective it has been in influencing priorities and
27 services in the HSC."
28
29 So how do you define research for the purposes of that

1 statement?
2 A. Okay. If you look at research you can take research as
3 to be on a continuum. So at the high end of research
4 there was some work that was undertaken in relation to
5 the PCC, where they would have received ORAC and trust 11:14
6 ethical teams assessment before they undertook it.
7 Then research for us can be anything in which you
8 gather information, could be from a one-to-one
9 conversation, a focus group, a workshop. So research
10 will always be on a continuum, it can go from a 11:14
11 conversation but it's about how you then gather data
12 information, concerns, what people are saying, put it
13 together in a report and one of the things account the
14 PCC is those reports are made public, so that report
15 goes out to the public and they share it. 11:15
16 94 Q. So the research isn't independently commissioned,
17 researched by, for example, an academic or connected to
18 a university or something like that for the purposes of
19 this?
20 A. We do have academic relationships we would partner with 11:15
21 but the organisation would not have a budget to be able
22 to commission in any research. We would participate
23 and take part in others.
24 95 Q. Yes. For the purposes of the term research, just so
25 we're clear, you mean that in a less rather than more 11:15
26 formal sense?
27 A. Yes.
28 96 Q. All right.
29 CHAIRPERSON: Are you going to move on to another

1 topic?
2 MR. McEVOY: Yes, I am.
3 CHAIRPERSON: I'm just aware that the witnesses have
4 been at the table, as it were, for an hour and a
5 quarter. 11:15
6 MR. McEVOY: If we pause there.
7 CHAIRPERSON: Would that be a good time? So we'll have
8 a 15 minute break and somebody will look after you, I
9 hope.
10 THE WITNESS: Thank you. 11:15
11 CHAIRPERSON: We'll see you back at pretty much 11:30.
12 Thank you.
13
14 SHORT ADJOURNMENT
15 11:27
16 CHAIRPERSON: Thank you.
17 97 Q. MR. McEVOY: Thank you, Chair. Ms. McConvey, just
18 before we broke there I was discussing the content of
19 paragraph 60 with you. Before I leave it, the last
20 sentence of that paragraph on page 26 tells us that the 11:34
21 functions and governance of the PCC are subject to
22 regular audit by the Business Services Organisation
23 audit team. The Business Services Organisation audit
24 team, the organisation itself is sort of an entity
25 which provide services to, among others, the Health and 11:35
26 Social Care Trusts?
27 A. Yes.
28 98 Q. And presumably then also other arm's length bodies of
29 the Department of Health, is that correct?

1 A. Yes.
2 99 Q. Would the audits pick up on the leadership instability
3 that you described at the outset of your statement if
4 those were scrutinised?
5 A. When I came in, first in to post in 2019 I met with the 11:35
6 BSO audit team because it was time to set the new
7 three-year plan for audits. And on a yearly basis you
8 always would have like a financial audit and then you
9 would set out different areas. So, for example, one of
10 the things I looked at in my early stage is also at our 11:36
11 Council level to do an audit of the Council, to look at
12 it and to use the audit system to give you pointers and
13 good ways of reviewing and reflecting on your practice
14 and on your work. Yes it would pick up on different
15 areas of the organisation, but they're all set out. 11:36
16 So, for example, you might audit -- well, every year
17 you audit your finance. You could be auditing your
18 risk, you could be auditing your advocacy processes,
19 engagement processes, council, you are setting out a
20 whole set of areas in which you want to have a look at. 11:36
21 100 Q. Okay. So an audit of finances could open up, let's
22 say, a frontier of concern or risk in another area --
23 A. (Witness Nods).
24 101 Q. -- and that would be examined?
25 A. Yes. 11:37
26 102 Q. Just to go back then to my question, if one was to
27 examine those audits from BSO one might see information
28 which would point to the leadership instability in the
29 years before you joined the organisation?

1 A. It may.
2 103 Q. You don't know for sure, but it may?
3 A. I don't know for sure, I couldn't really comment on
4 that.
5 104 Q. Okay, very well. Similarly is there any discussion 11:37
6 around an absence of provision or a relative absence of
7 provision for learning disability and mental health
8 services at Muckamore, is there anything as specific as
9 that in those audits?
10 A. No, there wouldn't be because what you'd need to be 11:37
11 thinking about is in relation to the role of the PCC
12 right across the whole health and social care spectrum.
13 105 Q. Yes.
14 A. That when you think about Muckamore as a bespoke
15 hospital facility right across mental health and 11:37
16 learning disability, you know, it would be one only
17 facility there, so you wouldn't see that coming up
18 through it.
19 106 Q. Okay. So it might not be in that granular detail, but
20 might it pick up on an overall absence or shortfall of 11:38
21 regard to, just say, for example, for learning
22 disability or mental health services across the trusts
23 on that level as opposed to on a granular level of an
24 actual establishment?
25 A. I'm really not sure. In the PCC audits are we saying? 11:38
26 107 Q. In the BSO audits of the PCC?
27 A. In the BSO audits of the PCC they would look at
28 specific areas. So it would look at your processes and
29 your governance to check about that. The BOS would not

1 be looking at the granular detail of checking out
2 whether as an organisation there is an area that you
3 are detailed that you are working in. The BSO is to
4 give that internal audit, which internal audit in those
5 reports would go to your Audit and Risk Committee, 11:39
6 which then would go on to your Council and from your
7 Council also would be part of your assurance framework,
8 your mid year assurance in the end of your annual
9 report. It's very much about your systems, your
10 processes and your governance. 11:39
11 CHAIRPERSON: Yes, I mean they are looking at you --
12 A. Yes.
13 CHAIRPERSON: -- not the wider system --
14 MR. McEVOY: Yeah.
15 A. Sorry? 11:39
16 CHAIRPERSON: -- so far as these audits are concerned,
17 they are looking at the PCC?
18 A. Yes.
19 108 Q. MR. McEVOY: Thank you. So you had begun to tell us a
20 little bit earlier on, just moving on to paragraph 62, 11:39
21 about what you had set out in paragraph 62 in terms of
22 those being examples of how you reach out and make the
23 PCC's functions and services available to, let's call
24 them service users or end users. Roadshows and those
25 other activities and those things listed, information, 11:39
26 papers and reviews of projects, and so on, and
27 particularly the roadshows how do you ensure the
28 success of those? In other words, how do you get people
29 to come along to them? How do they know about them?

1 A. Well it's not so much sometimes people coming along to
2 them but when I look back on how they've been
3 undertaken, they would have went to specific events,
4 sort of like the Balmoral Show, which is one of the
5 biggest shows in Northern Ireland, they might have went 11:40
6 to an air show up in Portstewart. I could see a
7 linkage in reviewing the PCC positioned itself with a
8 stall in the areas that the public would have went to
9 in relation to general activities for the public.
10 109 Q. Okay, so public events, big, large scale public events 11:40
11 --
12 A. Yeah.
13 110 Q. -- that are open to the general population?
14 A. (Witness Nods).
15 111 Q. All right. Those events, the workshops, and so on, and 11:40
16 the roadshows that we have referred to then were indeed
17 held over the period from, 2010 I think is the first
18 one mentioned there, through to you taking up post
19 then?
20 A. Yes. The PCC in relation to people understanding they 11:41
21 also would have had a membership scheme and at its
22 height in that membership scheme, so if you were out at
23 events like that, or they also would have taken
24 opportunities to go to shopping centres and to present
25 themselves and to set out membership. Then if one 11:41
26 became a member within the PCC that would mean on a
27 regular basis information would be sent out about the
28 work that's being undertaken by the PCC, if there was
29 any consultations going on or any specific events and,

1 therefore, then people could come back and opt in.
2 112 Q. Okay. I think we'll come back to membership shortly,
3 because you do talk in terms of numbers.
4
5 Moving on then to the practice methodology which was in 11:41
6 place between '09 and '19 then, which begins at 63. I
7 think you have described earlier in your oral evidence,
8 we're at the bottom of page 28, you have described
9 earlier on in your oral evidence, and indeed in the
10 statement, independent professional advocacy and 11:42
11 collective group advocacy. If you wish, you know,
12 please do give us a little bit more about that, but in
13 particular can you explain what self advocacy entails?
14 A. Self advocacy, when somebody contacts the PCC and
15 they're trying to navigate health and social care it's 11:42
16 very complex and sometimes you're not sure about how to
17 proceed. For people who are looking at self advocacy,
18 we may be providing them with advice and information,
19 so they have the ability to advocate for themselves but
20 what they require is the information, because 11:42
21 information is power; once you give that information to
22 someone they have the ability then to navigate a system
23 but they may not know from the outset about how to
24 navigate a system.
25 11:43
26 Collective group advocacy, there may be a number of
27 people who have the same issue. That could be, for
28 example, where we've had experience in my tenure of
29 people in, say, a care home in which there was a theme

1 of issues that had arisen and therefore the PCC went in
2 and acted collectively on that part on behalf of
3 everybody on similar issues. And collective advocacy
4 also can be in your engagement --
5 113 Q. Yeah. 11:43
6 A. -- and involvement in engagement where people come
7 around one issue and what you are doing is you are
8 collectively bringing a group of people together,
9 providing the support to them in order that they can
10 advocate. Independent professional advocacy, the reason 11:43
11 that we call it that is that if you look and understand
12 advocacy advocacy of itself is a continuum. In that
13 continuum where you may have someone who can self
14 advocate you then could have peer advocacy, someone who
15 has a similar issue to yourself and therefore they come 11:44
16 alongside you, understanding those situations, and they
17 would be able to become your advocate. You can have a
18 family advocate. You could have a carer advocate.
19 There is a whole range. Where we would be is situated
20 at a point in that continuum, that would be that the 11:44
21 staff, that is someone who is employed professionally
22 to provide advice and assistance across a wide range of
23 topics and issues and knowing and understanding what's
24 happening.
25 114 Q. All right. Is that a model that fits every sort of 11:44
26 patient, every kind of patient, regardless of their
27 need? It could be an acute patient in an acute ward in
28 an acute hospital, through to somebody who is a
29 long-term patient in an establishment like Muckamore,

1 with a learning disability, or are there adjustments
2 built into that model?
3 A. What you've described there is the ultimate challenge
4 for the PCC. In relation to where we currently are in
5 the development of the future, if I could talk about 11:45
6 that, is understanding that as an organisation that
7 must meet the need for the whole of the population
8 across Northern Ireland that's quite a wide brief.
9
10 What we also understand is there are other 11:45
11 organisations and advocacy organisations out there who
12 are being funded and supported through a range of
13 things, they may be procured through a system, they may
14 be commissioned by the Trust, they may also have
15 secured voluntary funds or through trust funds and 11:45
16 charities. They will have very bespoke knowledge and
17 information and in my experience as Chief Executive as
18 being an advocate, which I am and I have worked in
19 different areas, I've also worked alongside two other
20 advocacy organisations, the three of us as advocates 11:45
21 came together because it was a very particular
22 condition. Now, while I have the skills as an
23 advocate, the role and function as the PCC in relation
24 to the trusts, and that, they had the in-depth
25 knowledge both at a UK level and a local level about 11:46
26 the condition. So therefore with the three of us we
27 were able to come together and support a group of ten
28 people but it required each of us on that continuum
29 having different skills to bring it to there.

1 where the PCC has moved to, the event that I talked to
2 about April 19th, just past there, network and
3 networks, that as an organisation we must recognise
4 that, you know, as small as we are with 34 staff, and
5 eight of those being on the corporate end, and the rest 11:46
6 being on the advocacy and engagement end, from
7 Chief Executive all the way down that's what our role
8 is we do not have the in-depth knowledge for everything
9 so therefore it's incumbent on to us develop a model of
10 practice in which we connect in with other 11:46
11 organisations.
12 115 Q. You get the expertise where necessary?
13 A. Yes. Because you can't otherwise do that.
14 116 Q. Looking at paragraph 65 then, this is looking back,
15 once again before your tenure, on page 29: 11:47
16
17 "Based on a review of available records and the
18 complaints support service handbook that was in
19 existence the PCC approached advocacy and complaints
20 support pre 2019 was predominantly administrative." 11:47
21
22 Can you explain what you mean by the use of the term
23 administrative or predominantly administrative?
24 A. That is a judgment that I have made in coming in to the
25 organisation. 11:47
26 117 Q. Yeah.
27 A. When I came in the organisation was quite segmented,
28 where you would have had a research Department, you had
29 a PPI, personal and public involvement, and you had a

1 complaint service. In that complaint service you had a
2 manager with six complaints officers, client support
3 officers. Now they would have been dealing with a high
4 level of cases which would have came in as concerns and
5 that would have been giving advice and information and 11:48
6 they would have been dealing with people who had
7 complaints. It was quite a wide brief that they had.
8 In order to manage that and to manage that level of
9 caseload in looking at it what we would have seen was
10 that a lot of the work would have been done over the 11:48
11 telephone, over trying to understand what the problem
12 is, giving advice and information, helping people write
13 a letter and also, yes, going to meetings and to
14 supporting the connection and the communication with
15 the Trusts. But given that I felt looking at it it 11:48
16 felt a much more administrative role rather than the
17 role which we have developed now from Chief Executive
18 because I would be directly involved in casework all
19 the way down because any case could have a level of
20 complexity that requires either a service manager or 11:48
21 the head of operations or the chief executive to come
22 in and to be directly involved in this work to make
23 sure that you're representing families, whereas what I
24 felt happened previously with the resource they had it
25 felt like a department and a department actually 11:49
26 dealing with quite a high level of concerns, issues and
27 complaints and then how they managed, tried to manage
28 all that.
29 118 Q. Okay. So in essence whatever way the structure or

1 combination of them were set over that period of time
2 it didn't allow for advocacy at the sharp end, at the
3 hard end for families and patients to the degree you
4 felt was necessary, would that be a fair assessment?
5 A. Please let me think about that. 11:49
6 119 Q. Yeah.
7 A. I felt that the staff that they had there and the
8 resource that they had meant that the level of service
9 they could offer was one that's a little more distant
10 in trying to administratively talk people through and 11:50
11 to be there with them, as opposed to now where what I
12 would be expecting - and again, it's part of this as
13 well, I would like the Inquiry to understand, is, in
14 relation to advocacy models it's what you know and
15 understand and how you interpret that model. There is 11:50
16 nothing written down other than principles, but it's
17 how you actually take that and embrace that in an
18 organisation. So the first thing that I had done
19 getting in there, was to say, and within the PCC now
20 all their job titles have changed from complaints 11:50
21 officers, PPIs, to being practitioners, so the role is
22 to be there for people at the point so we have much
23 more staff at a range of levels and much more detail.
24 CHAIRPERSON: Yes, but I think what Mr. McEvoy is
25 getting at is there was a shift in the way that you 11:51
26 approached your, it sounds as if there was a shift in
27 the way that you approached the service. Previously
28 there was the administrative assistance to somebody
29 wanting to make a complaint and perhaps explanation to

1 them of how to do it and some level of support, whereas
2 now you are saying you are much more involved in the
3 complaints process, is that a fair...
4 A. I feel that's a fair comment, yes.
5 MS. MONAGHAN: Chair, if I could just add as well. I 11:51
6 think what demonstrates this is the pre model would
7 have had an extensive focus on the complaints process
8 and resolving or pushing everything down the formal
9 complaints processed, and that is evidenced by the fact
10 that when we came in that largely 80% of issues were 11:51
11 resolved or dealt with through the formal complaints
12 process, whereas in that shift you describe in the
13 model and how you work with people the focus has also
14 been on trying to resolve issues early and an early
15 resolution approach to that. Yes, the formal complaints 11:52
16 process as part of the HSE is part of that, but it's
17 one part of the continuum and that has meant that early
18 resolution or resolving issues prior to the formal
19 complaint process.
20 CHAIRPERSON: To try to prevent it getting to that? 11:52
21 MS. MONAGHAN: Yes. It is now 45% of how we respond to
22 cases as opposed to 20% previously.
23 CHAIRPERSON: Yes, thank you.
24 120 Q. MR. McEVOY: I suppose we can allow you the opportunity
25 to boast if you wish, Ms. McConvey, but would you say 11:52
26 what you introduced then was a qualitative improvement
27 to what the PCC did for patients and families based on
28 --
29 A. My only response to that would be how people responded

1 to the PCC and giving me feedback and saying it's a
2 different approach, that it is much more relationship
3 based, not saying we get it right for everybody. But
4 what I do believe is that we have implemented a
5 different, enhanced, improved advocacy service. 11:52
6 121 Q. Well, that's very modest. Okay, look, please, then, if
7 you can, at what has happened then in the period since
8 2019, which is what we've sort of begun to discuss. I
9 had asked you earlier about what had been done
10 historically in terms of reaching out and getting the 11:53
11 message out about the organisation from what you could
12 glean. What are you doing now? What's the approach now
13 in terms of getting on to the front foot and making
14 your services available to patients and their families
15 at Muckamore and indeed in other instances where those 11:53
16 with learning disabilities may require your help and
17 assistance?
18 A. Currently we have moved to, in the organisation to
19 develop a simpler, clearer picture of what the
20 organisation offers. From that what we produced was a 11:53
21 new service model that goes on to one page trying to
22 reach out to people to let them know because they said
23 there was a point of confusion about understanding what
24 the PCC could offer.
25 11:54
26 How we actually do this is we are in the process of
27 rebranding and publishing our organisation. We have
28 started off with making much more connected links into
29 the voluntary and community sector and other

1 organisations who support other people to see that we
2 are there to work in partnership with people. We have
3 our membership scheme. We have used social media. We
4 have a web site. We are in the regional guidelines in
5 relation to making complaints and we have significantly 11:54
6 increased our profile around our engagement and
7 involvement in theme based activities around quite a
8 wide range of things.
9 122 Q. Okay. I think that you had mentioned in your statement
10 - I think this is paragraph 76 in fact, which is on 11:54
11 page 32.
12 A. Yeah.
13 123 Q. I'll just pick up on this point. I'm going to go back,
14 but just since you mentioned it or hinted at it there,
15 there is a membership scheme currently numbering 8,000, 11:55
16 do we have any way of knowing a breakdown within that
17 number in terms of that membership, those with mental
18 health and learning disability needs and requirements?
19 A. We don't directly ask that question. But also we have
20 organisations who are part of the membership scheme. 11:55
21 124 Q. Okay.
22 A. So we would have organisations such as Mencap, Bryson
23 House, TILII, all organisations that would support
24 people with learning disability and organisations
25 supporting people with mental health. So our 11:55
26 membership scheme with any information that goes out on
27 a weekly basis would go to those organisations as well
28 because one of the things we're trying to do is develop
29 a concept of a network of networks.

1 125 Q. Yeah.
2 A. So it's the idea that what you're doing is there are
3 other people who are interfacing with the public and so
4 if you're trying to bring the information to them then
5 they disseminate that down as well. 11:56
6 126 Q. Okay. I suppose, you know, it's not impossible that
7 there may be families and patients who, for whatever
8 combination of reasons, don't interact with those
9 organisations, and others like them, and want to do
10 things on their own, want to take personal ownership of 11:56
11 the care of their loved one who is a patient.
12 A. (Witness Nods).
13 127 Q. So do you encourage them to become members of the PCC?
14 And if so, how do you do that?
15 A. Anyone who interacts with the PCC we would try to 11:56
16 promote our membership scheme with them to become
17 members. And any event that we would undertake or when
18 we're sending out publication about it we would try to
19 promote people to try to become a member of the
20 membership scheme. 11:57
21 128 Q. And the current number of 8,000 does that represent a
22 growth or a decrease in numbers year-on-year? Can you
23 give us any idea about that?
24 A. At its height it was 15,000. When I came in it was
25 about 12,000. But one of the things that we did was to 11:57
26 do a review because sometimes you can have people who
27 are on it and they're not using it or their
28 circumstances have changed. So we cleansed it. And
29 the other thing we did was we moved over to digital and

1 contacted a lot of people and asked them would you like
2 to receive this information digital wise or do you want
3 to stay in the membership scheme, or whatever, and so
4 we've been developing that all the way through.
5 129 Q. Okay. And do you set targets or are targets set for 11:57
6 you in terms of growing or maintaining that membership?
7 A. Yes.
8 MS. MONAGHAN: If I could come in on that, Chair? We
9 have moved to outcomes based accountability in the last
10 two years in terms of outputs we set and we had 11:58
11 previously set indicative targets around growing the
12 numbers on our membership scheme. On average in the
13 last two years we have added 100 to 200 new members
14 every year. We are revising whether that is the
15 appropriate output because adding members to your 11:58
16 membership scheme is one indicative target but how
17 active they are, how well they feel communicated with,
18 et cetera, is more where are focus tends to be.
19 130 Q. You are looking at the qualitative rather than the
20 quantitative. 11:58
21 A. What I would just add as well in relation to learning
22 disability, all of our materials we translate into
23 accessible versions and our web-site is available
24 through browser, et cetera, but we also would
25 facilitate two platforms, one for carers and people 11:58
26 with a learning disability which is facilitated by our
27 learning disability champion who is a member of staff
28 who has a learning disability themselves with a
29 particular focus on engaging individuals who may, as

1 you say, not be involved with organisations or may wish
2 to just represent themselves. But we also have another
3 platform for those with mental health issues as well
4 and those wanting to engage around that area of work
5 specifically 11:59
6 131 Q. MR. McEVOY: Okay. I want to just step back a
7 paragraph, if I could, to 75, please. You say:
8
9 "We adopt an approach across our practice which centres
10 on relationship building", and you emphasise then, "a 11:59
11 partnership approach placing coproduction and voice at
12 the centre of our work. This is critical in fulfilling
13 our purpose of promoting the involvement of the public
14 and representing their interests."
15 11:59
16 Just on that particular statement, you may be aware
17 from the patient experience and the evidence that was
18 given on behalf of patients by their loved ones and
19 indeed the loved ones themselves what came through in
20 the evidence was there was a lack of or indeed an 11:59
21 absence of coproduction. From your standpoint as the
22 PCC and adopting this approach into what you're doing
23 can you give any view about the extent to which
24 coproduction seemed to be a new concept in Muckamore
25 and perhaps even in learning disability services 12:00
26 generally?
27 A. MS. McCONVEY: I think coproduction across the piece is
28 a new concept and actually trying to understand it and
29 what it really means. So, for example, for families,

1 they can see that they want to have a seat at the table
2 and to be involved in that. But it takes a little bit
3 more than just sitting at a table and that's where I
4 think some things can go wrong. Because my opinion on
5 coproduction is it's a process in which you support 12:00
6 people to understand what's happening to give them the
7 information and the preparation long before they get to
8 that table in which decisions are being made.
9
10 Then when you're sitting at that table it's giving 12:01
11 emphasis to and space for people to speak and then
12 afterwards how after a meeting you would do a debrief
13 on what's happening and then preparing for the next
14 part of that.
15 12:01
16 So what can happen in coproduction is that, you have
17 people who are working on issues daily as professionals
18 and they could be racing on, whereas coproduction is
19 time intensive and resource intensive and it requires
20 you to step back and actually invite someone in before 12:01
21 you've written everything on the paper, not to come in
22 at the point where things are already designed and they
23 have not been able to influence the structures, the
24 process, anything, the design. So lots of times where
25 I have observed in health and social services where 12:01
26 they may feel that they are co-producing it's coming in
27 too late at a point, whereas people want to be in
28 early, early in the conversation and work alongside it
29 but also you need to put a resource in to support the

1 people who are engaging.
2 132 Q. Okay. All right. Briefly could I ask you then just to
3 look at the table which appears at paragraph 82 on page
4 35? It's going to be landscape format. In this table
5 you have demonstrated how the structure has evolved 12:02
6 since 2009-2018. And then I think over the page on
7 page 36 it then includes the period of your tenure.
8 Can you just help us with, there's one issue that
9 arises out of that, which is that there seems to have
10 been a reduction in the post of managers outside of 12:03
11 Belfast, is that right? What has happened? Essentially
12 the question is: What has happened in terms of
13 ensuring that there is an adequate level of sort of
14 senior management and leadership across the province?
15 A. Is this for my tenure? 12:03
16 133 Q. Yes.
17 A. Okay.
18 134 Q. What is the current position?
19 A. Actually there is an increase in managers. I probably
20 have not described that but I will describe it now. So 12:03
21 when I came in I had undertaken an organisational
22 review and one of those was to look at the structure.
23 I seen an organisation that really at that point had
24 three managers, one would have been in relation to
25 client support, which was the complaints, the other was 12:03
26 for a PPI manager and then we would have had a research
27 manager. Now they all were very compartmentalised parts
28 of the organisation and actually to me that's
29 inefficient and ineffective because then it just meant

1 someone was only working in one area, that meant you
2 were providing the public with a service you have as
3 opposed to meeting the public with the service they
4 require. Where we currently sit now where we had two
5 service managers I now have three service managers and 12:04
6 where we're working is to not be locality based, we
7 have three service managers right across Northern
8 Ireland with three themes and those teams are made up
9 of practitioners and senior practitioners.
10 12:04
11 There was a change where I think it went a little
12 adrift in relation to the research, where actually in
13 our legislation it talks about researching best methods
14 to engage, whereas the organisation was undertaking
15 pieces of research. So we then changed that Department 12:04
16 and what we have brought in is a manager which is
17 policy impact and influence manager and that is how all
18 of the data that is gathered from the organisation can
19 then be brought into one central place to be analysed.
20 We have more bespoke managers directly in practice than 12:05
21 there was previous.
22 135 Q. I suppose the question is really focused around, I know
23 you said it's less locality based --
24 A. Yeah.
25 136 Q. -- but I guess given the nature of our population once 12:05
26 we step outside Belfast it's quite a rural population.
27 Are you able to sort of ensure yourselves that the
28 service you provide adequately now covers the
29 population outside of Belfast and the area covered by

1 the Trust?
2 A. Yes, the PCC has an office base in Belfast, Ballymena,
3 Omagh, Lurgan and we have a hot desk available in Derry
4 city.
5 137 Q. Okay. So there is a presence in other words. 12:05
6 A. There is. Actually most of the staff are all outside
7 of Belfast.
8 138 Q. Yes, there is a presence then. Thank you, that's
9 helpful.
10 12:06
11 Turning then just to the review that you undertook of
12 complaints relevant to the Inquiry, it begins at page
13 38. Ms. Monaghan had adverted to this Alemba system
14 which was in use between 2012 and 2022, looking at the
15 data that was extracted from that system I think you 12:06
16 had in fact indicated this earlier on in your oral
17 evidence, Ms. McConvey, within the review of 236 cases
18 which were thrown up by the Alemba system 33 referrals
19 were specifically related to Muckamore:
20 12:06
21 "In all there was evidence of follow-up from the PCC on
22 the referral and where appropriate through to other
23 agencies. In many of the case files there was evidence
24 that families had sought the support of the PCC in
25 relation to a previous complaint made to a trust and 12:07
26 surrounding their loved one's care and treatment in
27 Muckamore. The records in these case files provide
28 evidence of requests for support by the PCC from
29 families who had fears and anxieties about the

1 provision of care by Muckamore Abbey Hospital, often
2 alongside their engagement and complaints processes
3 with respective trusts."
4
5 Now I've read back the whole paragraph but I guess the 12:07
6 Inquiry are very keen to know whether or not, from the
7 evidence of requests whether or not it was actually
8 given. So you have indicated --
9 A. Oh, yes, we have given you all this information.
10 139 Q. Yes. 12:08
11 A. Yes.
12 140 Q. So you are able to tell the Inquiry that when requests
13 for assistance were made --
14 A. Yes.
15 141 Q. -- that in fact that assistance was given? 12:08
16 A. Yes.
17 142 Q. Okay. There's then an examination of the casework
18 prior to the establishment of the PCC before 2009 and
19 then what you've said there is that that's basically
20 hard copy information? 12:08
21 A. Yes. I particularly in coming up to the Inquiry here
22 asked about those records from previous senior members
23 of staff to find out where they were and then had
24 undertaken a review of all hard copy records.
25 143 Q. Okay. 52 pre 2009 cases according to your research -- 12:08
26 A. Yes.
27 144 Q. -- or what you were able to locate containing
28 individual case records pertaining to individuals
29 referred to the relevant health and social services

1 council. Then you go on and say:
2
3 "From the review of all of the above 52, 33 cases were
4 within the mental health category and contained
5 information which identified issues of concern." 12:09
6
7 Was there a learning disability or learning disabled
8 category or anything approximating to it?
9 A. Yes, we...
10 MS. MONAGHAN: Sorry, Chair, at paragraph 93 we refer 12:09
11 to the learning disability cases, so it was learning
12 disability, mental health and Muckamore, three separate
13 categories.
14 145 Q. MR. McEVOY: So they were distinguished. Thank you.
15 We'll come back to the PCC and indeed the councils 12:09
16 perhaps in due course at a later juncture. But there's
17 an overall absence of information described in those
18 case files, why is that do you think?
19 A. MS. McCONVEY: When we looked at the files there did not
20 seem to be what you would expect in present day in 12:10
21 relation to a system of setting out a referral form,
22 what issue was dealt with, how it was dealt with, list
23 of contacts. In some of them, we have to say, it also
24 was a series of notes but we have taken and read
25 through every line of every file and at that time it 12:10
26 did not seem, in the folders that we looked at, I can't
27 say for anything else that was there, but it did not
28 seem that there was a system.
29 146 Q. Okay. At 94 then you summarise the review, this is

1 page 40?
2 A. Yeah.
3 147 Q. "In summary, this review involved an analysis of 52
4 hard copy case files, 33 of which were related to
5 mental health services, four relating to Muckamore 12:11
6 Abbey Hospital and 15 relating to learning disability
7 services, primarily care providers. The areas of
8 concern which were evidenced in files as being the
9 source of complaint were care and treatment,
10 particularly inpatient care in mental health hospitals, 12:11
11 day and residential units for learning disability and
12 complaints regarding alleged abuse."
13
14 I guess looking at it with 2023 eyes how would you
15 describe your professional feelings about what those 12:11
16 hard copy files revealed?
17 A. There wasn't enough data or information within them
18 that conclusively would allow you to follow a case
19 through and to understand everything that went on. I
20 suppose in relation to 2023 your expectation of how a 12:12
21 system would be set up and how information would be
22 retained is hugely and vastly different.
23 148 Q. Okay. Then at 95:
24
25 "There is an absence of information on some of these 12:12
26 records which would evidence the HSS council (and
27 laterally PCC's) implementation of relevant
28 safeguarding procedures or specific actions on the
29 follow up of information received with relevant

1 agencies."
2
3 So, you know, we note the phraseology you have used
4 there, Ms. McConvey, but is this a situation in which
5 the absence of evidence can also amount to evidence of 12:12
6 absence? In other words, there was no following up by
7 either the councils or, prior to your time, the PCC's
8 implementation of relevant safeguarding procedures?
9 A. When there is an absence of evidence I can't make a
10 judgment on whether they did or they didn't. My 12:13
11 expectation would be that if a safeguarding matter had
12 been raised when you were dealing with a case or with a
13 person you would have an expectation that that would be
14 recorded and on that record would state who did what,
15 what was the response and how that would be there. 12:13
16
17 To make a judgment in saying that they didn't do it I
18 couldn't say. But what I can clearly tell you is I'm
19 not seeing what I would expect to see.
20 149 Q. Okay. Moving on then, you say that: 12:13
21
22 "While some files were substantive and held clear
23 records of HSS council/PCC engagement and follow up
24 many files contained little information and held only a
25 single referral form or illegible written notes. The 12:13
26 review identified the absence of a standardised
27 recording practice across the region and there were
28 vast variations on what and how actions were recorded.
29 In many cases there was a lack of clarity on purpose or

1 role for the involvement of the HSS council/PCC or
2 evidence of decision-making processes and follow up
3 within casework practice."
4
5 That's a development, I guess, of what you've just 12:14
6 explained or what you've just explained is a
7 development of that.
8 A. It's a judgment made by us in looking at those records
9 --
10 150 Q. Yes. 12:14
11 A. -- and what we would expect to see.
12 151 Q. You describe a variability or a variation, some files
13 are better than others.
14 A. (Witness Nods).
15 152 Q. Can any inference be drawn from that, I mean, on a lack 12:14
16 of standardisation? Clearly, some personnel were aware
17 of a requirement to complete things properly and others
18 seemingly were not, or were aware of it and didn't. Is
19 that a possible interpretation?
20 A. That is one. The other interpretation could be that 12:14
21 what you're talking about here are four health and
22 social care councils.
23 153 Q. Yes.
24 A. Which were four separate entities, four separate
25 bodies. So when you're looking at evidence you're not 12:15
26 looking at one organisation, you're not looking at
27 something that would be streamlined or set up as an
28 organisation to look through. When you're talking pre
29 2009, you're talking about four health and social care

1 councils, which would have been situated within the
2 health and social care boards.
3 154 Q. Thank you. Okay. Turning to page 42 then, there are
4 two pieces of research referenced, one is: "Life After
5 Living in Hospital, the Experience of People With a 12:15
6 Learning Disability."
7
8 Then the other one is:
9
10 "What Matters to Me, Service Users and Carers' Views on 12:15
11 Learning Disability Services."
12
13 The Life After Living in Hospital or life after
14 hospital research was, I think, widely circulated, is
15 that right, or published you tell us at paragraph 105? 12:16
16 A. Yes. Any research or report produced by the PCC at
17 that point when I look back the majority of them had
18 what would have been a communication plan. And on the
19 communication plan, when I looked at that, and
20 particularly looking at this one, it would have said 12:16
21 where the report went to, and so a designated member of
22 staff would have written a letter, for example, that
23 went to the Minister of Health, that went to the
24 Permanent Secretary, it would have went to some of the
25 health committees, it would have went to MLAs, the 12:16
26 Trusts, the PHA, the Health Board, voluntary and
27 community sector. They would have had a comprehensive
28 plan, so that report would have been published widely.
29 155 Q. Everybody who you would expect to have seen it would

1 have seen it?
2 A. Yeah.
3 156 Q. Your statement tells us that both pieces of research
4 indicated concerns about Muckamore?
5 A. Yes, there were a number of concerns about Muckamore 12:17
6 and Longstone, some were already published in the
7 report and you will see them in the report. It makes
8 comment to it that looking at it from the eyes of today
9 you would look at that and you would say: That's a
10 safeguarding issue. But also we made a statement there 12:17
11 on paragraph 101 was that not all, because we had also
12 undertaken an exercise to go back into the records and
13 to look at the records in relation to the focus groups
14 and we found that there were other comments that were
15 made by people that didn't make it in to the report. 12:17
16 They would have been comments that talked about where
17 someone may have said that they were bullied, that
18 there was shouting. There was one that was a comment,
19 I can't remember which one of the reports, about
20 unwanted sexual advances. So they would have been, for 12:18
21 me, clear indications of a safeguarding issue.
22 Now what we tried to do then was to go back to that
23 period of time and to align with our Alemba system to
24 see whether that had come through because these are
25 anonymous being done. So what you're trying to do then 12:18
26 is: Can we correlate from what we've seen on these
27 records that those that didn't make it into the report,
28 remember, there are others in the report that are clear
29 in statements there that everybody had seen and these

1 other ones that didn't can we find a track within the
2 organisation that let's us know that they may have been
3 picked up. I can't report to you that I can see
4 something like that.
5 157 Q. All right. But I mean irrespective of what material 12:18
6 made it in or didn't make it in certainly we know that
7 concerns were raised in both reports?
8 A. Absolutely.
9 158 Q. Can you venture a view about why it is that having
10 produced the research and circulated it widely 12:18
11 apparently nothing was done about it, on the face of it
12 as far as we know nothing was done in terms of action
13 in relation to it?
14 A. I can't. Because clearly looking at it from the eyes
15 and reading the report at this time that you would say 12:19
16 that there were issues there that someone should have
17 picked up on and went back to and said: What's this
18 about?
19 159 Q. Paragraph 106 and paragraph 44 then, you know, you very
20 honestly told us there in terms of your efforts to 12:19
21 track concerns and track them across indeed to Alemba.
22 A. (Witness Nods).
23 160 Q. But you have included a reference to discussion about
24 the What Matters to Me report before the Board in
25 October 2015. Maybe if I just read it out before I ask 12:19
26 you some questions about it:
27
28 "The objective of this project was to gain a clearer
29 understanding of learning disability services from the

1 perspective of users and carers.
2
3 "Then Dr. Edmundson...", that was the then Chair of the
4 Council?
5 A. Yes. 12:20
6 161 Q. "... asked members if they agree that the conclusions
7 reflect the data available in the report and if the
8 recommendations made are based on these conclusions?
9
10 Members agreed that this is an important piece of work 12:20
11 but that it is 'the tip of the iceberg'. As the sample
12 size was limited members agreed that the PCC should
13 carry out a review to identify what local evidence is
14 available to support the findings in the report as
15 major work is done on learning disability services by 12:20
16 some of the voluntary and community sectors that
17 specialise in this area."
18
19 Then you go on to record:
20 12:20
21 "On discussion members agreed the recommendations but
22 asked that it be made clear that the issues identified
23 are 'tip of the iceberg' with more work needed by the
24 HSC system."
25 12:21
26 So presumably that message then was conveyed to -- I
27 mean the reports were circulated widely, as we have
28 discussed, but that message would have been conveyed to
29 those that needed to hear it?

1 A. Yes. So what we did as well when we were looking at
2 these reports, again apart from the Alemba system we
3 cross-referenced to see internally within the PCC where
4 the discussion would have happened and that Council
5 meeting there is the Council Board, our Board, and the 12:21
6 discussion was there following on from that, we weren't
7 able to track anything else.
8 162 Q. All right. Moving on then just to page 46, please, and
9 it's paragraph 112. So you have noted there, and
10 indeed referenced the document entitled "escalation 12:22
11 procedure", which was approved by the Board in April
12 2009.
13
14 There doesn't seem to be any other discussion or
15 reference to the escalation procedure and it doesn't 12:22
16 appear to have featured in - this is an opportunity
17 just to correct this impression if it's wrong, of
18 course, it doesn't seem to have featured in any
19 subsequent guidance for handling complaints, is that
20 correct? 12:22
21 A. It would have been in -- well, first of all, in
22 relation to understanding the escalation procedure, so
23 my understanding of how pre 2019 was when any PCC staff
24 were engaged or involved out there publicly, that would
25 have been in contact with the public, that they would 12:23
26 have had a small card and any concern they would have
27 taken that, they would have brought it to the client
28 support, which are the complaints officers, then that
29 would have been escalated through to the Client Support

1 Manager and the Client Support Manager undertook the
2 job and his role was to contact the Trust and the
3 appropriate authorities and to take action in relation
4 to that safeguarding issue.
5 12:23
6 It is in the previous older client support handbook,
7 the complaints handbook, where it would have said if a
8 safeguarding issue had been raised that the member of
9 staff would speak directly to the Client Support
10 Manager and the manager would undertake the role to 12:23
11 inform the relevant trust, or an authority.
12 163 Q. Okay. Turning then just to page 47 and to paragraph
13 115. You've been able to locate a paper on
14 resettlement at the meeting in December 2005 of the
15 Board. You've noted: 12:24
16
17 "A focus on the part of the Board in terms of balancing
18 rights between patients and their carers and between
19 those who wish to be resettled and the concern of some
20 families who did not want their loved ones to be 12:24
21 resettled from Muckamore Hospital into the community.
22 The December paper reflects feedback from some families
23 on the high standard of care being provided in
24 Muckamore."
25 12:24
26 Do you know what the basis for that conclusion around a
27 high standard of care was based on?
28 A. I think in relation to families, and if I could just
29 share my experience --

Gwen Malone Stenography Services Ltd.

1 164 Q. Sure.
2 A. -- since I have come in and having a conversation it
3 might throw light on this. For some families who had
4 an extensive period of time with their loved one in
5 Muckamore they had felt that the care that they were in 12:25
6 receipt of was of a high standard. But that goes in
7 relation to how much information those families
8 received. So I think for some of those families they
9 then were completely absolutely devastated when
10 knowledge and information came out. So they could only 12:25
11 go on what they were being presented with, what they
12 were being told by, how someone reported to them their
13 loved one was being treated, what was going on in their
14 day and daily activity. I'm sure you have heard from
15 families who, may have said to, you know, even having 12:25
16 access into the hospital, into the day-to-day living.
17 So you've got to realise that these families were only
18 subject to information that was given to them so the
19 judgment they could only make was based on what
20 somebody was telling them the story of the life of 12:26
21 their loved one. If they didn't have access to get in
22 through the front door, if they weren't in their living
23 quarters, if they weren't sharing the activities that
24 they were doing, if they did not have clear line of
25 sight in relation to that relationship to read it or 12:26
26 not read it you can only go on what's being told to
27 you.
28 165 Q. Okay.
29 A. So I would say that for some families that may have

1 been there they have been through a horrendous
2 devastation in relation to understanding what actually
3 then happened and what came out.
4 166 Q. In a similar vein it's noted just in the paragraph
5 above, as you mention it, that the Board indeed visited 12:26
6 Muckamore in November 2009. In terms of or in light of
7 what you've just said can you cast any light on why it
8 may have been that the Board did not appear to have
9 picked up on any concerns during that visit?
10 A. One of the things as well is, I suppose, if you want a 12:26
11 reflection from myself --
12 167 Q. Yes.
13 A. -- when you have a planned visit anywhere everybody
14 knows that somebody's coming so the whole of the system
15 will swing round to make sure that everything looks 12:27
16 great on that day.
17 CHAIRPERSON: It's the smell of new paint.
18 A. I was just about to say that. It's where the queen or
19 the king is coming and you walk in and you think,
20 that's what happens. If there is something that is 12:27
21 planned there everybody's got their Sunday best on and
22 it all looks like that. You cannot depend on safety to
23 be on a one-off visit to see anything that's happening.
24 168 Q. MR. McEVOY: All right. Can I then ask you just to
25 look at the section which you have helpfully provided 12:27
26 entitled:
27
28 "Reflections and lessons learned" and it begins at page
29 55.

1 In general as a matter of principle I think these are
2 issues maybe we'll return to as a later juncture
3 because, as we know, this is a module about information
4 building and gathering. However, it is noted at
5 paragraph 142 one of the issues in terms of 12:28
6 understanding advocacy, which is something that you've
7 discussed at length in the course of your oral
8 evidence, is:
9
10 "Advocacy is critical to the successful promotion of 12:28
11 and family engagement." You say: "It's to a large
12 degree determined by the Trust's commitment to and
13 investment in advocacy."
14
15 I suppose your statutory role is really all about 12:28
16 advocacy. Are you saying there, just so that we're not
17 at cross purposes, but are you saying there that you
18 rely on the Trust to commit and invest in advocacy in
19 order for it to work, in order for you, in other words,
20 to provide your service and discharge your statutory 12:29
21 function properly?
22 A. Okay. Well our statutory function is to be there to
23 assist people in navigating health and social services
24 with a concern or complaint. What needs to be
25 understood is advocacy is a model of practice, it's not 12:29
26 actually written into legislation.
27 169 Q. Yes.
28 A. If you were to ask me about enhancing our legislation I
29 would say that we are enabled as advocacy is a model of

1 practice but it's not enacted. So therefore a movement
2 to have that would mean that across the piece people
3 would understand it. I've been involved in advocacy
4 services for over 20 years and actually trusts
5 understanding that the range of people who can be an 12:29
6 advocate, the role of an advocate, the access to
7 information, the access to meetings, the acting on
8 behalf of or with or uninstructed, which means fully
9 for someone is not there.
10 170 Q. Yeah. 12:30
11 A. So therefore where I'm saying that that they need to
12 invest is a number of things, first of all, not just
13 for Muckamore, they invested finance here for advocacy,
14 but you need to invest in your staff and have a
15 parallel process so that they actually understand and 12:30
16 there's no interruption. Also, there's a commitment
17 and a time investment that's required in advocacy, it's
18 not just directly going to meetings, there's a lot of
19 work that advocates do on behalf of families outside of
20 it. Staff must make themselves available to that, must 12:30
21 make the reports available to everything that has to
22 happen there. So therefore, the trusts must commit. I
23 would say that there needs to be much more commitment
24 to understanding advocacy.
25 MR. McEVOY: Okay. Well, those are my questions, 12:30
26 Ms. McConvey, I don't have any further questions. It
27 may be the panel do have some questions so if you just
28 remain where you are for the time being.
29

1 MS. VIVIAN MCCONVEY and MS. MEADBHA MONAGHAN
2 QUESTIONED BY THE PANEL
3
4 171 Q. PROF. MURPHY: I just have one actually, I think at
5 paragraph 146 you say there were no plain English easy 12:31
6 read leaflets on safeguarding in Muckamore, which I
7 found very surprising. Have I understood it right?
8 A. Paragraph 146?
9 172 Q. Yes.
10 A. What I'm referring to there is feedback that we had 12:31
11 received from families. Safeguarding can be highly
12 complex. One of the things that you need to do for
13 people -- when you're working in system you understand
14 - I know I'm from a social work background so every
15 place has its own language -- for families the bit that 12:31
16 we feel needs to be there is everything put down in
17 easy read, one page, easily accessible so that if you
18 come across anything that someone is able to see who it
19 is but also who are the people that you directly speak
20 to. Now that requires at all times that information is 12:32
21 fully updated and some of the feedback that we had
22 received was people had changed post within Muckamore
23 and different things and families didn't know who to
24 relate to. So at all times an organisation needs to be
25 really up to date with the person: Oh, that's Vivian I 12:32
26 speak to. And if I have an issue with Vivian and it's
27 not working out I go to Meadbha. So you have something
28 that is there that didn't seem to be accessible. I
29 mean it may be in place now, I done that in January,

1 but to the best of my knowledge at that point.
2 173 Q. So are you saying there were easy read materials but
3 they were out of date?
4 A. What I'm saying is some of the feedback that I heard
5 from families was that there was a turnover of staff or 12:32
6 someone had changed post and they didn't know who they
7 were and I'm saying the suggestion here in the learning
8 is that what we should have is up to date all of the
9 time leaflets and documents for people.
10 PROF. MURPHY: Absolutely. Absolutely. Thank you. 12:33
11 174 Q. CHAIRPERSON: I have just got one question, going right
12 back to your paragraph 18, which is under the heading
13 of the MDAG. I'll just let you get that. I think you
14 went along to the meeting, this was on 30th October
15 2019, if you go back to your paragraph 17, but was the 12:33
16 PCC present at this?
17 A. I got an invitation to MDAG on 30th October and then
18 what happened from there was I had met two family
19 members and they then asked me to come along to a
20 meeting that had already been scheduled with the 12:34
21 Department.
22 175 Q. Yes.
23 A. With the Chief Social Worker and Chief Nursing Officer.
24 That was on the Monday then, and I went along to that
25 and that's where I started the conversation around how 12:34
26 PCC would respond in relation to Muckamore.
27 176 Q. So the answer is, yes, you did attend the meeting?
28 A. Oh, yeah, sorry.
29 177 Q. If we have a look at your paragraph 18.

1 A. Yes.
2 178 Q. Now bearing in mind this is October of 2019, so two
3 years after the 2017 revelations:
4
5 "The following issues were identified in discussion 12:34
6 with the 26 family members and carers present..."
7
8 The first bullet point is:
9
10 "Lack of reliable information and communication between 12:34
11 the Trust and family members on all aspects of the
12 service, including names of lead managers, information
13 on the future of the hospital and individual plans."
14
15 Do you have any recollection of that now or is that a 12:34
16 dim and distant...
17 A. No, its not dim and distant because it was a recurring
18 theme that has been happening since, all the way
19 through. It came up at MDAG, it also came up on the
20 forum, a forum was set up, a support forum for 12:35
21 families, continually asking the Trust to keep
22 information updated in a way that they would know who
23 was in post and turn over of staff because that's most
24 important in relation to who to go to.
25 179 Q. Are you saying that that's still continuing now? 12:35
26 A. Well my experience up to -- sorry, probably I'm talking
27 about into 2022.
28 180 Q. Right. And it was significant enough of an issue, in
29 other words,, I don't want to lead you, as it were, can

1 you remember what the force of opinion was? In other
2 words how many members were raising this as a problem?
3 A. I'm sorry I couldn't but I know that it was strong.
4 The record is there within the Inquiry, so I'd have to
5 go back into it, but I thought in reading the materials 12:36
6 it was very important to highlight certain issues and
7 so therefore that's what I chose out of it.
8 181 Q. And it means that even at that stage the families
9 didn't seem to know who was really in charge in terms
10 of lead managers -- 12:36
11 A. Yes.
12 182 Q. -- ultimately responsible for their loved ones?
13 A. Yes.
14 CHAIRPERSON: Can I just thank you both very much for
15 your statement and your very frank and very full 12:36
16 answers. I think we can close that there and I'll let
17 you go with the Secretary to the Inquiry. Thank you
18 both very much indeed.
19
20 I'll just remind everybody again, tomorrow morning 12:36
21 9:30. We'll deal with an application for a restriction
22 order if there is one. Thank you very much indeed.
23 MR. McEVOY: Thank you very much.
24
25 THE INQUIRY WAS THEN ADJOURNED UNTIL THURSDAY, 25TH MAY 12:37
26 2023 AT 9:30 A.M.
27
28
29