MUCKAMORE ABBEY HOSPITAL INQUIRY

SITTING AT CORN EXCHANGE, CATHEDRAL QUARTER, BELFAST

HEARD BEFORE THE INQUIRY PANEL

ON THURSDAY 8TH JUNE 2023 - DAY 50

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THE HEARING RESUMED ON THURSDAY, 8TH JUNE 2023 AS FOLLOWS:

CHAIRPERSON: Good morning, thank you.

MS. KILEY: Morning Chair, Panel. This morning our witnesses are Dr. Sarah Meekin and Mr. Sam Warren, and they are here to speak to the topics in Module 3. Neither of them have made statements themselves, rather they are speaking to particular topics in Mr. Chris Hagan's first and second statements. 10:05

So like yesterday, what I propose to do is have the witnesses sworn in, and I will take a little bit of time to have them explain their roles to the Panel, because that information isn't before the Panel, but also like yesterday bring up the relevant modules and identify the paragraph numbers that these witnesses will be speaking to. 10:05

CHAIRPERSON: That would be great, thank you very much.

MS. KILEY: So if there is nothing further, Chair, they can be called. 10:05

CHAIRPERSON: Thank you.

(Dr. Sarah Meekin and Mr. Sam Warren sworn)

10:06

CHAIRPERSON: Dr. Meekin, Mr. Warren, thank you very much indeed for coming to join us and to assist the Inquiry, and I know that you will have met counsel and had a brief discussion with her.

It is quite unusual, as you will probably appreciate, to have two witnesses at the witness table at the same time, but because we are an inquiry we can to some extent set our own rules. And as you'll know this isn't the first time we have done this. 10:07

The only thing that I will say is that we normally have a principal speaker, it is very important if the other interrupts, as it were, or has something to add that we get it clear on the transcript who is speaking. So this can't just become a conversation, we have got to know who has given what evidence. But subject to that I will hand over to Ms. Kiley. 10:07

DR. SARAH MEEKIN AND MR. SAM WARREN, HAVING BEEN SWORN, WERE DIRECTLY EXAMINED BY MS. KILEY AS FOLLOWS: 10:08

1 Q. MS. KILEY: Good morning to you both again, we met this morning. As you know, I am Denise Kiley, I am one of the Inquiry counsel team and I will be taking you through your evidence this morning. 10:08

Neither of you have made a statement to the Inquiry, rather you are speaking to portions of statements made by Mr. Chris Hagan, the Trust's medical director. And I will shortly come to identify the relevant portions of those statements. 10:08

But can I just ask you each in turn about your roles;

so, Dr. Meekin, if I could ask you first, could you explain please what your role is in the Belfast Trust?

A. DR. MEEKIN: I am head of psychological services within the Belfast Trust, so I have responsibility for the provision of psychological services, most of which comes under my remit in terms of management. And we provide across the various clinical directorates in the Trust, including within learning disability. 10:08

2 Q. Which directorate do you sit in?

A. I sit within mental health learning disability and psychological services. 10:09

3 Q. How long have you held that role?

A. So, I was appointed to the post in 2010 -- 2010, yeah.

4 Q. As part of that role, do you visit Muckamore Abbey Hospital? 10:09

A. I have done on occasions, yes.

5 Q. But your role is service wide, is that right?

A. Yes.

6 Q. So it relates beyond Muckamore Abbey Hospital and beyond the learning disability directorate, is that right? 10:09

A. Yes.

7 Q. And who do you report to?

A. I report to the director of mental health learning disability and psychological services. 10:09

8 Q. What size of team do you have in psychological services?

A. So probably around 200 staff. I suppose it maybe would be helpful to give some context in terms of what that

looks like; we would support every clinical directorate, so I have folk who work within children's services and paediatrics and looked after children, as well as within clinical health. So we would serve areas such as cancer and respiratory medicine and also within adult mental health services, as well as learning disability services, so the remit in terms of reach is quite wide across the Trust.

9 Q. Before your appointment in and around 2010, did you hold any other roles in the Belfast Trust? 10:10

A. So, I am a clinical psychologist by profession and I completed my training in 1995. I have actually worked within the Belfast Trust for all of my career in its various iterations. So when I was initially appointed it was the Royal Group Hospitals and I was appointed into children's services as child and adolescent mental health services and paediatric psychology. I eventually became the head of paediatric psychology services. And following our PA, I became the head of the children's services within the Belfast Trust, which included the previous Royal Group of Hospitals and also South and East and North and West Trust, and then became head of psychological services in 2010. 10:10 10:10

10 Q. And in your time in clinical practice, did you ever work in Muckamore Abbey Hospital? 10:11

A. No.

11 Q. Okay, thank you, Dr. Meekin. I will ask you Mr. Warren to do the same, could you explain to the Panel your role in the Belfast Trust at the moment?

A. MR. WARREN: My substantive post at present is a Trust Advisor and Safety Intervention, previously known as MAPA training, and that is based in Knockbracken, based up in Knockbracken with the corporate or the Trust team. 10:11

I am currently on a secondment in Muckamore Abbey Hospital. As a senior nurse manager I have been there for approximately eight months now, since last, so at the end of last August, start of September, and I am currently filling that post in Muckamore Abbey. 10:11

Previously, as I say, I joined the Trust, I think it was February 2020, as a Trust Advisor and trainer in MAPA, or what is now known as safety intervention. I am a mental health nurse by background, I am a mental health nurse, and I have spent a lot of time in England, predominantly the majority of my experience has been in England, working in the south coast of England, working in psychiatric intensive care units and high secure services, and also working in community teams, community dementia teams, et cetera, in the south coast of England. 10:11 10:12

During which time since qualification in 2005, since about 2008, I have also been, if you like, a MAPA or a safety intervention training, so it was previously PMVA in England working with the West London Mental Health Physical Intervention System, as such, and general 10:12

services as well, so three different systems essentially in regards to physical holding or restraint, et cetera. So I have got experience in different models of physical interventions and restraint reduction as well, so... 10:12

12 Q. And in your substantive post, the safety and intervention team in the Trust, I think we will come on to talk a little bit more about the role of that team, but I just want to place it in the wider Trust structure, so which directorate does it sit in? 10:13

A. Currently it sits under the Occupational Health Directorate, so it's managed by the manager of the Occupational Health team at the moment. I think previously before my commencement in the Trust it was managed under the health and safety, it was managed 10:13 under health and safety teams, but that had changed at some stage. So it's managed by the Occupational Health Directorate.

13 Q. And as a result then, does that team have wider responsibilities than Muckamore Abbey Hospital? 10:13

A. Well, essentially you have two teams, I know they are referred to in the statements, there is two teams or ATCs, which are accredited training centres.

Muckamore Abbey, and this is legacy agreement, have had 10:13 its own accredited training centre and its own team delivering safety intervention, or previously known as MAPA training, to their in-patients, and more recently their community services.

The Trust team, or the team based in Knockbracken, would deliver MAPA or safety intervention training to the rest of the Trust, the rest of the Belfast Trust, so a much larger remit, if that makes sense?

14 Q. Yes. 10:14

A. So you have two separate entities as such.

15 Q. Okay. Well, I am going to ask you more detail about that in due course, so we will come to that. For now what I want --

16 Q. DR. MAXWELL: Can I just clarify; so Occupational 10:14 Health, does that sit under the Human Resources team?

A. Oh, sorry, yeah, yeah, it sits under it.

17 Q. DR. MAXWELL: So it is not in a clinical directorate, it's under the human resources?

A. Yes, sorry, sorry, I should have clarified that. 10:14

DR. MAXWELL: No, no, that's fine.

18 Q. MS. KILEY: Thank you both. What I am going to do now is establish which particular topics we are going to address today, because as you know Mr. Hagan's statements deal with a wide number of topics. 10:14

So if we could bring up on the screen please the evidence modules document, and scroll down to Module 3 please. And you should see that on the screen in front of you, this is a list of the issues that the Inquiry 10:15 is considering under Module 3, which deals with policies and procedures.

And today the topics which you are addressing are 3G,

Policies and Procedures Re Psychological Treatment, Speech and Language Therapy, Occupational Therapy and Physiotherapy.

And that topic is addressed in Mr. Hagan's first statement at paragraphs 32 to 63, and his second statement at paragraphs 23 to 69. 10:15

And the next -- I beg your pardon, the paragraphs I have just given you are in fact for policy -- Module 3C, Policies Regarding Restraint and Seclusion, that's the other topic we are dealing with. So Policies Regarding Restraint and Seclusion are dealt with at paragraphs 32 to 63 of Chris Hagan's first statement, and paragraphs 23 to 69 of his second statement. 10:15 10:16

And then Module 3G is dealt with at paragraphs 106 to 191 of Mr. Hagan's first statement and paragraphs 70 to 85 of his second statement.

So, those are the two topics you have both been put forward by the Belfast Trust to address today. Can I ask you first of all, Dr. Meekin, have you had an opportunity to read those relevant paragraphs in Mr. Hagan's statements? 10:16 10:16

A. DR. MEEKIN: I have, yes.

19 Q. And are you content that they are accurate?

A. Yes, I am.

20 Q. And Mr. Warren, can I ask you the same, have you had

the opportunity to read the relevant portions of Mr. Hagan's statements?

A. MR. WARREN: Yes.

21 Q. Are you content that they are accurate?

A. DR. MEEKIN: Sorry, can I just make one clarification; I am here to address in terms of psychological, in terms of speech and language therapy and physiotherapy, et cetera, they fall into the remit of Allied Health Professionals, and I wouldn't be qualified to speak to them, so there would need to be someone else. 10:17

22 Q. MS. KILEY: And who would be qualified to speak to those sorts of issues?

A. There would be head of Allied Health Professionals within the Trust, and they would be most relevant person to speak to those. 10:17

23 Q. Where does the head of Allied Health Professionals sit within the Trust?

A. I'm not sure that I know the answer to that, apologies.

24 Q. Okay. Well, the Chair has already explained briefly the logistics of giving evidence, and we discussed it when we met this morning. So, as you know, I am going to take each topic in turn, and as I identify each topic I am going to identify who I am going to address my questions primarily to. So I would ask that person to be the primary speaker. 10:17 10:18

If the other person does have something to add, please do that, but please wait until the first witness has finished, and then please identify yourself so that our

stenographer can follow along.

And the first topic then is topic 3C, Policies Regarding Restraint and Seclusion, and I am going to address those primarily to you, Mr. Warren. It may be that you can add, Dr. Meekin, and, if so, please do in the way I have just outlined. 10:18

So, Mr. Warren, Mr. Hagan provides a little bit of context about this topic at paragraphs 34 and 35 of his statement, and I am going to read those to give us context for the rest of this topic? 10:18

CHAIRPERSON: And when you refer to his statement, we'll use that as the first statement, and then you can distinguish that if you are referring to the second. 10:18

25 Q. MS. KILEY: Yes, thank you. Yes, please. So if we can bring up please page 19 of the first statement. I should say, Chair, there are some difficulties in navigating this statement because it is over 20,000 pages long, so it sometimes takes a little bit of time to get it up on the screen. 10:19

CHAIRPERSON: Yes.

26 Q. MS. KILEY: Thank you. So you have that on the screen in front of you, Mr. Warren. And Mr. Hagan says this at paragraph 34: 10:19

"It is important to note that the two specific areas which the MAH Inquiry has asked the Belfast Trust to address, restraint and seclusion are two forms of what

are commonly referred to as restrictive interventions. Restrictive interventions are a subset of restrictive practices more broadly."

And then at paragraph 35 he goes on to say: 10:19

"The term restrictive interventions has been defined in the 2014 England and Wales Department of Health positive and proactive care, reducing the need for restrictive interventions document (further referred to 10:20
below) as deliberate acts on the part of other persons that restrict a person's movement, liberty and/or freedom to act independently, in order to take immediate control of a dangerous situation where there is a real possibility of harm to the person or others 10:20
if no action is undertaken, and end or reduce significantly the danger to the person or others and contain or limit the person's freedom for no longer than is necessary."

10:20

Mr. Warren, do you agree with that definition of the broader term, restrictive interventions?

A. MR. WARREN: Yes.

27 Q. And can you just give us a feel for what that means in practice, so the type of interventions that fall under 10:20
that broader term, restrictive interventions?

A. Well, it's -- I suppose it could mean anything effectively that is restricting what a person wants to do. So, you know, we can think about probably one of

the most prominent ones, certainly from my background in physical intervention or safety intervention training, could be potentially restraint, so you know --

28 Q. A physical restraint? 10:21

A. So actual holding of an individual, that is a restrictive intervention. Other things, you know, in regards to restrictive interventions could be potentially medication. So, you know, aspects of medication that potentially could subdue someone, 10:21 potentially sedate someone, these would be known as restrictive interventions. Preventing people from going where they want to go, as in locks and doors, these sort of things, so that could be --

29 Q. Seclusion? 10:21

A. Well, not necessarily seclusion, but actually, you know, if you think about potential clinical areas and doors are locked, potentially a person wants to leave and they are being prevented from doing so, then that would be a form of restriction, which could be 10:22 described as restrictive intervention. So those would be sort of loose -- well, more general terms in regards to restrictive interventions.

Restrictive practice is the sort of overarching term 10:22 for restricting -- for these sort of things. Sp restrictive practices could be, and they are described in our policies, and examples given, our policy and also the new regional policy as well, in regards to

restrictive practice. And the understanding of those restrictive practices by staff members is very important, because actually if we are restricting people what they want to do, and albeit for the benefit of that individual, whether they have capacity or not, we need to be aware of these restrictive practices and restrictive interventions and document and, I suppose, assess, plan and implement the same in regards to the review of those interventions and/or restrictive practices. 10:22 10:23

30 Q. And you refer to that term restrictive practice there. In Mr. Hagan's first statement he refers to two Trust teams, which you referred to a little bit when you were discussing your role?

A. Yes. 10:23

31 Q. So if you could look at paragraph 49 of his first statement please. It's at page 28. At paragraphs 49 and 50 he refers to two teams. At 49 he says:

"The first team is the Belfast Trust restrictive practice team ('the Trust team')." 10:23

And at 50:

"The second team is the restrictive practice team, formally known as the management of aggression team based at MAH." 10:23

Now, I want to take each of those in turn and just

understand a little more about them. So dealing firstly then with the Belfast Trust's restrictive practice team, so this is the team that Mr. Hagan refers to at paragraph 49. He describes it as the Trust team, and he says: 10:24

"The Trust team was formally known as the management of aggression team and is sometimes known as the corporate MOAT team. The Trust team is based at Knockbracken. Initially the Trust team was managed by the Belfast 10:24 Trust's Risk and Governance Department. However, since around September 2013, the Trust team has been managed through the Occupational Health services under the Human Resources Directorate. The Trust team lead is currently Anne Brannigan who reports to Caroline 10:24 Parks."

Now, earlier on whenever you were discussing your role you referred to the safety intervention team. That's not language that's used in that paragraph. Can you 10:24 explain how it the safety intervention team relates to the Trust's restrictive practice team?

A. Yes. In regards to the restrictive practice team, that's not a term, although the team do deal with restrictive practice, as I have already alluded to, 10:25 that's not a term that the team would actually be called, if that makes sense. I think what's meant there is what the team sort of manage, deal with, support services with in regards to restrictive

practices. It was formally known as the MOAT team, the management of aggression team, and it's now -- the teams are being re-branded, certainly the team in Knockbracken has been re-branded as the safety intervention team. And that is simply because the training that is delivered now used to be known as MAPA, under CPI, the Crisis Prevention Institute, which was management of actual potential aggression. That has since been re-branded and is now called safety intervention training. So we wanted to re-branded the team, as such, in line with that training, because that is predominantly the core work of the team, as in delivering the safety intervention training, if that makes sense. 10:25 10:25

32 Q. So in fact the safety intervention team is the Trust team -- 10:26

A. Yes.

33 Q. -- he that Mr. Hagan is referring to here, is that right?

A. Yes, that's correct. 10:26

34 Q. Can you tell the Panel a bit more about that team, what disciplines are represented on the team, how many people are on it?

A. Well, the Trust team, as in the safety intervention team, previously to me being on secondment comprised of two Band 7 nurses, qualified nurses, and we fulfilled two functions; one was the delivery of the safety intervention training, previously known as MAPA training. The other function was the Trust Advisor and 10:26

liaison part, which would be providing advice to services across the Belfast Trust in regards to the zero tolerance policy and regards to the zero tolerance risk assessments, identifying training needs collaboratively with those services, and obviously providing that training.

Now, that was two members of the team, there was previously three Band 7s within that team; one of those members of the team is actually mentioned in Mr. Hagan's statement here, is actually on secondment within a different part the Trust at the moment, so essentially there were two Band 7s fulfilling that function.

More recently there was another two expression of interest, two Band 5, not qualified nurses, but two Band 5 trainers, seconded into that team, to again bolster up the team and to provide additional training throughout the Trust.

35 Q. And you mentioned the role as providing training and advice throughout the Trust?

A. Yes.

36 Q. So is it right that the team is providing advice on safety interventions, not just in the learning disability field, it is in wider Trust services?

A. Absolutely. Predominantly it's across the rest of the Trust, so...if I give you an example; within the Royal Hospitals the Mater Hospitals, obviously where medical

care is delivered, medical care is provided, we are providing substantial amounts of training within those aspects of the Trust now, within community teams as well, within, you know, providing on -- dependent on the risk assessments from the zero tolerance policy, that would identify various levels of training. We would provide that across the rest of the Belfast Trust within the safety intervention team, the Trust team.

37 Q. When was the Trust team created do you know?

A. I wouldn't have that information, I'm sorry, I have been there since 2020, but I think it's been -- I couldn't hazard an exact guess, I'm sorry, apologies.

38 Q. And who does the team report to?

A. So the team reports to in regards to?

39 Q. In regards to its functions, so in its delivering of training and its providing of advice, does it have to account to anyone within the wider Trust as to how it fulfills its functions?

A. Well, essentially the team itself would provide regular reports to the likes of the risk and governance departments. We provide annual reports to health and safety and the statistics on training delivered to the Health and Safety Department as well.

We also provide various different reports to Trust litigation teams as well in regards to potential litigation cases that is ongoing within the Trust, either by staff or patient litigation cases as well.

Our immediate line manager, we would report through her. Then we would sit in various different -- or the team would sit in various different committees, like the health and safety committee, et cetera, to report stats, et cetera, in regards to training delivered. 10:29

And I do believe, although I am not responsible for the specific report, a lot of our training stats within the Belfast Trust are reported to the Department as well, I believe through some channels, but I couldn't advise 10:30 who that goes through, if that makes sense.

40 Q. Mr. Hagan provides a little more detail about the role himself at paragraph 51 of his statement, he says:

"The Trust team is responsible for the development, 10:30 implementation, communication and ongoing review of the Belfast Trust's restraint reduction framework and the following Belfast Trust policies in this area."

Which he lists. Can you explain what that term, what 10:30 the Belfast Trust's restraint reduction framework is?

A. The restraint reduction framework essentially is part of the restraint reduction network standards. So there is restraint reduction framework, devised by BILD, and the restraint reduction network that actually we as a 10:30 Trust have signed up to in regards to that. And there is, I believe, although I don't have it in front of me, I believe a copy of that restraint reduction framework has been provided in some of the evidence in regards to

that there.

41 Q. DR. MAXWELL: This is the UK-wide restraint reduction network?

A. Yes.

42 Q. MS. KILEY: I see, so it is not a Belfast Trust -- 10:31

A. No, that is in line with BILD, the restraint reduction network and the latest evidence base, so...

43 Q. But Belfast Trust does have some of its own policies, and Mr. Hagan lists them there, that he says the Trust team is responsible for the policy. So I want to look 10:31 at those now with you.

The first policy that Mr. Hagan refers to at paragraph 51A is the Use of Restrictive Interventions For Adult and Children's Services. And that policy is given 10:31 evidence S and G 1509. Mr. Hagan says about that:

"The iterations of this policy during the period with which the MAH Inquiry is concerned are addressed in topic 3 above, every iteration has been co-authored by 10:32 an advisor, trainer on management of aggression within the Trust team."

Now, I just want to ask you, if you can please, Mr. Warren, to help identify the earlier versions of 10:32 that policy, because I think some of them appear to have slightly different names, but that same reference number, so I just want to make sure that we are looking at the correct policy.

So, if we could turn back please to paragraph 39, page 25, you can see that this is the list of earlier iterations that Mr. Hagan referred to in the portion of the statement that I have just read. And there are some policies there with slightly different names, but just looking at the reference number which is SG 1509, it appears that the earlier versions of that Use of Restrictive Interventions For Adult and Children's Services Policy, were those policies set out at 39B, a June 2010 policy, 39C, August 2010. 39D, January 2011. 39E, May 2015. Is that right, Mr. Warren, are they the earlier versions of that policy, even though they have slightly different names? 10:32 10:33

A. I am going to make an assumption, obviously it is before my time in the Trust, but yes, they do look right. Now, obviously as a policy is reviewed there could be potential changes to a title of a policy, as such, obviously with the content being reviewed as well. So I'm going to assume, obviously it was before my time, if you would like we can take it back and feedback formally, but I am going to assume that is correct, yes. 10:33 10:33

44 Q. I am going to look at one of them anyway by way of example with you, and that is the May 2015 version. It appears at paragraph -- at page 5199, so it should come up on the screen in front of you shortly. 10:34

So this is the 2015 version and it is entitled "Use of Restrictive Interventions For Adult and Children's

Services". And you can see there that that's noted as version 3. And if we scroll down please to the next page, and just pause there, you'll see that the background of the policy is explained. And in the second paragraph it says: 10:34

"Patients and service users might be exposed to restrictive interventions as a response to some form of behaviour that places them or others at risk in a wide variety of different settings and situations. This may include settings where people are well known to staff and where individualised support can be planned with the aim of reducing the frequency and severity of such behaviours. 10:34

"In other settings where this is not possible, because the individual may not be known to the service or indirect response to clinical risk, robust governance is essential to ensure appropriate practice with regard to the use of restrictive interventions." 10:35

And if we could scroll down again then please under "purpose" in the second paragraph there it says:

"The policy will provide a framework within which the Trust can create a culture and develop ways of working that will reduce the need for restrictive interventions based on the six key restraint reduction strategies, as defined by the Restraint Reduction Network 2014." 10:35

So just to be clear on the scope of this policy, Mr. Warren, is it right then that this is a Trust wide document rather than focused purely on the learning disability sector?

A. Yeah. 10:36

45 Q. Okay. And if we continue down then please to page 5203, you will see that the various roles and responsibilities of a number of persons are set out. Just zoom out of that please so we can see the whole page. You'll see there the responsibilities of the 10:36 medical director. And keep scrolling down please, co-director for risk and governance, directors and co-directors, line managers and all staff.

I am not going to go through all of those, but there is 10:36 one that I want to focus in on at page 5206 please, the next page. You can see there, there is reference to the management of aggression team, which we have already discussed. And it says there that one of the role of the management of aggression team is: 10:37

"Liaising with directorates to ensure that all training is identified through risk based training needs analysis, and is delivered to an accredited approved standard to ensure the quality and consistency of 10:37 training across the Trust."

And if we -- you have already referred to that training function, and it's picked up again at page 5208 if we

can scroll down there please under that heading "implementation of the policy", it says:

"It is the responsibility of all the managers to ensure risk assessment has been completed in areas where staff are expected to engage in any form of restrictive intervention, as defined within the policy. This assessment and subsequent management plan should include service specific preventative strategies, safe systems of work, training, support and supervision for staff which is sensitive to the needs of their service users. These assessments will require regular audit to determine their acceptability and efficiency." 10:37 10:38

Now, the requirement for risk assessments and subsequent management plans appears in all the versions of the policy, earlier and later that have been provided as part of Mr. Hagan's statement. 10:38

Can you tell us a bit more about those documents, the risk assessment and the management plans. Who creates them first of all? 10:38

A. In regards to the risk assessments themselves, certainly I feel that this policy here will reference the zero tolerance risk assessment, which I have alluded to before. 10:38

If we think about specifically MAPA, previously known as MAPA, or safety intervention training, that zero

tolerance risk assessment will identify, now, it comes, if you look at the back of the zero tolerance policy, there is examples of potential risks within a service, okay, so it is set out in the standard health and safety template, but it will give examples of various risks, okay. 10:39

So if we take, for example, an A&E Department may be at risk of people displaying challenging behaviours or aggressive behaviours; they will fill out that risk assessment, that risk assessment which will give them a score, which will then take them to a training needs analysis at the back of that policy which will indicate what level of training potentially that service will need. 10:39

Each service should have at very least a zero tolerance risk assessment and training needs analysis completed, as per the policy, and that will indicate the level of training that potentially is needed for that service, okay. 10:39

46 Q. And how does that work in an area like Muckamore Abbey Hospital, because it seems that that is an area where there will always be a risk of aggressive behaviours, or always a risk of need for restrictive interventions. So is it the case that even with that said there will have been a requirement to conduct a risk assessment and to create a management plan in respect of Muckamore Abbey Hospital? 10:40

A. Absolutely, yeah.

47 Q. So they will exist, they are paper documents that are recorded and could be made available to the Inquiry?

A. I would hope so, yes.

48 Q. And who -- 10:40

49 Q. DR. MAXWELL: Can I just ask, are they done by ward?

A. They should be done by ward.

50 Q. DR. MAXWELL: So there will be more than one for Muckamore Abbey?

A. There should be, and certainly the status as is at the moment, there is one per ward in regards to the zero tolerance risk assessments and training needs analysis, yes. 10:40

51 Q. MS. KILEY: How often are they done?

A. They are reviewed at least annually. They should be reviewed at least annually, and they are audited as well in regards to this zero tolerance risk assessment will feed into and provide evidence for their BRAAT standard 10, so it's the Belfast Risk Assessment tool, standard 10, and that zero tolerance risk assessment will give evidence to that BRAAT. So it is indicated in your BRAAT standards in regards to the Belfast Risk Assessment tools and obviously this will provide evidence for that. 10:40 10:41

52 Q. So, in terms of the audit, that's slightly different then to the review, is that right? 10:41

A. Yes.

53 Q. And who carries out that audit function?

A. The audit is carried out by service managers, and then

that is reported to the Board in regards to the Belfast Risk Assessment. But the zero tolerance risk, you've essentially two separate things, the zero tolerance risk assessment should be completed by service, should be completed by service and within Muckamore. Or even if we think about mental health services, each individual ward will have a zero tolerance risk assessment and training needs analysis completed.

54 Q. DR. MAXWELL: And can I ask, what data is used for the audit? 10:41 10:42

A. In regards?

55 Q. DR. MAXWELL: So when you are auditing it, are you just auditing there is one, or are you auditing its efficacy?

A. It's the Health and Safety Department would be responsible for auditing the BRAAT, the Belfast Risk Assessment (BRAAT), the health and safety team are responsible for auditing that. 10:42

56 Q. DR. MAXWELL: I suppose I am asking you, do they look at the number of incidents of restraint or aggression as part of that audit? 10:42

A. I am not entirely sure, but we can take that away and I can get back to you on that, but those -- in regards to actual episodes of restraint or physical holding, et cetera, they are monitored by different means as well in regards to that, not just in regards to the Belfast -- the BRAAT audits as well. 10:42

57 Q. MS. KILEY: You referred there to two different types of documents, the risk assessment and then the training

needs analysis, and I know the zero tolerance policy refers to that training needs analysis, and I will come on to look at that policy. But this document that we are looking at refers to a risk assessment and then a management plan, so is that management plan a different document? 10:43

A. The management plan, I would assume, now obviously I wasn't responsible and it was before my time as well, but the management plan, as such, in regards to this policy here, I am assuming that that would mean individual management plans with regards to management plans for the patients themselves, you know, in regards to trying to reduce restrictive practices, et cetera, that would be down to the individuals themselves. 10:43

Obviously the training function or the training that's attached to the training needs analysis, that will be another aspect to and formulate a bit of a management plan with regards to reducing restrictive practices, et cetera, and that's fully included within the training function that we would deliver within the MAPA or the safety intervention team. 10:44

58 Q. So that is something different then, so there is an assessment of risk that feeds into an assessment of what training staff need, is that right? 10:44

A. Yeah.

59 Q. And that flows from the zero tolerance policy that we will come on to. But then there is also a risk assessment and a subsequent management plan that is

more patient orientated, is that right?

A. Yes.

60 Q. And that's what arises from this policy?

CHAIRPERSON: Sorry, I need to explore that; does the risk -- I understand you have a risk assessment of the ward, as you discussed with Dr. Maxwell. And so you will have to look at, I suppose, the nature of the patients that would be housed in a particular ward. I understand also you would have a management plan, a separate management plan, presumably for each patient, but do you risk assess each patient, or is your risk assessment in relation to the area in which they are accommodated? 10:44 10:44

A. Every patient should have an individual risk assessment. 10:45

CHAIRPERSON: They should, right, okay.

A. One hundred per cent should have an individual risk assessment and a personalised risk assessment that will indicate this individual's needs, how we can support these individuals. If things do, and sometimes will, go wrong, how do we support that individual in the least restrictive way as regards to what can we do to understand the triggers to potential behaviours, how can we reduce these and potentially negate the need to... 10:45 10:45

CHAIRPERSON: And are you able to say for how long that has been the system?

A. I am quite new to the Trust, but certainly from my experience, you know, working in clinical work all

across England, you know, in the south coast of England, every single patient had a risk assessment in place.

61 Q. DR. MAXWELL: Can I just clarify that, because there are some patients who access mental health services who don't have episodes of aggression. Are you saying all patients have an assessment, or are you saying that the professionals involved in their care make a judgment about whether to conduct a risk assessment? Or are you saying it is mandatory for every patient whether they have shown any signs of aggression or not? 10:46 10:46

A. Every patient should have a risk assessment. Any patient who is an in-patient within this Trust, and certainly within previous trusts I have worked have a risk assessment, certainly within mental health services. There will be a risk assessment completed of those individuals. And that's not just relating to aggression, you know, it could be a more generalised risk assessment in regards to, you know, what are the risks to this individual and why are they in contact with these services. 10:46 10:46

62 Q. DR. MAXWELL: And that's my point, health professionals do risk assessments.

A. Yes.

63 Q. DR. MAXWELL: They will screen people, and sometimes they will do a more detailed assessment in relation to certain things. So some people -- everybody will have a risk assessment, some of them will go on to have a more detailed assessment of their behavioural needs and 10:47

some won't.

A. Yes, absolutely.

64 Q. MS. KILEY: And who would usually author that risk assessment document, the one that you have just been discussing with Dr. Maxwell that you expect every patient to have? 10:47

A. The individual risk assessment or...

65 Q. The individual one?

A. It would be the -- you know it depends which service, you know, if you've got maybe A&E Departments, liaison departments -- 10:47

66 Q. I am thinking about patients at Muckamore Abbey Hospital?

A. That would be, you know, down to their sort of key nurse, associate nurse, their named nurse, as such, in regards to who is responsible for the individual who has that sort of key contact with this individual, it would be, you know, delegation from the ward manager or ward sister would, you know, review these regularly. And they wouldn't review them in sole, that would be reviewed as part of an NDT approach. 10:47 10:48

67 Q. The other document that you have referred to a few times now is the zero tolerance policy, so I think it is an appropriate time to look at that. It appears at page 5453, if we could bring that up please. 10:48

This is the August 2019 version of the policy. Just to confirm, is this the policy that you have had in mind whenever you have been referring to the zero tolerance

policy?

A. I'll just check, I do have mine here, sorry. Yes that's correct.

68 Q. This is the one that you're thinking of. And we can see then if we could scroll down to the next page please and look at the introduction. We can see that it is staff focused, and it says: 10:49

"The policy is to ensure that the need to protect staff is properly balanced against the need to provide health and social care to individuals. The Trust recognises that staff and those they provide services to have a right to feel safe from threat and violence from others. It is acknowledged that while there is an increased risk of aggression and violence against healthcare staff this risk be greatly reduced by effective communication, effective risk assessment, prevention planning, service user involvement, learning from incidents and training. The Trust is committed to staff safety and incident reduction through the provision of safe ways of working and provision of training." 10:49 10:49

CHAIRPERSON: Is there a problem with the screen?

SECRETARY: Is everybody's screens flicking? 10:49

CHAIRPERSON: I think it's working though, isn't it?

SECRETARY: It is flickering though, it is quite bad.

MS. KILEY: Mine is, but only a little.

A. I have got the policy in front of me here, so...

69 Q. MS. KILEY: Are you happy to continue?
CHAIRPERSON: Can we continue, and then we will look at it again in the break?
70 Q. MS. KILEY: If it becomes difficult to follow, Mr. Warren, please let me know. In respect of the scope of this policy, is it right again then that this is a Trust wide policy, so this isn't just looking at learning disability or mental health services, it is all services? 10:50
A. Trust wide, yes. 10:50
71 Q. But would you agree that in the context of learning disability services, I'm thinking particularly of Muckamore, it is impossible to achieve zero tolerance?
A. I think zero tolerance is a term that has been used, and certainly from my experience in England, zero tolerance was used some years ago and... 10:51
CHAIRPERSON: It's Rudy Giuliani, who was mayor of New York who started it, I think, much misused.
A. And although it is a -- I think the ethos and the concept is good, I think it is very difficult to achieve within the services that we deliver, not just within the Belfast Trust, but you know within the province, and actually within the UK. We are always going to come in to contact, we are always going to be supporting individuals who are very complex in nature with very complex needs, and that's across the board. And with those complex needs and complex nature we are going to experience associated challenging behaviour and behaviours that challenge and potentially will 10:51 10:51

present a risk to staff members, as in the workforce, but also the other individuals within the Trust. So, I suppose, the whole ethos and the whole concept of this policy and the training associated with it, and that's why the training function is vital to give staff the skills, equip staff with the skills and confidence that should they come in contact, or should they experience any of these behaviours that challenge, they are equipped to deal with it.

CHAIRPERSON: Is it really -- sorry to interrupt, but I think zero tolerance is a difficult phrase, although that may be the aim, but is it really about mitigating the risk as far as you possibly can? 10:52

A. It's about reducing.

CHAIRPERSON: Reducing the risk. 10:52

A. Eliminating risk where we can. If we can't eliminate, to minimise that risk and reduce that risk. And one of the key things, I suppose, from my perspective is to provide staff with the appropriate skills and training to deal with, manage and mitigate those risks as best we can. 10:52

72 Q. MS. KILEY: And training is dealt with further on in the policy, if we can go to page 5470 please. Is it right to say, Mr. Warren, that this policy provides the basis of Trust assessments, and it allows the Trust to assess risk in a certain area and to then develop training needs accordingly, is that right? 10:53

A. That's correct.

73 Q. And that is what we see then at Appendix 3. It says

there:

"Zero tolerance on abuse of staff regional training strategy requires the Trust to have in place training plans underpinned by risk assessment to ensure that staff receive the appropriate level of training. This assessment will detail how often they will be trained and also outline the techniques in which they will be trained."

10:53

And then there is a series of further detail, and particularly some types of training that all staff should receive.

But again I am just wondering how this works in practice in a facility like Muckamore Abbey Hospital, because is it not the case that all staff, there is a risk that all staff may be subject to aggressive behaviour, for example, and consequently there is a requirement that all staff need to be trained to the highest standard? 10:53 10:54

A. If you think about it, you know, there is different levels of training. So, you know, what I would expect a front line staff, when we are talking about front line staff we are talking about nurses, healthcare assistants. Now, this is not just within the Muckamore site, this is within all in-patients, so if we think about the Psychiatric Services as well, they should be fully trained in safety intervention, previously known 10:54

as MAPA in the five day course, so foundation, advance and emergency. And I can talk a bit more about the training if we have time to do that.

Maybe a member of domestic staff, a member of cleaning staff potentially wouldn't need do that, they may just require maybe a one day disengagement course, whereby you know that is protect themselves, so if they did potentially get into a situation where someone was behaving aggressively towards them, they may be able to disengage, raise the alarm, et cetera. 10:54 10:55

So dependant on people's roles within those clinical areas, the training will be dictated by that. Now, as I said before, and I have alluded to before, each area will have -- each area should have and will have one of these zero tolerance risk assessments. So, you know, if you think about a team of nursing staff or a ward sister, they will complete that for their team. If there is other -- 10:55 10:55

74 Q. Just to pause you there, again in the Muckamore perspective then would that be ward based or...

A. Yeah, ward based.

75 Q. Ward based. So each ward will have a risk assessment?

A. One hundred per cent, yes. 10:55

76 Q. And would it then consequently have a training needs analysis related to each ward?

A. Yes. In line with the policy, yes, they should have.

77 Q. And the risk assessment, who completes that?

A. The ward sister, ward manager would be responsible for completing that. And certainly in my experience within the Trust team, or the safety intervention team, those ward sisters or service leads would send those risk assessments to one of the Trust Advisors, as in myself or one of my colleagues. We would then contact those individuals, work through and review that with those collaboratively, and then identify, through the training needs analysis, the level of training that we feel is appropriate for their staff. 10:56

78 Q. How often is that process conducted?

A. In regards to reviews?

79 Q. Yes?

A. It should be reviewed annually, minimum annually.

80 Q. And do you know what the training requirements are assessed at for staff at Muckamore Abbey Hospital? 10:56

A. Yes.

81 Q. Can you tell us about those?

A. Yes, because it is one of the pieces of work I completed whenever I went down on secondment. All of the zero tolerance and training needs analysis were updated and all staff, front line facing staff, as in nurses, support workers, learning disability assistants are all trained to the advance and emergency level safety intervention course. 10:56 10:57

82 Q. And when did that commence, when did that requirement come into place?

A. Well, I reviewed it when I moved down on my secondment, but as I understand it that was in place before.

83 Q. Do you know how long for?
A. I can't answer that, I'm sorry, I wouldn't be best placed, it would be -- probably one of the previous managers would be best placed to answer that, but we can take that away and -- 10:57
84 Q. DR. MAXWELL: But there will be training records?
A. Yes, there should be.
85 Q. MS. KILEY: And should there be those risk assessments and training needs analysis documents for a period of time that would show the Inquiry what level it is assessed of training that is required? 10:57
A. In line with the policy there should be, yeah.
86 Q. How does all that work in respect of agency staff? So we know that Muckamore Abbey Hospital now and historically has relied heavily on agency staff, so how does the Trust ensure that agency staff are trained to the appropriate needs? 10:58
A. The agency staff, obviously there is a contractual agreement with the agency staff who are more or less block booked into the Muckamore Abbey site at the moment. Now, the contractual agreements are held by the nurse bank, and that's one of the contractual obligations in regards to staff will be trained to an appropriate level to be deployed within the Muckamore site. 10:58 10:58
87 Q. And who is responsible for ensuring that those staff are, have that level of training, is that the agency or the Trust?
A. Well, it would be a collaboration between the agency

and the Trust nurse bank. Obviously they would provide -- before any agency staff is deployed into the Muckamore site they would be, there will be a wide range, not just with safety intervention, previously known as MAPA, but all the mandatory training would be, a list would be provided to the nurse bank. They would review that and say that this individual is good to go and step them on site for an induction, so that would be the process before they actually enter onto the site. 10:59

CHAIRPERSON: And who would deliver that training, is it the same people who deliver the training to the Trust staff, or...

A. Are you talking about the safety intervention training?

CHAIRPERSON: Yes. 10:59

A. Well, actually the agencies themselves, everybody will be trained with the CPI accredited model, and the agencies that are feeding into the Muckamore site are all trained in the CPI accredited module, so the Crisis Prevention Institute. They do have their own trainers, so these people would be trained before stepping foot on site. 10:59

For those, you know, we have on occasion, certainly since my time down, we have actually trained some agency staff to get them on site quicker due to staffing pressures and stuff like that. So it is a collaboration, there is also a collaboration between the Muckamore site and I think it's partly down to my 10:59

background as a Trust Advisor and trainer as well, we have updated some of their staff as well, so their annual updates we have updated some of their staff, one to keep them in date, but two to keep them in work as well, so they didn't have to go off and get trained by their agencies, if that makes sense.

88 Q. DR. MAXWELL: This training would be required for any mental health nurse working in most settings, wouldn't it? It would be a common training an agency nurse would be expected to have if they were in an RMN? 11:00

A. It depends really. Within the Belfast Trust, yes, it is CPI accredited model that we teach, you know, safety intervention we teach. Now, I do know in England and Wales there is many, many different derivatives, you know, but certainly within the region, it is safety intervention, previously known as MAPA, that people would be expected to know. And certainly in-patients, certainly people working in in-patient areas would definitely --

89 Q. DR. MAXWELL: And you would expect that for agency nurses going to work in the mental health units of the Trust as well? 11:01

A. Absolutely.

90 Q. DR. MAXWELL: It is not unique to Muckamore?

A. It is not unique to Muckamore, no, that's across the Trust. 11:01

91 Q. MS. KILEY: You have referred to training a number of times and you have used the phrase "we deliver", so am I right in saying that the Trust team delivers

training, the safety and intervention training to Trust staff?

A. Yes.

92 Q. And can you tell the Panel more about what that training involves? It previously was referred to as MAPA, is that right? But, it is now referred to as safety and intervention training? 11:01

A. Yeah.

93 Q. So can you tell the Panel what type of elements that training contains? 11:01

A. Well, there is -- it depends -- there is a few different derivatives of the training, if that makes sense. So I touched briefly on it whereby there is a one day course, which is commonly known as the personal safety and disengagement courses, so the likes of some of our medical staff would attend that course. Some of our maybe domestic cleaning staff would attend that course. So people who would be patient-facing, but you know not on the wards day in and day out. 11:01

11:02

So that one day course would look at various different things in regards to, you know, understanding behaviours, how to communicate with people, how to communicate with people whose behaviours are potentially escalating. How to deescalate people, how to keep yourself safe, and then the day would finish off with disengagement, so all else has failed in regards to your communication, someone has maybe grabbed, took hold of you and you need to disengage 11:02

from that individual to get yourself to a place of safety. So that would be the one day course which we -- sorry, the Trust team deliver, that would be the most common course that's delivered across the Belfast Trust. 11:02

Next up there would be a two day foundation course, which would cover all of the elements on the first day, on the one day disengagement course, you know, in regards to communication, understanding triggers, 11:02 deescalation, et cetera, but it does include, and it would include the disengagements, but on the second day they would look a bit more in regards to actual physical holding, so holding with two people, so maybe, two staff members holding an individual by the arms, 11:03 whereby all else has failed in regards to the communication and non-restrictive strategies. So that would be the two day foundation course in regards to that. And we teach that, and the Trust team are delivering that to quite a lot of services across the 11:03 Royal Hospitals, et cetera, at the moment as well in regards to that foundation course.

Your next course, which would be probably the most common, would be the five day safety intervention, or 11:03 previously known as MAPA course, that's your foundation and your advanced and emergency holding, okay.

Now, obviously I do know that information has been

provided in regards to the intricate details of all those courses, and I will be honest, I am probably not the best at selling it, you know, I know how to teach it, if that makes sense, but I am not the best at selling it. But effectively it will look at, you know, much more in regards to introducing maybe three people to potentially holding somebody. It will look at holding people in standing positions. It will look at holding people potentially who have transitioned to the floor on their knees or maybe sitting on the floor. And then as a very last resort it will look at interventions, maybe holding people on the floor in maybe even a prone or a supine restraint. 11:04 11:04

Now, I suppose, it is very important -- that is the bare bones of the course, but in regards to the physical skills, it's very important and, I suppose, it is critical to convey that these courses, any physical holding of an individual is a last resort, everything else has failed, all else has failed, and we spend considerable time within those courses talking about what do we need to do with these individuals. Looking at their my safety and support plans or positive behavioural support plans, okay, to understand individual triggers, to understand those individuals, when their behaviours are escalating, what could we do to prevent us from having to put our hands on these individuals. 11:04 11:05

It also covers in regards to even when you are potentially in a hold with someone, maybe holding somebody's arms, how do you opt out, so what do we need to do to let this person go? How do we assess it? How do we make it safe? And everything is reinforced in regards to it has to be reasonable and proportionate in accordance with the perceived risk at that time. 11:05

94 Q. PROFESSOR MURPHY: Can I just clarify, what percentage of the five day course would be spent on deescalation, because the way you have described it, it sounds like in the two day course there is like half a day on communication skills before you get into interventions. And so would that remain the same in the five day course, so you're basically spending half a day on deescalation techniques, and then after that you're into techniques of holding people. 11:05 11:06

A. Not necessarily, and actually I do have the course guide here. So in regards to our five day courses, it's very important to remember that each and every stage is broken up throughout the week. And each and every stage, whereby even before you -- so you would go probably for maybe three quarters of the day before you actually get into, on day one, before you would actually get into someone taking hold of you and you disengaging from them. 11:06 11:06

On the second day, there is the group work and activities and case studies covered throughout that whole week. Now, percentage wise I don't know in

regards to that there, but I do know that the vast majority of that course is spent on prevention. Okay. What do we need to do not to hold these individuals? What do we need to do to proactively manage potential behaviours of challenge with people in escalating behaviours, and how do we avoid having to hold them, okay.

You know, I do, and I think it's been provided in the evidence as regards to the safety intervention, previously known as MAPA training, the majority of that week is spent on prevention, but as we know there will be occasions whereby these interventions will not work, the non-restrictive strategies will not work, okay. 11:07

Now, I would love to, and we would love to as a team say that, you know, we don't need to teach any of that, but we know that's not realistic, because there will be times, there will be occasions whereby staff need the skills to manage these individuals, to manage these behaviours and manage them safely, to keep that individual safe, but also to keep staff and others safe as well. 11:07

I suppose the sense I get from this course and, you know, I had alluded to it at the start, you know, I've been taught in other systems as well across England, and certainly I think it's come with recent guidelines from the restraint reduction network, you know, in the 11:08

BILD code of practice and stuff like that there as well, but this safety intervention or MAPA course certainly in regards to the theoretical elements, understanding these behaviours, understanding why people may present and behave in the way they do, certainly this system spends a lot of time on that there, and more so than any of my previous systems.

You know, the MAPA, or safety intervention, you know, the safety intervention has been a bit of a re-brand by the Crisis Prevention Institute, the CPI, they have re-branded it early last year, and we have taken that on board as well.

They have also introduced a trauma informed element to these courses, whereby people will focus on previous traumas and will talk about previous traumas and adverse childhood experience and why these individuals may present in the way they do. Because, you know, one of the key themes and the key messages throughout the whole course is that behaviour is a form of communication. By these behaviours these individuals are trying to tell us something and what do we need to do to try and understand these behaviours and support these individuals in the least restrictive way.

11:08 11:08 11:08 11:09 11:09

95 Q. PROFESSOR MURPHY: So was SI the re-branding? I mean that says to me that it was changing the way it is seen by others, but did that really change what was taught?

A. There was introductions -- the re-branding, as such,

you know, the way people are held, if you get to the higher end of stuff, the way these individuals are held, the way you would effectively restrain someone, that hasn't really changed, that has not really changed. But what it is implementing and what it is including is that trauma informed element in regards to understanding why people may behave in the way they do, okay. And if we know how people behave, or why people are behaving in the way they do, then there is something we can do about it, okay. And there is a lot of time spent throughout those courses doing group work, activities, stimulations, scenarios in regards to what can we do? And giving staff the confidence and the skills to actually take this out into their clinical practice. 11:10

Another essential element, and sorry if I'm holding you up here, another essential element to it was the introducing the lived experience element to the safety intervention courses and stuff like that there. And it's my opinion, my personal opinion that, you know, we introduced this within the Trust team. 11:10

CHAIRPERSON: Sorry, was the expression "the lived experience"?

A. Service user or lived experience whereby someone, an ex patient of the Trust, okay. So, we actually manage to get someone who actually was a patient within our Trust some years ago, has experience of restraint, has experience of restrictive practice and restrictive 11:10

interventions, and she actually comes and delivers a talk on our safety intervention courses now from that lived experience perspective.

And in my opinion, and certainly the feedback we are getting from our participants and stuff like that there, is probably the most important, one of the most important things that is delivered on that course at the minute. 11:11

CHAIRPERSON: Could I just ask this, although MAPA, as you put it, has been re-branded -- 11:11

A. Yes.

CHAIRPERSON: -- and I suppose things may change over the period of time, and techniques have probably changed over the period of time, if we took any one period of time, would you expect everybody, whether agency staff or any other, or permanent staff to have the same training? 11:11

A. If people are teaching, if people are delivering that training in line with the Crisis Prevention Institute, who licence us to deliver that training, the training should be pretty much standard across the board. 11:12

CHAIRPERSON: Right. So looking across the ward, you would expect a member of staff, if somebody was using an inappropriate technique to be able to identify that and, if necessary, challenge it? 11:12

A. Absolutely. I would agree with that, yeah.

CHAIRPERSON: Thank you.

96 Q. MS. KILEY: Mr. Warren, Mr. Hagan referred to some

challenges in delivering the training in his second statement, so I want to ask you about that please. If we could turn up page 69 -- paragraph 69 of the second statement, page 24, this is STM-105, page 24. It's just on the screen in front of you there. This is preceded by a lot of detail on the type of training and the programme that you have just described. And at paragraph 69, Mr. Hagan says: 11:12

"The training managed by each Belfast Trust team ATC...", which I think is approved training centre, isn't that right? 11:13

A. Yes.

97 Q. "... is extensive, and demand within the Belfast Trust now exceeds the resources available to deliver it. The Belfast Trust currently has approximately 13,500 patient-facing staff. By way of example last year the Trust team managed training was delivered to approximately 3,000 staff. The Trust team is currently preparing a business case in relation to the enhancement of this resource." 11:13 11:13

Has it also been your experience that demand, demand for the training outstrips the resource?

A. Yes, that is correct, yes. 11:13

98 Q. And are staff in facilities like Muckamore Abbey Hospital prioritised to receive training over others?

A. In-patient, in-patient staff would be prioritised, absolutely, and that's not just within Muckamore, but

that would be within the mental health units as well, yes they would be prioritised.

99 Q. And can you ever recall an occasion when a staff member at Muckamore Abbey Hospital was assessed as needing MAPA training, but was unable to receive it because of a resource issue? 11:14

A. That wouldn't necessarily happen. And certainly from a previous -- before actually coming down to Muckamore, you know, we would have had, you know, general collaboration with the team, so if someone couldn't be trained within Muckamore, we could quite easily have brought them up and put them on to one of our courses, and vice versa. So it shouldn't -- in my experience that hasn't presented as an issue. 11:14

100 Q. DR. MAXWELL: Was the fact that there was a dedicated training team in Muckamore indicative of the fact that there was more need in Muckamore than the rest of the Trust? You quite interesting have two training teams, one for the rest of the very large Trust and one just for Muckamore? 11:14

A. I don't know the exact answer to it, and obviously it is before my time, but I understand it was a bit of a legacy agreement whereby each -- you know that Muckamore had its own team, its own training team. The rational and the reasons for that I can't, unfortunately I can't answer that, so... 11:15

CHAIRPERSON: And that's not purely post 2017?

A. Pardon?

CHAIRPERSON: Is that post 2017?

A. No, as I understand it that's been -- maybe even 2008, 2009, that's been in place for, so that's about all the detail I have on that, my apologies.

101 Q. MS. KILEY: Mr. Hagan refers to it at paragraph 55 of his first statement, so if we could just bring that up please, page 31 of the first statement. 11:15

A timeframe isn't given, but you see the role of the MAH team is set out at paragraph 55: 11:15

"The role of the MAH team is to provide a training function within MAH to build staff capabilities in managing challenging situations and behaviours in ways that prioritise care and minimise risk in relation to both in-patient and community learning disability services." 11:16

And the team also oversees provision of training in Ivy. So that is the Muckamore specific team. You are unable to tell us whenever that was put in place, but can you explain a little bit more about how that team interacts with the Trust team? 11:16

A. I suppose, there is a regional group, a regional, previously known as MAPA, or safety intervention group, that sits across all trusts within Northern Ireland and they sit quarterly, I believe. And obviously there would be interactions from there. I then alluded to obviously, you know, potential for Muckamore staff to be trained up in Knockbracken and vice versa. Okay. 11:16

The relationship, I feel, since I've moved from Knockbracken down to Muckamore, I would feel there is a lot more of a collaborative relationship there in regards to that there. And, I think, ultimately the aim will be to merge the two teams, and there is currently a business case, as it is alluded to there being prepared for that, in regards to the resource issue so that we can ensure consistency of training across the Belfast Trust. 11:17

Now, I suppose, on top of that there, there will be intricacies in regards to the Muckamore site and caring for and supporting those individuals within it, you know, in regards to specific training, in regards to positive behavioural support, et cetera, which will be sort of included, and has been included in the safety intervention training on the Muckamore site. 11:17

102 Q. Is the Muckamore team only responsible for training, or does it have any other sort of advisory role whenever it's based at Muckamore? 11:17

A. Predominantly training. Advisory role, I think, I don't think it's necessarily been -- now, this is me surmising, has necessarily been a problem, and certainly wasn't as prominent as my role within the Knockbracken team in regards to that advisory role. 11:18

103 Q. So it's not the case that a staff member working on a ward in Muckamore one day encounters challenging behaviour and can phone the Muckamore team for advice?

A. They could do, and I think it has happened, I just

don't know if it is a matter of process, if that makes sure, I'm not one hundred per cent sure.

104 Q. DR. MAXWELL: Are the Muckamore team only trainers, or are they people who have other roles and train as well?

A. There is two substantive staff on the Muckamore team at the minute, they have one Band 7, who is ATC Coordinator, and then one Band 5, so you've two staff. 11:18

105 Q. DR. MAXWELL: I am just wondering if they also do clinical work, so sometimes, you will know from England, the concept of link nurses who work, have a responsibility for training their team in something in particular? 11:18

A. Yeah. No, they don't fulfil that function. And I suppose me professionally, I would fulfil that role since moving down to the Muckamore team. 11:19

106 Q. DR. MAXWELL: And can I ask about your secondment, is your secondment specifically in relation to safety intervention?

A. Not specifically, but it is certainly one of my -- it would be one of my passions, as such. 11:19

107 Q. DR. MAXWELL: Your secondment was as a nurse manager?

A. Yes.

108 Q. DR. MAXWELL: The fact that you happened to be a safety intervention expert was just fortuitous?

A. Yeah. 11:19

109 Q. MS. KILEY: Thank you, Chair, I am conscious of the time, I am going to move on to a different topic, so it maybe an appropriate time for a break.

CHAIRPERSON: Yes, excellent, so we will take a 15

minute break now and we will try and get those screens sorted as well. Thank you very much. Okay, 15 minutes.

THE HEARING ADJOURNED BRIEFLY AND RESUMED AS FOLLOWS: 11:19

MS. KILEY: Before commencing can I raise just two housekeeping matters, the first is that the issue with the screens hasn't been fixed, but a work around has been found, so the issue remains, but the IT team have 11:40 found that if we zoom in then the issue isn't as apparent. So we are going to try doing that as much as we can.

CHAIRPERSON: Great, thank you very much.

MS. KILEY: And the second issue is that we have had a 11:40 request to slow down a little bit so that the stenographer can make sure that she is properly capturing all of your evidence, Mr. Warren.

A. My accent, sorry.

MS. KILEY: No, you're not the first -- 11:41

CHAIRPERSON: I normally slow people down, so that's my fault. So...yeah.

110 Q. MS. KILEY: Thank you. We are still on the topic of policies on restrictive practices. And we have discussed already this morning, Mr. Warren, the policy 11:41 surrounding that area and the training, so that is the theory, if you like, but I want to ask you a little bit more about how that works in practice in the hospital.

Mr. Hagan has provided some statistics which are on the screen in front of you now, now the graph may be hard to see, but can we just scroll out so we can see the whole page just for context first. So you can see that this is data which is collected concerning violence and aggression incidents at Muckamore Abbey Hospital. If we can just zoom into the graph on the top left please. 11:41

Now, for context I should say there is no need to turn this up on the screen, but for your information, Mr. Warren, Mr. Hagan explains about this, that this: 11:42

"Is provided by way of illustration...", this is Mr. Hagan's paragraph 63:

11:42

"...is provided by way of illustration to assist the Inquiry, and that these pieces of data were collated by the risk and governance team concerning violence and aggressive incidents at MAH, specifically for the periods since the Belfast Trust Datex records commenced." 11:42

And the charts reflect incident figures from the period 2009 to 2022. So you can see that in the heading of the graph: 11:42

"MAH behavioural incidents by selected incident type tier 2, January 2009 to December 2022."

And if we just scroll down to see the key on the graph please, you can see that there are various colours. And blue indicates:

"Inappropriate aggressive behaviour towards patient by staff." 11:43

Green is:

"Inappropriate aggressive behaviour towards staff by a patient." 11:43

Red:

"Inappropriate aggressive behaviour towards a patient by a patient." 11:43

Purple:

"Inappropriate aggressive behaviour towards staff by staff." 11:43

So, I want to focus firstly on the green line, so that is:

11:43

"Inappropriate aggressive behaviour towards staff by a patient."

And you can see along the horizontal axis that the time

periods are set out. And if you look at the period 2014 to 2018, you can see a large spike in those incidents. And it is hard to see the numbers on that version, but when you zoom in the numbers read from 2014, there were 682 incidents. And in 2018, that rose to 2,505 incidents. 11:44

And if you just look then for comparison at the blue line for the same period, which runs along the bottom, that's: 11:44

"Inappropriate aggressive behaviour towards patients by staff."

And for that same period it was 17 incidents in 2014, and 24 incidents in 2018. So there was a slight rise in that category, but a steep rise by any description in the inappropriate aggressive behaviour towards staff by a patient. 11:44

Now, one of the things that you have said this morning, Mr. Warren, was that one of the purposes of training in MAPA safety intervention is to avoid the need to use restrictive practices, and to use deescalation techniques instead. And presumably it follows then that one of the aims is to use deescalation techniques and to avoid aggressive incidents, is that fair to say? 11:45

A. Attempt to deescalate them, yeah.

111 Q. And I think you said earlier that it was impossible to

get to zero in terms of a number of aggressive incidents in a facility like Muckamore, but the aim is to mitigate, is that right?

A. I think, you know, not specifically to Muckamore, but across all in-patient services. And if we think about mental health, intellectual disability, learning disability, you know, there is a reason why some of these individuals are in hospital, because of the complex nature and stuff like that there. And because of the complex nature and needs of these individuals there will be subsequent behaviours that may challenge okay. Some of these may result in aggressive outbursts and stuff, because essentially if these individuals aren't complex to the need whereby they are presenting with these behaviours, they wouldn't probably be in hospital, they would be looked after in the community, if that makes sense. 11:45 11:46 11:46

So, you know, staff will try, as best they can, staff are taught and trained, as best they can, to use the least restrictive ethos in regards to deescalation, deceleration, understand the individual and why these individuals are presenting with these behaviours, okay. 11:46

But there will be occasions whereby those deescalation skills will not work, hence the training, they will be trained to deal with that, should they need it. 11:46

112 Q. And looking at the green line:

"The incidents of inappropriate aggressive behaviour towards staff by a patient."

And the spike that I have described, does that demonstrate a failure in the training or the application of the training by staff at Muckamore during that time? 11:47

A. I think it is very difficult for me to answer that, if I'm honest, you know, obviously we have got a graph there, we have got raw data there, I would need more information to be able to answer that there. I would also need to, you know, in regards to the actual MAPA, as it was called then, the MAPA training, I would need to look at the syllabus then. But I wouldn't say that that directly, surmising, I wouldn't say it directly results in the failure of training. We would need more information in regards to the rational why, so there has to be some sort of substance of rational to the increase in those incidents, which I can't comment on unfortunately. 11:47 11:47

113 Q. DR. MAXWELL: Can I ask you, this is historic data and you can't comment on it, but in your time at the Trust, do you monitor aggression from patients to staff, and do you in-depth analysis of the incident reports?

A. Certainly from my experience in Muckamore at the moment, yes, absolutely, we do. 11:48

114 Q. DR. MAXWELL: But prior to Muckamore, when you were working in the corporate team --

A. Yeah.

115 Q. DR. MAXWELL: -- would the team be tracking the number of Datex, and would they be looking at the type of incidents and doing a more detailed analysis?

A. Absolutely, one of the corporate functions was for the Trust team or, you know, myself and one of my colleagues as Trust Advisors, is to review every incident, whereby it is recorded on Datex, where MAPA or safety intervention is used. 11:48

So, it is based essentially on Section 8 of your Datex form and whereby staff would complete that, whether they used the disengagement, holding skills, et cetera, and then we would review that independently, as part of that corporate team, in regards to looking at the detail of the incident, understanding themes, trends, potentially identifying different training for specific teams, if the same themes and trends were flagging up, and that would be a sort of, that additional layer of governance whereby we are reviewing incidents independently of the service. 11:48 11:49 11:49

116 Q. DR. MAXWELL: So you are reviewing them on Datex --

A. Yeah.

117 Q. DR. MAXWELL: -- so your review would be in the comments section on Datex?

A. Yeah. 11:49

118 Q. DR. MAXWELL: Would that ever be aggregated into a report for an area or for a time period?

A. That could be discussed, and was at times discussed, certainly if I think, I'll give an example, it was the

child and adolescent, the CAMHS in-patient centre, whereby we did -- we were receiving a lot of incidents, a lot of Datexes, whereby individuals were held and young people were being held.

11:49

So we were able to run reports on that, and the service was actually able to run reports on that in line with their divisional nurses as well, where we would get those themes and trends and actually identify different training for those individuals.

11:50

119 Q. DR. MAXWELL: So potentially the Datex system has these, and it would be potentially possible to do a retrospective review of this data if it hasn't been done?

A. Possibly, yeah, it is a possibility.

11:50

DR. MAXWELL: Thank you.

120 Q. MS. KILEY: I want to move on now, Mr. Warren, ask you particularly about seclusion. And I think it's fair to say that that falls within the category of restrictive practice, is that right?

11:50

A. Yeah.

121 Q. And it also falls within that other description of a restrictive intervention...yes, that there, okay. Mr. Hagan's first statement refers to some regional guidance on restraint and seclusion, and he refers to this at paragraph 38 of his first statement, if we could just bring that up please, page 24.

11:50

In fact if you give me page 21 first please, 21. So at

point I there you can see a reference to:

"August 2005, DHSSPS Human Rights Working Group on Restraint and Seclusion, Guidance on Restraint and Seclusion in Health and Personal Social Services." 11:51

And that document appears, that's the regional guidance that existed at that time, and it appears at page 3254, if we could bring that up please. Are you familiar with that guidance, Mr. Warren? 11:51

A. No, no.

122 Q. Okay. So, you can see the title there is, as I have read it, and if we scroll down to page 3262 please, you will see at paragraph 1.2, the purpose of the guidance is set out: 11:52

"The guidance is intended to be of an overarching nature to be used to inform at provider level the development of policies and procedures, training and practice across the relevant client groups in both 11:52 hospital and other residential settings.

"The starting point for establishing good practice in the use of restraint and seclusion is in the development of organisational policies which reflect 11:52 current legislation and case law as well as departmental guidance, professional Codes of Practice and local circumstances, including the characteristics of children or adults cared for within particular

services. Every agency included within the remit of this guidance is expected to have a policy on the use of restraint and or seclusion."

Now, this is the regional policy, and you can see there it refers to the need for healthcare agencies, of which the Trust is one to have local policies essentially. 11:53

Now, Mr. Hagan lists, the Trust policies later on in his statement. And the first policy on seclusion is dated November 2016, and I will turn to that, but the reason I wanted to show you this was you may be able to help, or you may not, but I am wondering what the policy that governs seclusion before the Trust's November 2016 one was? 11:53

A. I'm sorry I can't answer that, apologies. Now, I can -- potentially we could take it away and try and get a bit of background to that there, but it was way before my time unfortunately.

123 Q. Yes. Might it have been the case that it would have been covered by a more general restrictive practice policy? 11:53

A. It's possible.

124 Q. Well, we will turn then to the 2016 policy, it appears at page 5230. Have you seen this policy before, Mr. Warren? 11:54

A. Yes.

125 Q. So we can see there that the title is Seclusion Within Learning Disability in-Patient Services, Children and

Adults Procedure. So this is not a Trust wide document, it is directed specifically at learning disability in-patient services, isn't that right? So this Muckamore Abbey Hospital falls squarely within this policy, is that right? 11:54

A. Procedure, yeah.

126 Q. A procedure, yeah. So if we scroll down please, the operational date is November 2016, and the review is November 2021.

11:54

Scroll down please to page 5234, and to the section "key procedure principles". And if we just pause there please. You can see it is said:

"There are a number of principles, seclusion must only be commenced when there is a clear and identified risk that the person who is to be secluded presents a significant degree of danger to other people and that the situation cannot be managed as or more safely by another means. 11:55

"The decision to use seclusion will always be based on the immediate presenting risks, professional judgment and knowledge of the patient.

11:55

"Seclusion will be used in the context of clear policy. It is only ever used as a last resort undertaken in a proportionate and least restrictive way and for the shortest time possible.

"Seclusion should be distinguished from the use of low stimulus (quiet area). A registered nurse will initiate the seclusion episode. The responsible consultant or duty doctor will be contacted as soon as practically possible and will be involved in decisions about continuing the use of seclusion and the ongoing management of the patient in seclusion."

I just want to pause there, Mr. Warren, there is reference there to a registered nurse initiating the seclusion episode. Is a registered nurse the only member of staff who can initiate a seclusion episode? 11:56

A. It should effectively be -- yes, it should be a qualified nurse or the nurse in charge of a shift, I would assume. 11:56

127 Q. So could a healthcare assistant initiate a period of seclusion?

A. It shouldn't be a healthcare assistant, no, it would need to be a qualified member of staff.

128 Q. DR. MAXWELL: Could it be an agency nurse, or would it have to be a substantive member of staff who was employed directly by the Trust? 11:56

A. Agency staff, you know, obviously they still operate under the same roles and remits in regards to the Nursing and Midwifery Council, you know, agency staff should be able to initiate that providing they have got appropriate training, appropriate orientation to the unit and appropriate knowledge of those individuals, yeah. 11:57

129 Q. DR. MAXWELL: And I understand a lot of the agency nurses are RMNs rather than RMLD, does it matter which registration you have?

A. It shouldn't, no. It is obviously quite a serious decision to make as regards to restrictive practice and seclusion, as such, but, you know, it should not, providing that individual has specific knowledge about the units that they are working in, et cetera. 11:57

130 Q. DR. MAXWELL: And we heard from Brona Shaw that there is always a Band 6 on every shift on every ward, would you expect the Band 5 registered nurse to discuss this with a Band 6 before doing so, or is it -- that not practical? 11:57

A. I suppose in regards to always a Band 6 on the wards, maybe there is a wee bit, a small bit of clarification that is required on that there, staff on the Muckamore site, are we talking about current status? 11:58

131 Q. DR. MAXWELL: Yes.

A. There is not currently -- there would not currently across all five wards be a Band 6 on all shifts, I just need to clarify that. 11:58

Now, on top of that obviously I think, you know, there would be a minimum of Band 5s, there are Band 6 on some shifts, however, within office hours there are always, on the majority of wards, a Band 7, and failing a Band 7, there will be assistant service managers and senior nurse managers during office hours. 11:58

Out of those office hours there will be always be at very minimum a Band 7 site coordinator, senior help and support as well, but in regards to the Band 6s across every shift, I would not say that, I would not say that's the case currently. 11:58

132 Q. DR. MAXWELL: Okay, where there is a more senior nurse, would the Band 5 be expected to involve the more senior registered nurse in decisions about seclusion?

A. I would definitely advocate that. You know in regards to the decision to seclude somebody, now I am not 11:59 talking about Muckamore, because obviously I have no experience of Muckamore, but certainly the decision to seclude somebody from a past experience there would be, and me as a Band 5, a Band 6 and even a Band 7, I would be including more senior staff in that there. 11:59

Now, obviously it is clearly a high risk situation and that decision is being taken to mitigate that risk and all other avenues have been exhausted, okay. But, you know, there should be an appropriate time to at very 11:59 least get someone else involved in that conversation, or if someone has been secluded someone knows immediately to actually look, discuss that decision, make up the rational, the risks and how that decision to seclude somebody would mitigate those risks. 11:59

CHAIRPERSON: You say you would advocate that, but is it a policy do you know?

A. Say that again, sorry?

CHAIRPERSON: You say you would advocate involving the

Band 6, if there was a Band 6, or a Band 7, if there was a Band 7, but is that actually the policy?

A. Well, it's in this procedure in regards to, if you look through the end of the procedure, obviously the decision and who has been involved, notification to senior nurse managers, office out of hours, on-call, senior nurse managers, duty doctor, et cetera, so... 12:00

DR. MAXWELL: That's after the event.

CHAIRPERSON: Yes, so that is what should always happen? 12:00

A. Yes, so it is clearly set out within this procedure.

133 Q. MS. KILEY: If we return to the procedure, you will see the next bullet point says:

"Seclusion will take place in a safe, secure and properly identified room where the risk of the patient harming themselves or others is reduced. It will have adequate heating, lighting, ventilation and appropriate furnishings based on individual patient assessment. 12:00

"A member of the staff will be within sight and/or sound of the patient at all times during the seclusion episode. The room should offer complete observation from the outside, whilst also offering the patient privacy from others." 12:01

So just pausing there; for example, those requirements to be within sight and sound of patient and the requirement to have a properly identified room,

effectively means that seclusion can only legitimately take place under the policy in the seclusion room, is that right? So, for example, someone couldn't be secluded in their bedroom?

A. It shouldn't be, they should be -- in regards to this procedure, it is identifying a seclusion room, as such. So, you know, if we are going with this procedure, then it should be in a dedicated specified room. 12:01

134 Q. Do staff go with the procedure?

A. Well, there has been no seclusion on the Muckamore site since, I think, it's August '22, I think was the last. 12:01

135 Q. The Inquiry has heard from Brona Shaw, as Dr. Maxwell had referred to earlier, and Brona Shaw referred to there being no seclusion episodes from August 2022?

A. Uh-huh. 12:02

136 Q. So that's your experience, is it?

A. That's my experience, yeah. Certainly the last report that I looked at, you know, in preparation for this, for speaking to you today, was August '22, so there has been no seclusion on site since. 12:02

137 Q. Why is that?

A. It could be down to a number of reasons. Now, obviously there are less, there are less patients, okay. In regards to there is less patients on site, so potentially patients may not escalate to the extent whereby they require seclusion. That could be a reason. 12:02

Other reasons, as you know, there is a more, albeit

predominantly agency, but there is a more stable workforce within the Muckamore site at the minute with block booking of agencies. And staff are able to -- and staff are much more aware of patient needs.

There has also been another couple of pieces of work in regards to the upskilling of some of the agency staff with the RMLD upskilling programme as well, which a lot of the agency staff have found very useful. 12:03

There has been a lot of work done in regards to agency staff and our substantive staff as well in regards to reading and understanding of the patient's positive behavioural support plans, et cetera, et cetera. And I think that potentially could be a rational as well. 12:03

138 Q. So does it follow from that then that prior to that new situation essentially, so in previous times a lack of skilled staff, or an instability of the workforce contributed to increases in the use of seclusion?

A. I think it's quite -- that would be a bold assumption for me to make, a very bold assumption for me to make, and I could not make that. 12:03

139 Q. But it's a possibility?

A. What I am saying is, you know, since I have came into post, and that would be some of my sort of clinical, my clinical rational for potential for patients. I can't put my finger on it wholeheartedly, because I don't know what the patient population and what the staff population potentially was before my arrival as well. 12:04

So I can't wholeheartedly comment on that unfortunately.

140 Q. Yes. Well, we will return to the procedure. The next bullet point says:

"The patient will be offered drinks, food and toilet facilities, as required for their comfort." 12:04

And if we can scroll down please:

"The patient should be able to see a clock outside the door. Seclusion should not be used as an intervention for suicidal or self-harming behaviour. Seclusion must never be used solely to protect property. Staff who maybe involved in managing violence and aggression should be fully trained in MAPA. Any patient subject to seclusion must be told, if practicable, the reason for the seclusion, and informed throughout how it might come to an end. 12:04

"Any patient who has been secluded should be supported after the event to help him or her understand why the seclusion took place. 12:04

"All use of seclusion will be reviewed at the patients' weekly MDT meeting. 12:05

"A patient with capacity will be involved, if appropriate, in planning seclusion as an emergency

intervention, through their care plan and risk management plan."

Can I ask you about that final bullet point, how does that work in practice, are you familiar with circumstances where a patient has had capacity to be involved, and has had input into planning seclusion as an emergency intervention? 12:05

A. That last statement, now obviously I wasn't involved with this procedure and stuff like that there, my thinking is, my sort of clinical opinion is, although each individual is different; if a patient, you know, albeit within Muckamore, or a patient with mental health services, you know, is planning seclusion, there is a degree of collaboration there with that individual, and that would lead me to probably be having the conversations with these individuals, do we need to use seclusion? There are other options that can potentially be -- other less restrictive options as opposed to potentially locking somebody in a room. If those individuals are involved in planning a seclusion, we have already identified, this is an emergency, this is when all else has failed in regards to seclusion, you know, it is quite high risk, the trauma that patients potentially have experienced and will experience from being locked in a very sterile room, that can't be underestimated. 12:05 12:06 12:06 12:06

So, you know, if we are having that dialogue with

patients, with the patients advocates, that yes, you know, potentially we could use seclusion, I think there is other options could be used there, and that's my personal, my clinical opinion.

141 Q. And if we return to the policy, or the procedure, you can see then the next section is about the seclusion record. If we could scroll down please. There is, and I won't go through all of this, a plan. And then there is a review of the seclusion episode. And if we scroll down you can see that there are timed increments, so a 15 minute review, an hourly review, and all of these require entries, so two hourly review, over four hours, the sleeping patient, all of those require the nurse to document certain matters that are set out, isn't that right? 12:06 12:07 12:07

So is it the case then that for every seclusion episode, there should result in a quite significant amount of documentation, is that right?

A. If going with that procedure absolutely, yeah, absolutely. 12:07

142 Q. DR. MAXWELL: Can I ask, who is the Duty Officer?
MS. KILEY: It's referred to there at the top of page 5236.

143 Q. DR. MAXWELL: "Two hour and four hour reviews need to be done by the Duty Officer." 12:07

A. I am assuming, and again I didn't write this procedure, I am assuming it would be the duty doctor, I would

assume, and there would be the two hourly and four hourly reviews with the duty doctor along with the nurse in charge and senior manager, et cetera, I would assume, but we can certainly take that back for clarification. 12:08

144 Q. MS. KILEY: There are significant recording obligations there, and there should be the result of, as you say if the procedure is being gone by, should result in an amount of documentation. Does the Trust monitor that documentation that results from seclusion episodes? 12:08

A. I would have to take that away. If we are talking specifically about Muckamore I would have to take that away and how that was monitored. Now, obviously as I have already said, there has been no seclusion in Muckamore since August of 2022. 12:08

We do receive, as senior nurses and within our sort of live governance structures, we would receive a sort of a weekly and a monthly report, part of that report is allocated to, you know, episodes of seclusion, et cetera, and that there, so we could monitor it that way. 12:09

145 Q. Yes, I think there is reference to this further on, if we go down to page 5237 please, we can see those monthly reports, but just pausing before I ask you a little bit more about those; is it the case then that in your role, in the Trust corporate team, analysis of seclusion episodes wouldn't come to you regularly? 12:09

A. Not necessarily, now obviously there is a section and

there is currently regional work going on at the moment in regards to Datex and the regional group of Datex that's looking at the use of safety intervention or MAPA, and whether that resulted in episodes of seclusion and stuff like that there. So what they are doing is they are actually reviewing the actual format of the Datex forms to ensure consistency across the region. And I think a lot of that has been driven by the regional restrictive practice policy as well to try and make sure that there is a regional approach to it. If there is -- 12:09 12:10

CHAIRPERSON: Can you remember to slow down a little bit, sorry.

A. Sorry, so, yes, that's being monitored in regards to -- reports can quite easily be run from the Datex system if seclusion is used. It's few and far between, certainly within mental health services, there is not, certainly, there is certainly not a lot of seclusion that is actually used. 12:10

146 Q. Now at this present time? 12:10

A. Presently, yeah.

147 Q. DR. MAXWELL: So the reports on seclusion are taken from Datex?

A. Yes.

148 Q. DR. MAXWELL: If there is seclusion on the ward, is there a proforma to fill in, or do people just write in the ordinary records? 12:10

A. No, there is -- obviously at the back of this form there is also proforma recording, performance, who was

contacted when, et cetera, so there is that proforma. It would also be recorded on the parser system, on the electronic patient notes and also recorded on Datex.

149 Q. DR. MAXWELL: So there is three, there is a paper record system, there is the electronic paper record and there was a requirement to fill in a Datex incident report? 12:11

A. Absolutely.

150 Q. MS. KILEY: So the type of analysis that we just looked at, the graph that we looked at in terms of aggressive behaviours, documents like that are capable of being generated from Datex information, isn't that right? 12:11

A. Yes.

151 Q. So in theory one could generate graphs like that, that analyse the use of seclusion in Muckamore, for example? 12:11

A. Exactly, yes.

152 Q. You referred to the review of seclusion through reports and monthly reports. And I think that this is the part of the policy that gives rise to that. Under Part 6, you can see it says: 12:11

"The multidisciplinary team will monitor the use of seclusion through regular reports and incident reviews." 12:11

And then it says:

"Monthly statistical data on the use of seclusion is provided to the core hospital management team. An

annual report on seclusion is presented to the Trust Board and then the procedure will be reviewed on a three year basis."

So just breaking each of those down. The first level appears to be the review or monitoring by the multidisciplinary team through regular reports and incident reviews. How regular are those reports to the multidisciplinary team? 12:12

A. What I assume they are looking to there is, you know, your weekly PIPA meetings, which I think has already been discussed, in regards to their use of seclusion, if seclusion has been used, okay. So that's your sort of local level. 12:12

Obviously the monthly data is pulled from the Datex system and reported on to ourselves as hospital managers, but also to the sort of regional governance, the sort of directorate governance structures as well in regards to seclusion, if it is being used. 12:12

153 Q. And just on that, how is that data organised, so is it presented at an individual patient level, or is it a higher overview as to the number of overall incidents of seclusion?

A. At present, you know, the reports can be ran in a number of ways. However, how it is presented to us and how it is presented, because there is not a high volume of patients within Muckamore Abbey Hospital at the minute, so it is individual -- it can be 12:13

individualised. Now, obviously since I have commenced this recent role it has been sitting at zero. However, it can be itemised into individual patients, individual wards, et cetera, and that data can be drawn down.

154 Q. And this policy has been in place, we have seen, since November 2016, so there should be then already existing those documents if they have been created as a result of the requirement under this policy? 12:13

A. I would assume so, yeah.

155 Q. Who is the core hospital management team referred to there, if you see the monthly statistical data? 12:13

A. Again I think again that that probably refers to ourselves, the senior nurse managers, and the assistant service managers who are within that structure.

156 Q. And then the annual report on seclusion is presented to the Trust Board. Do you at local ward level see an annual report? 12:14

A. I would need to get back to you on that, I certainly haven't seen an annual report. Now, I sort of ran, prior to coming here to prepare for this obviously, because I knew we were talking about seclusion, I sort of had a look at the stats myself, but I haven't seen an annual report per se. 12:14

157 Q. And just to complete the picture; the Trusts, this seclusion policy was, Mr. Hagan says, updated in February 2022, isn't that right? So that's perhaps the one that is being used at the moment. 12:14

Mr. Hagan refers to this. It appears at paragraph 400

of his second statement, I don't think we need to turn to it, but it is more for the record that this is a document that has been updated. You are not familiar with that update, Mr. Warren?

A. Not off the top of my head. The last one I have here is November '21 for the next review. That's the one I have (indicating). 12:15

158 Q. Yes, and I think there is now one in place that was dated February 2022. Perhaps we will turn it up, it's page 400 of the exhibits to the second statement? 12:15

CHAIRPERSON: It's page 400, not paragraph 400.

159 Q. MS. KILEY: Yes, and if we just scroll down there, it is on the screen now. It's the same title, Policy and Procedure For Use of Seclusion in Adult, Disability in-Patient Services. And scroll down please. And the date there is operational, August 2021 is the operational date in fact. So you can see that. So that is the document that will be in place now, is that right, Mr. Warren? 12:16

A. Yes. 12:16

160 Q. Whilst we have Mr. Hagan's second statement open, could we go to page 14 please, and paragraph 37 and 38. Just go up to the bottom of page 13 please, that's it.

I just want to look at this, we are slightly off seclusion, but I want to take you to this, Mr. Warren, while we are on the second statement and while it is on the screen. 12:17

Now, this is, at this section of his statement Mr. Hagan referred to the Trust's local restrictive practices policies. And he then also refers to that being updated and there being regional guidance on that.

So if we could just scroll down then to paragraph 37, what he says is:

"In anticipation of the publication by the DOH of the new regional policy, that is the regional policies on restrictive practices, the authors of the updated Belfast Trust policy included a one year review date of February 2023. Now, that the new policy has issued, the Belfast Trust will reconvene a task and finish group with representatives from relevant key areas across the Belfast Trust, including mental health and older people and children's services to discuss and operationalise the new regional policy in a way that is most accessible to the Belfast Trust staff to whom it will apply. The group is scheduled to meet in April 2023, and will be chaired by Sam Warren, advisor, trainer on management of aggression within the Belfast Trust safety intervention team based at Knockbracken and one of the authors of the 2022 policy." 12:17 12:17 12:17 12:18 12:18

Can you tell the Inquiry a little bit more about that process of updating the new policy and where that is, when it is envisaged that that will come into place?

A. Well, it is clear there obviously the regional policy has been released. Now, the Trust restrictive practices policy, it was ratified through standards and guidelines in 2022, but obviously we were aware that the regional guidance were being released and there was a few delays on that there, so we had agreed a one year turn around on that. 12:18

Since the release, obviously a lot of the definitions are quite similar in regards to our Belfast Trust policy and the regional policy, and that's simply because we were able to provide feedback to the department in regards to, you know, the specific and standard definitions in regards to restrictive practice and interventions. 12:19

The group itself, the task and finish group has started, and we have sat, we have had two meetings so far, and we are looking at various different things, because the regional policy does have quite a lot of procedural guidance in it as well. And especially if you look towards the last section in regards to seclusion and stuff like that there as well, so there is a lot of procedural elements to it. So, it is quite a big group in regards to we need representation from -- you know because the Belfast Trust is a sizable organisation and we need representation from the majority, from a lot of those areas to feed into this policy, because actually it will have a significant 12:19 12:19

impact.
It is early days in regards to whether we get that over the line. And when we get that over the line, however, it is due for review and we are due to present our findings from the task and finish group in December of this year, December standard guidelines. And we are hopeful that we are going to make it, we will obviously be on track to do that, to obviously incorporate the regional policy and make sure that it is standardised with our own policy. 12:20

From experience, the previous restrictive practices policy and the task and finish group, not chaired by myself, but by another divisional nurse in mental health, it was quite hard to get that across the line to get agreement across the board. And I don't expect this one to be any different, but we are working very hard to do that. 12:20

161 Q. And that is restrictive -- is it restrictive practices, or restrictive intervention that is being looked at the new policy? 12:20

A. The Department's policy?

162 Q. The Belfast Trust policy, maybe you haven't got to this stage of giving it a name yet?

A. Well, no, no, our restrictive practices policy for adults and children obviously will incorporate the regional policy in the use of, and the Department's policy, which is restrictive practices in health and social care settings. 12:21

163 Q. And what impact will that have on the seclusion policy that we have just looked at? Is it envisaged that the seclusion policy will remain a separate policy or will it be subsumed into the wider restrictive practices policy? 12:21

A. Again that's conversations that need to be had. And obviously the authors of that procedure, as such, now obviously we do and we will talk about seclusion within our policy, the restrictive practices policies, but in regards to those local procedures, the authors of those 12:21 policies and those decisions will be made in the task and finish group, in collaboration with the authors of those procedures as well.

164 Q. So it is on an ongoing process?

A. Absolutely, yeah. 12:21

165 Q. The final more specific intervention that I want to ask you about is pharmacological intervention, so that type of medical medicine intervention that you had talked about that is sometimes used to manage aggressive behaviours. 12:22

That particular type of intervention is noted in some of the already existing versions of the restrictive practice policies that we have. 12:22

So, if we can take up one of those as an example please, the 2009 policy, refers to it at page 5190. This is the exhibits to the first statement, so statement 105, page 5190. And if we can just scroll

down please. This is the restrictive practice policy that we have looked at previously. This is an earlier version of the one that we looked at previously. There are social restrictions. And keep scrolling down please, and pharmacological restriction appears there. 12:23
So I am just bringing up this version by way of an example, but all of the restrictive practices policies deal with pharmacological restrictions.

And whilst they are contained in the wider restrictive 12:23
practice policy, we have seen, for example, other specific policies on seclusion, like the one we have just looked at, so seclusion might be dealt with under the wider restrictive practice policy, but also under the more specific policy. And I am just wondering, you 12:23
can see that the pharmacological restrictions are contained in the more general policy, but are you aware of more specific Trust policies that govern pharmacological interventions?

A. From that time or now, I suppose, just for 12:23
clarification?

166 Q. That time, first of all, and then now please?

A. That time honestly I can't comment.

167 Q. So what is it now?

A. So obviously there is regional guidance now in the use 12:24
of rapid tranquillisation in acute behavioural disturbance, and there was a lot of work, obviously I am not a pharmacist, but there was a lot of work done regionally to adopt NICE clinical guideline 10, and the

suggestions from NICE guidance into that regional document.

168 Q. That's regional, but is there anything Belfast Trust specific that you are aware of?

A. At present, the Belfast Trust has adopted the regional policy in regards to rapid tranquilisation. 12:24

169 Q. DR. MAXWELL: Does it only address rapid tranquilisation, because people can be prescribed oral Diazepam on a PRN basis, which presumably wouldn't fall under rapid tranquilisation? 12:24

A. No, no, no, rapid tranquilisation in line with the regional policy, and again I am not a pharmacist, but my understanding of it would be that, you know, it is given by IM medication --

DR. MAXWELL: Injectables, yes. 12:25

A. -- and in rare circumstances intravenously. If someone receives oral medication, and diazepam being referred to, that would be PRN medication, and that would form part of a deescalation plan, it would not be described as rapid tranquilisation. 12:25

170 Q. DR. MAXWELL: So are there any policies or guidance on the use of something like oral diazepam?

A. Again NICE guidance will refer people on. Now, again I am not an expert, and I do understand that the team, the Trust has prepared a statement on PRN medication, I think that was submitted last night. 12:25

MS. KILEY: Perhaps it hadn't made its way to us yet.

A. So I do understand, because that was being gathered, and I believe a statement on regards to the use of PRN

medication has been submitted, or will be submitted to yourselves.

171 Q. So someone else is going to speak to that?

A. And that will be -- now, I will be honest, I haven't one hundred per cent prepared for that today. 12:26

172 Q. DR. MAXWELL: We did hear from Brona Shaw that every PRN drug in Muckamore is now reported, which seemed quite an onerous task --

A. Reported in what respect, sorry?

173 Q. DR. MAXWELL: By Datex, I think she said? 12:26

A. By Datex?

174 Q. DR. MAXWELL: Yes.

A. That wouldn't be one hundred per cent accurate, no. PRN medication would not be reported. Now, rapid tranquilisation, absolutely, because there is a fair 12:26 chance that rapid tranquilisation, those individuals are probably going to be required to be held whenever they are doing it.

Now, there is other, PRN medication, no, but certainly 12:26 you know, PRN medication and the use of PRN medication is reported, and it is reviewed and it is discussed on a monthly basis in the ward clinical improvement groups, but it certainly wouldn't be Datexed on every occasion, no. 12:26

175 Q. DR. MAXWELL: So, is that by review of the prescription administration record, or is it when somebody brings it to the meeting?

A. No, well, the use of PRN would be reviewed, all use of

PRN is sent to one of our emphamatics teams within the Muckamore site, who produce a monthly report on that.

176 Q. DR. MAXWELL: So do you have electronic prescribing, so it is not an electronic record of administration?

A. No. 12:27

177 Q. DR. MAXWELL: So somebody is physically looking at the medication and administration charts?

A. Yes, yes.

178 Q. DR. MAXWELL: And is that somebody from the pharmacy Department, or do you know who that is? 12:27

A. Well, the pharmacy are actively involved in the weekly meetings in regards to PRN medication, would form part of that, with regard to your weekly MDT meetings and the use of PRN medication. But it's also the PRN administration sheets are sent to the emphamatics team 12:27 who produce reports delving down to the frequency of medications, who received the PRN medication, et cetera.

And, I suppose, just to add to that, that there is also 12:28 a -- any PRN medication that is given out across site currently, there would be a critical clinical discussion between two qualified members of staff as to the rational for the presenting issues, presenting risks, the rational for administering that PRN 12:28 medication, and that's agreed to by two qualified clinicians.

179 Q. DR. MAXWELL: So that's two nurses, because currently the NMC guidance is single nurse administration, but

you have policy for PRN in Muckamore of two nurses have to be --

A. It is not policy, as such, but it is certainly guidance.

180 Q. DR. MAXWELL: It's practice. 12:28

A. Yes, best practice at the moment, yeah.

181 Q. DR. MAXWELL: And I ask, this intensive review of PRN medications, does that happen in the mental health services or something particular to Muckamore?

A. I think its particular to Muckamore, I could be wrong, I am not aware of it in the rest of the Trust, but I think it is particular in Muckamore at the moment. 12:28

DR. MAXWELL: Thank you.

182 Q. MS. KILEY: Does the use or administration of PRN form part of the safety intervention training? 12:29

A. In the Trust team, the Trust team in Knockbracken, we felt it useful for the pharmacy or pharmacy colleagues to deliver a presentation on rapid tranquilisation, because actually, as I have already alluded to, sometimes, and a lot of the time, if someone is receiving rapid tranquilisation, obviously it is as a last resort, everything else has failed, but they are more than likely going to be held whilst they are receiving that. Because actually if somebody is accepting of medication you would not be administering an injection, it would be oral tablets, et cetera. 12:29 12:29

So we felt it very important, you know, that that presentation was delivered by our pharmacy colleagues.

It is also very important, because, you know, of the risks of restraint, it is obviously risky any way when somebody is being held. But, you know, administering medication, as in sedative medication, antipsychotics, benzodiazepines, obviously do have an impact on an individual on their function and on their physical health. And the monitoring of those individuals is key and critical, especially if they have had to be held during the administration of that there. So we felt it would be a really good addition to the safety intervention course. 12:30 12:30

183 Q. When was that added?

A. That was added, the history, I don't know, in regards to that, it has been in place for certainly a few years now, in regards to the five day and the elongated, the five day course, it's part of that there. 12:30

At present in Muckamore it is not part of that course unfortunately, because I think predominantly it is down to capacity issues in regards to our pharmacy colleagues, but it is something we are working very closely and very hard to try and rectify as well. 12:30

184 Q. So is there a difference in the safety and intervention course that is delivered by the Trust team and by the Muckamore team? 12:30

A. Slight differences, yes.

185 Q. Why is that?

A. Those differences -- well, the positive -- obviously as I have said before, we are trying to standardise the

courses across the two sites, we are almost there, but not quite yet. The positive behavioural support team will provide a session in the five day and the update courses in the Muckamore site that wouldn't necessarily be applicable in mental health services, as such. 12:31

The adult safeguarding team, also within Muckamore, will do a small presentation. And with regards to their role within the Muckamore site, that wouldn't necessarily be appropriate within mental health services as well. So there are slight differences in that respect, and obviously the pharmacy presentation in regards to rapid tranquilisation is something we are looking to introduce within the Muckamore team. 12:31

However, what I would say is that rapid tranquilisation within the Muckamore site presently is minimal, is minimal.

186 Q. Coming back to some of the difference between the training by the Trust team and the Muckamore team, reminds me that you had mentioned earlier that there was a slight difference in the roles of the teams, so the Trust team had a training and advisory role, but the Muckamore team had primarily a training role, isn't that right? 12:32

A. Uh-huh.

187 Q. Is there a reason for the difference in the roles, because presumably the purpose of having a Muckamore specific team is to have that expertise on site, but is

there a reason why they don't have an advisory role?

A. Well, they do advise to an extent, you know, I wouldn't say that they solely do not have an advisory role in regards to the trainers in Muckamore. They would advise ward if there is specific issues. What I found since I have joined the team, and certainly the team within Muckamore, is that a lot of those issues would come to me, or a lot of those challenges would come to me because of my background and my experience. So, you know, it wouldn't necessarily need to reach those individuals, because actually I am fully aware of the patients within the Muckamore site, fully aware of some of the challenges, and I am fully aware of how to support staff to support these individuals pro-actively, so... 12:32 12:33 12:33

188 Q. Okay, thank you.

Mr. Warren, those are all the questions I have on the topic of restraint. I am conscious of the time, Chair, I think I will probably only be about half an hour more with Dr. Meekin, so I am in your hands as to whether you would like to consider, or... 12:33

CHAIRPERSON: We have got another witness of course this afternoon.

MS. KILEY: We do. 12:33

CHAIRPERSON: Would you be okay to start now?

MS. KILEY: Yes absolutely. I think if we were to run slightly beyond 1 o'clock, maybe five past, ten past one, I will get finished. So I think that's probably

preferable rather than to delay the witness scheduled for 2 o'clock.

CHAIRPERSON: Yes, well, I think, we will make a start and see how we go, we won't push it too far.

189 Q. PROFESSOR MURPHY: Could I ask one last question on restraint before we move on; would you ever get asked about individuals who seem to have rather confrontational style and who perhaps have been involved in more restraints than would be expected on a ward say? 12:34

A. I suppose if you think about the training, and this is a more general view, if we think about the training and safety intervention, previously known as MAPA training, obviously we are assessing individuals throughout that week, we are assessing various different things. 12:34
Though the key part is, we are assessing their physical ability, okay, physical ability to complete these physical skills and do them safely, if it gets to that extent.

12:34

Probably more importantly, and it's more important for me as a trainer's perspective is, we are assessing people's attitudes, people's attitudes in regards to their whole ethos, their culture, how they would refer, and that is done through a number of different aspects 12:35
in regards to the course. So we will do a number of role plays, simulations, scenarios, we look at how they communicate with ourselves, potentially playing the part of a patient or a person distressed, et cetera,

and we will assess them that way.

There has been occasions, certainly from my experience up in Knockbracken, whereby I did not feel that people's attitudes were right, and certainly they did need to be pulled up on it in regards to that there. And that would be done by having conversations with those individuals, conversations with their line managers as well in regards to whether we feel, and obviously giving them an opportunity to improve and potentially adjust, because actually if people are behaving in a manner that does not make me feel comfortable as a trainer, I certainly would not -- don't want those individuals out on a patient-facing role. So it is addressed proactively. Recorded, as such, in regards to the course reports and the safety intervention training documentation, and obviously sent back with these individuals in regards to potential things that they need to improve on. 12:35 12:35 12:35

We have also brought people back early, you know, obviously there is a 12 month turn around in regards to the refreshers, we have brought people back early, within three and six months before, just to see how they are getting on to assess their physical skills, but also those communications skills as well. 12:36 12:36

190 Q. PROFESSOR MURPHY: But obviously you only see them for, like, five days once a year, typically?

A. Uh-huh.

191 Q. PROFESSOR MURPHY: Would you ever have, for example, ward sisters saying, well, I am worried about so and so's deescalation skills, could you give them some extra training or anything like that?

A. It's happened on occasions, I wouldn't say it is a general rule of thumb, it has happened on occasions. And certainly, you know, within the Trust we have quite a close relationship with a lot of the ward sisters and ward managers, we do discuss challenges with them, certainly in regards to safety intervention, or previously MAPA, and we would have that dialogue with them. So if people are constantly being involved in various -- so we can tailor that training, we have even delivered one to one training for individuals in regards to us as a team of trainers to work with individuals to try and improve. 12:36 12:36 12:37

Ultimately, you know, communication is key, and communication at one of our key concepts is communication, if people can't do that properly that could increase incidents. So it is a very keen focus of us. 12:37

The last part of it I would say, before I close, is that, you know, at the end of that week we will run simulations or role plays, as such, whereby staff will have the opportunity to test those verbal skills, test those deescalation skills, but also test the physical skills out on us within that controlled environment. 12:37

And we will asses a number of things; their physical ability, their communication, their deescalation skills, but also their decision making, that they are acting in an appropriate and proportionate manner in accordance with the risk that we are presenting, or the perceived risk at that time. And it is a very good way for us to assess, putting people under a bit of pressure, but also assess those individuals within that controlled environment, as such, before we send them back out into their clinical areas. 12:37 12:38

PROFESSOR MURPHY: Thank you.

192 Q. MS. KILEY: Thank you, Mr. Warren. Dr. Meekin, I want to turn to our next topic with you, that is policies and procedures regarding psychological treatment.

12:38

Now, I know you will have seen that the topic that the Inquiry is looking at is wider than that, it is about policies and procedures regarding psychological treatment, speech and language therapy, occupational therapy and physiotherapy, but you have explained earlier that you can only speak to psychological treatment. And you referred to a head of Allied Health Professionals who maybe able to assist with those other matters. Do you know the name of the head of the Allied Health Professionals? 12:38 12:38

A. DR. MEEKIN: It has changed over the last...the previous head was Paula Cahalan who has moved into an interim directorate position, but I can certainly inform our counsel and that can be passed on, there is

difficulty with that.

193 Q. Thank you. Turning then simply to the psychological policies and procedures, they are dealt with at paragraph 107 of Mr. Hagan's first statement. So if we could bring that up please, the first statement STM-101, page 56. 12:39

Scroll down to paragraph 108 please. And in fact at 107, Mr. Hagan refers to you, Dr. Meekin, as having assisted him in making the statement, is that right? 12:39

A. Yes, it is.

194 Q. And at paragraph 108, it is said that:

"Psychologists and behaviour therapists have formed part of the service provision at MAH since at least the beginning of the primary time period with which the MAH Inquiry is concerned." 12:39

Now, as you know the Inquiry is looking at a large span of a time period. And is it fair to say that the fields of psychology and behaviour therapy have grown and evolved significantly over that period? 12:40

A. Yes, within ID or generally?

195 Q. Within -- generally first of all?

A. Yes. 12:40

196 Q. And thinking specifically about the service provision at Muckamore Abbey Hospital then, can you give the Panel an idea of how that has evolved, so perhaps the type of psychological and behaviour therapy

interventions that a patient at Muckamore in 1999 and the early 2000s might have received as compared to now?

A. So I can't speak in terms of 1999, because obviously that's well sort of outside of my time span in this area. 12:40

In terms of the provision of the number available, I suppose, that has definitely grown. And also in terms of specificity in Muckamore. So there has been a variation in terms of, for example, psychology 12:41 provision, partly around commissioning, so whether posts were commissioned specifically in terms of Muckamore, or whether they were commissioned in terms of community and provided some input into Muckamore. So there has been a variation in terms of that over the 12:41 years.

We have had more specific commissioning in Muckamore, for example, the consultant post which was very focused on forensic. And more recently the Trust received some 12:41 demographic money, which we chose to put additional posts into Muckamore at that point as well.

Alongside potentially an increase in commissioning we have had a challenge in terms of workforce, so the 12:41 potential number of posts isn't always equitable in terms of the posts that are available in terms of people being in them, and that's a workforce issue, which is wider than learning disability and wider than

the Belfast Trust as well.

197 Q. Is that a general challenge in recruiting psychologists?

A. Yes, yes, just in terms of capacity and demand. As you noted a psychology remit has expanded considerably across a number of services, so there are more jobs across a wider variety of services looking for practitioner psychology input and, therefore, there is a challenge in recruitment in terms of the number here trained to meet the need for that. 12:42

198 Q. You referred to the recruitment of a consultant forensic psychologist, and Mr. Hagan sets that out at paragraph 109 of his statement. He talks about the commissioning of a Band 8C, consultant forensic psychologist post, with specific remit to support Six Mile, the Forensic LD in-Patient Ward at MAH. Can you recall when that was commissioned? 12:42

A. I can't, but I can definitely get you that date, yeah.

199 Q. We are talking about the later 2000s though, I think, isn't that right, because Six Mile didn't come into existence until then? 12:43

A. Yes.

200 Q. And he also says:

"For many years due to the difficulties in funding hospital posts, posts which were community funded also involved the provision of hospital services at MAH." 12:43

Does that mean that Muckamore was relying on using

community psychologists?

A. So, my understanding is from those years there would have been people who worked across, so they might have had some sessional input into Muckamore, as well as sessional input into the community, rather than being solely based in one or the other. 12:43

201 Q. Okay. And then at paragraph 110, Mr. Hagan refers to the demographic money, which I think you referred to, he says:

12:44

"By 2018 demographic money for psychological services was allocated and additional staff were recruited and deployed to MAH to provide support on site. This included a consultant clinical psychologist and two Band 8A psychological practitioners." 12:44

Was that the first time that psychologists were specifically based on wards at Muckamore?

A. They would have had input on wards in the past, but it is the first time that a single post was created across the site. 12:44

202 Q. Now, Mr. Hagan exhibits a number of policies to his statement which relate to psychology, for example, professional ethics and standards documents. But what is absent is any sort of policy document or protocol that sets out the role of psychologists or behaviour therapists in Muckamore. And I wonder does such a document exist? 12:44

A. No, it doesn't actually.

203 Q. Is there a reason why not?
A. I suppose we don't have that document for other areas in terms of a specific role. It's a useful question.
204 Q. Well, in the absence of it, can you explain to the Panel, and I appreciate that the role has evolved over time, and that the therapeutic needs of individuals differ, but for a typical patient, if there is such a one, what interaction would a typical patient at Muckamore have with psychology services? 12:45
A. So we would be looking at a role across the variety of areas, potentially the role within the ward and the system working alongside our behaviour therapists. There would also be potentially the role within individual work, if that was appropriate. And then potentially a role in terms of transition and looking at supporting what the needs might be moving into community settings. So I think that the role is across the system as well as an individual one to one level. 12:45 12:46
205 Q. Yes. And is it right to say that not every patient in Muckamore would have psychology input? 12:46
A. Yes.
206 Q. And so how does that work in practice, if someone is admitted to Muckamore, do they only encounter psychology services if they are referred?
A. Yes, and that would be a capacity issue in terms of the number of psychologists that would have been available versus the number of patients at a given point in time? 12:46
207 Q. Has that historically been a problem?
A. I couldn't say that anybody hasn't got psychology that

require it, but we don't have the clinical psychologist on site and haven't been able to recruit that. But we would have been requested to see someone as opposed to have a remit to see everyone that came into the hospital. 12:47

208 Q. PROFESSOR MURPHY: Can I ask, the behaviour therapists that are referred to from time to time, are they nurse trained behaviour therapists, not psychology trained?

A. So they are a mix. So historically they have mostly been -- behaviour nurse therapists would have been the terminology. And more recently we also have psychology graduates, who have done some additional training in terms of behaviour therapy, so we current have a mix between behaviour therapists who have a nursing background and some who will have a psychology graduate background. 12:47

209 Q. PROFESSOR MURPHY: So, psychology graduates, do they fall under your Department?

A. So since 2018, the behaviour therapy service has all fallen under my Department, that was a decision taken that as a psychological therapy it would sit better under psychological services. 12:47

Prior to that, the behaviour therapists in post all were from a nursing background and they sat within the remit of the nursing structure within the hospital. 12:48

PROFESSOR MURPHY: Okay, thanks.

210 Q. MS. KILEY: And if a patient is referred to behaviour therapy or for behaviour therapy, what is the typical

input that a behaviour therapist would have with a patient in Muckamore?

A. So the systems kind of work co-jointly now as one service, but we aim to have behaviour therapists more involved in the wards, and the psychologist go in there to be part of multidisciplinary conversations. But typically a referral would be potentially around perhaps an escalation in behaviour, and the behaviour therapist and psychology would be there to look then in more depth at was happening for that patient at the time, to do observations on the ward, to do a behavioural analysis in terms of the incidents. And also if there was a positive behaviour support plan in place to review that positive behaviour support in order to see whether there was a change needed or whether there was a new challenge that had emerged in terms of why the patient at that time might be presenting in that way. 12:48 12:48 12:49

211 Q. And so psychologists are parts of the weekly MDT meetings, is that right? 12:49

A. When there would be psychologists available, then they would have -- there would never have been enough to be part of every weekly MDT meeting, but our behaviour therapists, where possible, tried to attend those as well. 12:49

212 Q. Okay. And the Inquiry has heard from families of some patients who displayed challenging behaviours during their time at Muckamore, who when asked said that their family member didn't receive any sort of behaviour

therapy. Were you ever aware of a problem with patients being referred or not being referred for behaviour therapies?

A. To be honest I am not aware of obviously all the evidence that has been presented so I can't really comment on anything that has been said, and I haven't been prepared to sort of look at the delivery, more the processes today. 12:50

213 Q. But just in terms of the processes and the flow of referrals and information, were you ever aware of any difficulties in the referrals? 12:50

A. All I can say is, not every patient that would have come into Muckamore would have required input from behaviour therapy, or would have required a positive behaviour plan to be put in place in terms of how they were and what their behavioural challenges would have been displayed. 12:50

214 Q. PROFESSOR MURPHY: But would they all have had a behavioural support plan, a positive behavioural support plan? 12:50

A. Not necessarily, no.

215 Q. PROFESSOR MURPHY: No?

A. Because they would have maybe had a care management plan which met their needs. The behaviour support plan tended to be where behaviours were more escalated and where there were more challenging behaviours that were presenting. 12:51

216 Q. PROFESSOR MURPHY: So if they had a PBS plan that would have been drawn up with the help of a behaviour

therapist or a psychologist?

A. Yes.

217 Q. MS. KILEY: And in that case if they did have a plan, did the behaviour therapist or psychologist who helped draft the plan then have a role in observing how that is working in practice and whether it is working? 12:51

A. Yes, well, possibly it would have been training delivered in terms -- well, the positive behaviour support plan would be drawn up very much in collaboration with the staff on the ward. Obviously a lot of the information in terms of the management would come from the day to day staff managing, so it is quite a collaborative process. And then when pulled together it would be discussed with the staff in the ward. And where possible, we would be looking to give a sort of training session and to have a discussion, you know, and to kind of review it collaboratively with staff. 12:51 12:51

218 Q. Is that a training session for staff on an individual's particular needs?

A. Yes. Training is maybe not quite the right word, but more of a clinical discussion in terms of, I suppose, some of the observations and the potential ways of managing that. 12:52

And certainly that would be the aim, as would at times a formulation more recently, we have started to introduce a formulation model as well, and that is partly around making sure that we consider, I suppose, the narrative of why a patient might be behaving in 12:52

this way. So, I suppose, that process of moving from a solely behavioural approach to including trauma informed practice, and that conversation around the communication of the patient and what they might be saying in terms of their challenging behaviour has become part of the package around positive behaviour.

So positive behaviour support, I suppose, in terms of terminology is very widely used now, but wouldn't have been in 1999 or even in the early 2000s, so it's become --

219 Q. When would that have started to emerge?

A. So, I suppose, in terms of what I can say with clarity in terms of my involvement, there would have been behaviour support plans in place before 2014. We reviewed all of that around 2014, 2015, with a more positive behaviour support lens, because I think the concept of positive behaviour support became -- was becoming more kind of heightened or, you know, the usefulness of it.

It is also probably important just to say, positive behaviour support is not the remit of psychology or behaviour therapists only. And it's not a therapy, as such, positive behaviour support is more around ensuring the culture of the delivery of care, so it includes an aspect of applied behaviour analysis, which would be more the remit of psychology or behaviour therapy, but it also has at its core the importance of

individual needs being considered. And also it's based on principle of normalisation and inclusion. So a resettlement agenda very much promotes and proposes and supports the idea that a positive behaviour culture is very -- and Bamford would have been part of that as well in terms of increasing discussions around inclusion, normalisation, individual needs led, those kind of principles. So positive behaviour support in itself is an umbrella term and delivered at lots of different levels. 12:54

220 Q. And how is that culture achieved?

A. So, I suppose, part of it is looking at providing training, looking at the kind of concept of positive behaviour support, enforcing issues such as looking at inclusion and normalisation, particularly within a resettlement agenda, what that looks like for people moving out into communities, what their needs are. Emphasising the importance of activities, and that kind of normalisation of what do we all do with our days, and how do we translate that then in terms of what the needs might be for each of our patients. As well as thinking about behaviour as communication and what it is that someone might be saying with their behaviour and the importance of taking that trauma informed perspective as well. 12:55

So that we appreciate sometimes people come into hospital with a history of trauma and admission to any hospital, even within physical health care, can be

quite challenging and upsetting and distressing in itself. So taking into account all of those aspects is, I think, part of trying to promote a culture of positive behaviour support.

221 Q. And does the presence of psychologists and behaviour support therapists on wards contribute to that? 12:56

A. I think it does, yes.

222 Q. Aside from the presence at multidisciplinary team meetings that we have discussed do psychologists and behaviour therapists have any other regular presence on wards at Muckamore? 12:56

A. They would for individual patients. So, I mean, in developing positive behaviour support plans there would be a fair amount of being on the ward and being part of the team doing observations. Actually also working on a one to one basis, so looking at, you know, does this management strategy work so that they can inform them, the positive behaviour support plan, and be able to, so there is an element of supporting staff also in looking at ways of management that might have better outcomes. 12:56

Sometimes as well they would be involved in helping support patients in terms of activities, doing support in terms of transitions, so being on the ward and taking patients out would be something that would be part of their work as well and helping support patients to go and visit other facilities, or if they are moving out to a new home, being part of that process and helping have those discussions with patients around 12:57

that.

223 Q. And in terms of supporting staff on the ward, you refer to a training input, is there any other advisory relationship between ward staff and psychologists or behaviour therapists, for example, if a member of ward staff encountered an issue could they pick up the phone to a psychologist or behaviour therapist? 12:57

A. Yes, they could, yes.

224 Q. And is that regular practice?

A. I think it is, yes. 12:57

225 Q. And all the things, I am conscious that we have discussed are, they are not policy based, but they are custom and practice, is that right?

A. Custom and practice, yes.

226 Q. And you have referred to the positive behaviour support plans, who authors documents like those? 12:57

A. So they would be authored by the behaviour therapists with input from psychology, so around 2014/15 we also changed the way in which we authored or put together those support plans to make them more accessible. So we have moved to a traffic light system. And again to emphasise also, to make sure we are emphasising the proactive strategies, so we have a kind of green, amber and red, really with green reflecting, I suppose, how we know that our client group are feeling relaxed or happy, and ways that you can identify that, and proactive strategies that we know are helpful in terms of trying to promote a positive environment, but also good relationships and things that they enjoy doing. 12:58 12:58

And then the amber and red would be more things to look out for in terms of, I guess, communication that might be starting to express distress. And also ways in which you then can deescalate and strategies that can be helpful in that. 12:59

And we have done grab sheets at times to kind of again try and help people with quick recall as to things that might be helpful in terms of implementing those strategies as well. 12:59

227 Q. And does the psychology service have a practice or a policy about how often it would review those types of documents, the behaviour support files?

A. The aim would be to review them on yearly basis, but sometimes that could be sooner if issues are arising. 12:59

228 Q. And how would you know if issues were arising? We know about the attendance at multidisciplinary team meetings. Is there any other sort of data analysis that the psychology service conduct?

A. In terms of the wider system? 12:59

229 Q. In terms of Muckamore. So say, for example, there is a patient who has a positive behaviour support plan, and we have seen that, for example, incidents of aggression can be recorded on Datex, on the graph that I brought up with Mr. Warren earlier. Would psychology service 13:00 be looking at and analysing that sort of data for a particular patient who has a behaviour support plan to see if the support plan is working?

A. Yes, so part of the behaviour support plan would

include a fair amount of data analysis. We can, with the focus on the individual, I suppose, rather than on the more macro, we would have produced charts at times to demonstrate the higher incidents. And then with the use of the positive behaviour support strategies the reduction in incidents. And for a period of time we would maintain a monitoring of that. And then if there is an escalation of incidents, that would be brought to our attention, either through an MDT or through a direct referral or a conversation to ask for further input in that as well. 13:00 13:00

230 Q. And the positive behaviour support plans and the type of data that we have talked about is individual patient based?

A. Yes. 13:01

231 Q. But does Psychology Service have a role in providing general advice or training to staff at Muckamore Abbey Hospital about how generally to promote positive behaviour in wards?

A. Yes, so that would be in the more generic sort of positive behaviour support training that has been identified. I think it maybe might not be this module, but in terms of various trainings offered throughout a time span, looking at positive behaviour support and that type of modality to increase knowledge around the types of strategies that might be helpful. 13:01 13:01

232 Q. Can you tell the Panel any more about that training, is that something that psychology service deliver?

A. We do it in conjunction with our behaviour therapists,

so it would be jointly delivered. So maybe look at kind of positive behaviour support, looking at the principles of positive behaviour support, emphasising the importance of the key drivers, I suppose, in terms of inclusion, normalisation, in terms of ensuring an individual led aspect. We would talk around proactive strategies. We used training such as the range training, I am not sure if you are familiar with it, reinforcing appropriate and promoting constructive behaviours, which was run through the Association for Psychological Training. 13:02 13:02

And, I suppose, a big emphasise being on the importance of promoting an environment and activities that help support someone's quality of life, thus reducing the likelihood of more challenging behaviour being a predominant part of the presentation. So those are the key aspects of that sort of positive behaviour support training. 13:02

233 Q. Do all members of staff at Muckamore receive that training? 13:03

A. The training is offered to everyone, yeah. So we are the providers of the training, we don't monitor who attends the training, or have a remit in terms of, you know, looking at the attendance. What we do -- it's not -- again it's not a policy decision that psychology provide that. I suppose we can see a need, and in supporting our colleagues began to provide that training. 13:03

234 Q. Do you know when that began?
A. I don't think --
235 Q. I don't think it's in Mr. Hagan's statement?
A. So, I think, in Module 4, and I am sorry, because I haven't prepped it today, I am happy to discuss again, there is a little bit of a history in terms of the delivery of that training and, you know, the types of ways in which it was offered over time. 13:03
236 Q. The way you are describing it as psychology being the provider of the trainer, is it right it is not mandatory for... 13:04
A. It is now mandatory, so part of the kind pathway towards this, it is now mandatory, both in terms of the hospital staff and the community staff to attend the positive behaviour support training. 13:04
237 Q. PROFESSOR MURPHY: How long would the training be?
A. Sorry?
238 Q. PROFESSOR MURPHY: How long would that mandatory training be?
A. I think it is about a day, and we try to link in to induction as well so that there would be emphasis in some of the induction, would have, you know, an aspect of PBS in that. And also in terms of the agency staff when they are being updated, we have also provided support in that also. 13:04 13:04
CHAIRPERSON: And I ask this as a lay person obviously, but does this link in any way to Mr. Warren's expertise in terms of deescalation. Do the two come together at any point?

A. Yes, they do. And I think as Mr. Warren spoke earlier, we now alongside the safety intervention do an additional sort of PBS training that fits along, so it is like an extra in terms of the safety intervention training. So there is a little bit additional. And that's just, I suppose, in terms of making sure we are reinforcing that message of, that culture of positive behaviour support, and that that's what we are aiming for within the environment. So there is that -- we come together as a safety intervention training team and as a psychological services team, that together we reinforce those messages. 13:05 13:05

239 Q. And the mandatory training, are you able to say when that became mandatory?

A. It has only just, so we have been working towards that. 13:05

240 Q. You referred also to the work that psychologists do for patients in respect for preparing them for moving into the community. Again I don't think there is a policy document in that respect, is that right?

A. No. 13:06

241 Q. Are you able to explain, is there a typical role that psychology, including behaviour therapists, have for a patient at Muckamore who is going to be resettled into the community?

A. So I'll talk about psychological services, because that includes them, our behaviour therapists are a big part of that, and even more so when we have less psychologists. But part of that will involve a discussion potentially around what would be important 13:06

to consider in terms of their transition. At times we have been involved in going out to assess the environment in placements and to think a little bit about whether that's going to meet their needs in terms of needing space, outdoor space, and how...and we work with our OT colleagues, so it is quite a multidisciplinary approach in terms of that. 13:06

We might also be involved in supporting conversations with patients around potential moves. It can be anxiety why people obviously want to move, and it is also a time of anxiety and change, so helping them manage some of that and thinking about hopes for the future and what that might look like. And also in terms of our positive behaviour support plans, updating them to think of a community context and what that might look like. And we work very closely with our providers. So we will support that transition in terms of taking the positive behaviour support plan and the formulation out into the community and work with our providers in a handover perspective. 13:07 13:07

Sometimes they will have their own positive behaviour support staff, so it is a handover. At other times we might remain involved in supporting a provider in the ongoing support of that kind. 13:07

242 Q. And is the Psychology Service involved in all resettlements then?

A. No, not necessarily, again it would be more when maybe

there might have been a high level of transient behaviour, or there is maybe a higher anxiety, so it would be specific to an individual need that that would be.

243 Q. And is there a usual time that the Psychology Service will be asked to become involved in a resettlement planning? 13:08

A. No, it's very individually driven.

MS. KILEY: Those are all the specific questions that I have for you, Dr. Meekin, the Panel may have some more. 13:08

244 Q. PROFESSOR MURPHY: Could I just ask you about the extent to which you involve families. So, for example, when someone is being admitted to Muckamore, do you talk to them about strategies that have been used, that have been successful, and does that inform your PBS plan? 13:08

A. Yes, we do try and do that have a family voice in that. The strategies obviously can be quite different in terms of what you would use at home and what you would use in a hospital, and we try to ensure that the families are part of the development of the positive behaviour support plan, and that they would have sight of it and have comments to make on that as well. 13:09

245 Q. PROFESSOR MURPHY: And does that involvement of the families continue during the person's time in MAH? 13:09

A. In terms of the review of the plans?

246 Q. PROFESSOR MURPHY: Yes.

A. Yes, the aim would be to do that.

247 Q. PROFESSOR MURPHY: And then when they are being

discharged, does that also -- the work you were describing in relation to resettlement, does that also include family members in those discussions?

A. Yes, yes, and I mean we would continue, because, I suppose, we have a team in Muckamore and we also have community, and there is a bit of interchange between those now so that we can provide, because it is all under one umbrella now, we can sort of -- so some of our Muckamore behaviour therapists may actually continue to support clients as they have moved into the community, because they have good knowledge of them and good relationships with them and also with families. So that kind of ongoing process of engagement with families which continue, and there are families that we continue to see regularly, and others that may need our input at varying points just depending on how they are and how their family member is as well. So it is quite individual, it is hard to put a generic statement on that. 13:09 13:10 13:10

PROFESSOR MURPHY: Thank you. 13:10

CHAIRPERSON: Can I thank you both very much for coming to attend. I was wondering at one point why there was a crossover between you, but there plainly is something of a crossover in terms of your specialisms. So thank you both very much for coming to assist the Inquiry. Thank you. If you would like to go with the secretary. 13:11

THE WITNESSES THEN WITHDREW

CHAIRPERSON: We are next sitting -- obviously we have got Ms. Somerville this afternoon, but otherwise I think we are next sitting on Wednesday of next week. And at the moment we have Wednesday and Thursday in our diaries, but we are going to look at Thursday and just consider whether we do actually need Mr. McGuicken back, but we will let everybody know as soon as possible.

MS. KILEY: Yes. And are you content to commence at 2 o'clock for Ms. Somerville, Chair? 13:11

CHAIRPERSON: Well, I have got other inquiry work I have got to do, so I am going to ask if we actually come back at 2.15, so we will have an hour for lunch, but I don't think we will be all afternoon.

MS. KILEY: Ms. Tang is taking that witness and I don't understand that it is anticipated that it will be lengthy. 13:12

CHAIRPERSON: No, okay, thank you. Well, thank you very much indeed. So quarter past two.

13:12

THE HEARING ADJOURNED FOR LUNCH

THE HEARING CONTINUED AFTER LUNCH AS FOLLOWS:

CHAIRPERSON: I'm sorry that we are a bit later than we said we would be, there was an administrative issue which has now been sorted out, which I think we are going to hear about, but I think otherwise we are ready for Ms. Somerville please. 14:29

MS. TANG: Thank you, Chair. Good afternoon, Chair, Panel. Yes, the Inquiry will hear evidence from Ms. Somerville this afternoon, she will be dealing with issues around Belfast Trust and Muckamore management and governance structure, specifically looking at the risk and governance arrangements of the North and West Belfast Trust up to 2007. 14:29

As you may recall, she will be speaking to June Champion's statement and dealing with some of the issues that Ms. Champion was unable to provide further details about. 14:29

I am going to be looking specifically paragraphs 91 to 123 of the statement. The statement itself is numbered 0881, and the pages that I will be zooming in for the most part will be pages 24 to 33, and there are a couple of exhibits that I may reference as well. 14:29

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

MS. TANG: Okay, Miriam Somerville please.

(Ms. Miriam Somerville sworn)

CHAIRPERSON: Thank you for coming back. You know how this works.

MS. SOMERVILLE: Yes.

CHAIRPERSON: So I will hand you over to counsel.

14:31

MS. MIRIAM SOMERVILLE, HAVING BEEN SWORN, WAS DIRECTLY EXAMINED BY MS. TANG AS FOLLOWS:

248 Q. MS. TANG: Good afternoon, Ms. Somerville. You and I have met briefly this afternoon, I am Shirley Tang and I am one of the junior counsel in the Inquiry. 14:31

You have agreed to speak this afternoon on a topic that has been dealt with in the statement of June Champion, and can I check that you have a copy of that statement with you? 14:31

A. I have, yes.

249 Q. I am going to be focussing in on the paragraphs on pages 24 to 33, that's paragraphs 91 to 123 of that statement. Can I check that you have had the opportunity to read those paragraphs in particular? 14:31

A. I have, yes.

250 Q. I am not going to ask you to formally adopt the evidence, because Ms. Champion has already done that, but can I confirm that you are content to speak to the evidence that Ms. Champion has already given? 14:31

A. Yes, I am.

251 Q. Now, you have given evidence previously to the Inquiry in an earlier hearing, and I understand that you have

been following the evidence since that time, and that most recently you had some observations from your own personal recollections that you would like to make the Inquiry aware of. So can you confirm what your personal recollections that you would like to add are please? 14:32

A. Yes, thank you for the opportunity to do that. I was watching the evidence yesterday, and there were two issues that came up, one was about patient money in locked drawers and the other one was about a patient smoking and their money being used to buy cigarettes. And I thought it might be important to put my experience and put those issues into some kind of context, so if I may do that? 14:32

CHAIRPERSON: Yes, certainly. What I was going to say is obviously your opinion is one thing -- 14:32

A. Absolutely.

CHAIRPERSON: -- but what we are interested in is your actual personal experience, and you've just introduced that. 14:33

A. And that's what I am going to talk about. So if I come to the patient money in the locked drawers; this actually came about because patients had complained that if they wanted to go and buy a bar of chocolate they had to walk all the way over to the cash office, get some money and take it back to the restaurant where they were going to buy their bar of chocolate. And they asked if there was some way of managing that in a more accessible way. 14:33

Now, my experience and what I saw on the ward was not --

CHAIRPERSON: Just remind us of when this was?

A. This was between 2002 and 2011. I am not sure when the policy of the patient money in the drawer started, I am not sure of the date of that, but it was -- I'm pretty sure it was within that timescale. 14:33

So, working with the Finance Department and working under existing finance policies, a procedure was developed where each patient has their own drawer. What I saw was those little filing cabinets with small drawers, each drawer was labelled with a patient's name, and in the drawer there was an envelope with patient money. 14:34 14:34

Now, the patient could -- the amount of money was limited, to my recollection it was somewhere between £10 and £12. A patient could take money from that, spend it, go and buy his bar of chocolate and bring his change back and it would go back in the envelope. But if a member of staff spent that money they had to provide receipts, even if it was for a mars bar they were bringing back after their lunch for a patient, they had to provide receipts, and the receipts went in the envelope. 14:34 14:35

Now, the ward manager tallied the receipts with the amount of money in each envelope at the end of every

week. That was checked in the cash office, it was also audited by the Finance Department, and patients money was very -- it was very high on the agenda, certainly in North and West Trust, and so internal audit, every time internal audit visited the Trust they audited how patients' money was managed. So I felt it important to just put that, my personal experience to you.

252 Q. DR. MAXWELL: Can I ask you, you said that the ward manager tallied the money at the end of the week, but if you were only getting receipts if staff were spending the money and you weren't getting receipts if the patient were spending the money, how could you tally it? 14:36

A. You would tally -- I think I probably didn't explain that entirely properly; you would tally the staff's spend on the money. Patients were free to spend their own money in whatever way they wanted. 14:36

CHAIRPERSON: But then -- well, I think, Dr. Maxwell said, how do you know, if you have only got the staff receipts? 14:36

A. Well, you've got -- the difficulty is, what you would be looking for would be if staff are spending money inappropriately. And if the receipts are there you know what the staff have spent money on.

253 Q. DR. MAXWELL: But you don't know if the receipts aren't there. If the money doesn't tally with the receipts, and you're assuming that's because the patients have spent it, that's not a fail-safe way of making sure that staff have provided receipts? 14:36

A. The person who provided -- the patient didn't come and just take money out of the drawer themselves. So the patient would come and ask either their named nurse or the ward manager for a certain amount of money, and whatever it was they wanted to buy, so that would be noted although the patients weren't asked for receipts.

CHAIRPERSON: So where would that be noted?

A. That would be noted in the envelope.

CHAIRPERSON: So if a patient asked for money, the staff member or the patient could take it, but the staff member would note on the envelope how much had been taken for the patient?

A. Yes.

CHAIRPERSON: So you would have the notes on the outside of the envelope relating to patient spend and receipts on the inside of the envelope relating to staff spend, is that right?

A. I don't actually know if one is on the outside and one is on the inside, but I know that the envelope contained how that money had been spent.

CHAIRPERSON: And can I just ask, what sort of thing would the patients have to pay for that wouldn't be provided free?

A. If they wanted sweets.

CHAIRPERSON: So sweets and chocolate bars.

A. Usually sweets, chocolate bars, drinks, something extra that... or sometimes a patient might want to go over to the restaurant with a family member and have a cup of tea, which they liked to pay for, or which they wanted

to be pay for, or which they choose to pay for, so patients would like to have some money to be able to do that.

CHAIRPERSON: Right.

254 Q. MS. TANG: Thank you. Ms. Somerville, you mentioned a recollection in relation to patient's use of funds for cigarettes as well, is this the same issue or is there something else? 14:38

A. Yes, I listened to this yesterday as well. Now, I am not aware of that incident, and I think this was about somebody who had never smoked and had come into Muckamore, and a staff member was using the patient's money to buy cigarettes. So I'm not aware of it, but what struck me listening to the evidence was what I would expect to see would be a note documentation in the patient file that there had been a discussion with that patient about the dangers of smoking, that the patient had been given information about smoking. And if the patient was deemed to have capacity to understand that information and to process that information, I would expect it to be documented as well, but that patient then has the right to make what we might think of as a bad decision, in the same way that any of the rest of us do. 14:39 14:39 14:39

So if, if it was clearly documented that the patient had capacity, had been given information, then there wouldn't be grounds for a staff member to refuse to buy the cigarettes, if that was the case. 14:40

Sometimes these tricky issues arose for us, but I listened to that yesterday and I just wanted to give my experience of that as well.

CHAIRPERSON: Thank you.

255 Q. MS. TANG: Thank you. That's helpful, thank you very much. So moving on to focus on the topic that you have kindly agreed to give us some further evidence on today; I have a couple of introductory questions for you first of all just so that we can set it in context. You worked for North and West Belfast Trust, I understand, what period of time was that covering? 14:40 14:41

A. From 2002 until we became the Belfast Trust in '06/'07.

256 Q. And what role did you carry out, or what roles did you carry out whilst you were in North and West Belfast Trust? 14:41

A. I was director of learning disabilities for hospital and community services.

257 Q. Throughout that period?

A. Yes.

258 Q. And what sites would that have covered, Muckamore, I take it was one of them? 14:41

A. Muckamore was one of them, and all the community learning disability services in the North and West geographical area in Belfast. So there were day services, supported living services, some residential services and community teams. 14:41

259 Q. Thank you. So for North and West Belfast Trust generally, can you just give us a very brief overview of what the structure of that Trust was?

A. Yes, so the structure of the Trust was not dissimilar to Belfast Trust, when we became Belfast Trust. We had Chief Exec and a number of directors, obviously executive directors and operational directors, like myself, so we had director of nursing, finance, social work, director of older people services. And underneath that director team, in my team I had three assistant directors, one for the hospital, Muckamore, one for the community services, and one whose title I think it was assistant director of business development. 14:42 14:42

260 Q. Who did you report into in your role?

A. To the Chief Executive.

261 Q. The Chief Exec, okay. That's helpful. Can I take you to paragraph 101, which is on page 27 of the statement please. As I understand it this paragraph references a previous exercise that had been conducted by the Department of Health which was "Best Practice, Best Care". Do you recall Best Practice, Best Care? 14:43

A. I do, yes. 14:43

262 Q. And I believe that at this time the Department was encouraging the Trusts to take a new look at how they conducted their governance?

A. Uh-huh.

263 Q. Would your role have brought you into contact with those plans and new systems and processes? 14:43

A. It certainly would, we were -- as a directors team we were very familiar with Best Practice, Best Care. And we gave some thought to what was the best way to

proceed to make sure the departmental circular was implemented across the Trust. So one of the things that happened was there were a number of committees established to look at the various governance sort of, sections of governance, but we had an assurance committee, we had an audit committee, we had a complaints committee, and there may be other committees that I don't remember. Each committee was chaired by a non-Executive Director and supported by the directors team and other relevant people. 14:44

Now, the Chief Executive as well with his director team, each of us in our own programmes of care, as they were called then, were asked to look at what we would do within our directorate to make sure our staff understood what was being expected of them. 14:45

One of the -- one of the initiatives that happened in the Learning Disability Service, and I have brought a copy here which I can leave if the Panel would like me to, I know this isn't something that anybody has seen in evidence, a bookmark was produced, and I have a photocopy of the bookmark, and distributed to every single member of staff in the programme. And the bookmark said: 14:45 14:45

"Question: How can I develop my practice in order to improve the service I offer to people with a learning disability?"

And the answer was:

"Ask yourself the following?"

And there are five questions, I am not going to read them all out, but I will just read two: 14:46

"What do I need to know to help improve my practice?"

And two: 14:46

"What can the Trust do to help improve my care for patients, patients, carers and users?"

So what we were -- what the Trust, what the Chief Exec was expecting was that within each programme of care we also established our own governance arrangements. So in the learning disability programme we also have a local Governance Group where we were looking at incidents, complaints, staff training and research, best practice. 14:46

264 Q. Can I ask, when you say local, does that mean local to a hospital site such as Muckamore or...

A. No, it means local to the learning disability programme. So for our governance arrangements we combined our hospital and community services to look at the issues together. For the management structure, separate to the governance structure in the hospital, we had a -- first of all I should say, the Chief Exec 14:47

met with all his directors every week, we had a two hour meeting every week. And in Muckamore we had a management meeting which we called Core Group, which was a relatively small group of people who met every week as well at Muckamore. And we also had a learning disability programme management meeting, also which included hospital representatives and community service representatives.

265 Q. You've referenced a number of different groups or regular meetings, can I ask you about the Muckamore management meeting, the Core Group, what was that Core Group focused on? 14:47

A. Okay, it was focused on both operational issues, mainly operational issues within the hospital, but it was also looking at progress with resettlement. And what -- there might be, for example, a local issue that say an incident report came in and Core Group might want to investigate that incident and look at that locally, could that be resolved locally. 14:48

Whereas, there might be other issues that would progress to the wider group, the programme management meeting or the programme Governance Group and might be escalated to the Trust Assurance Group. So Core Group was really looking at the local management within the hospital. 14:49

266 Q. Thank you. It might be a good time to call up an exhibit which is on page 1422 please. Thank you. Can you see that okay, Ms. Somerville?

A. Not very well. Thank you, yes, that's much better.

267 Q. Good. The Department has written out in this letter to the service just to ask for some new governance arrangements to be implemented for the Trust to start working on that. And if I could ask for the scroll down to page 1427, there is some further details there of what the Department was asking the Trust to do? 14:49

CHAIRPERSON: Sorry, this is a letter sent on 13th January 2003.

268 Q. MS. TANG: Yes, yes, that's correct. A letter sent out to Trust Chief Executives and different senior officers in the Trust from the Department. 14:50

And on page 1427, what we can see there is if we go down, if I can ask you to scroll down, there is a bullet pointed list, and that sets out what the Department was anticipating the clinical and social care governance framework that the Trust should be aiming for should include. 14:50

I want to pick out a couple of those things there just to try and understand what would have been in place for learning disability in response to those. So can you tell me a little bit more about how the learning disability services responded to the risk assessment and risk management aspect of that? 14:50

A. Yes, I can. Risk assessment at this stage, and certainly what we think of now is risk registers were very much an unknown quantity, this was very new to us

to be looking at risk registers, but that was part of what we had to learn about, how did risk registers work. Risk assessment had always been there in the clinical forums and, you know, risk assessment of an individual patient and their needs was a very familiar process to staff, but wider risk assessment and looking at it from the point of view of producing a report about risk was less well known to us.

But, one of the things the Trust did, which actually -- well, the learning disability programme did which covers quite a number of these bullet points, was in 2005, I suppose, I'd call it a quality measurement tool, was developed called "Evaluating Quality Care", EQC. And this tool in consultation with families, patients, carers, set standards for both risk assessment and a number of the other bullet points there. So standards were set and then random audits were undertaken right across the learning disability programme. But, mainly, it's main focus was in Muckamore, and it was looking at both clinical issues and non-clinical issues.

269 Q. So to help us understand how that worked, can you give us an example of the type of standards it might have set?

A. So there were standards, so there might have been a standard that a patient could have a cup of tea when they wanted to have a cup of tea, they didn't have to wait for some tea trolley to come round or a tea time

to be developed. Or there might be a standard that in the restaurant patients felt that they were welcomed and understood when they went in to buy their bar of chocolate. So those would be the sort of standards.

14:53

But also bigger issues, such as if you have heard of COSHH, so the management of substances, cleaning materials and that, how was that being processed, were we performing properly in line with guidelines.

14:53

And the important thing about this was the audits then came to the learning disability Governance Group, they also came to the core management team.

270 Q. Okay.

A. If there were issues, so they would be discussed in both those groups, and it may be that there were issues that needed to be escalated upwards to...and in some of the risk assessment, for example, if there was a risk around patients not being able to be admitted to the hospital because beds were full, that would obviously be escalated to the assurance committee to the Chief Executive and that would be, you know the Chief Exec would be talking to the commissioners, to the Health Board and probably to the Department.

14:54

14:54

So we had all kinds of risks from somebody, a risk of patients losing their clothes in the laundry to patients not being able to be admitted, so more strategic risks and operational risks.

271 Q. So you've helpfully given us some detail on those kinds of operational risks. In terms of their clinical care, would there have been standards developed as part of any of these groups that would have said clinical care, you know, use of restraint or seclusion or -- 14:55

A. Absolutely.

272 Q. -- things like that?

A. There were policies and procedures around restraint, around seclusion, around how -- behaviours that challenge were managed. And those also featured in the 14:55 risk assessment and risk management processes. And reports came regularly to both the hospital Core Group and to the Assurance Group, both within learning disability and also, for example, incidents and management of seclusion would also have come to the 14:56 Chief Executive's meeting, and usually the Assurance Group as well.

273 Q. So you mention reports of seclusion coming to the Chief Executive. In practical terms, does that mean the chief executive was told how often it was used and why, 14:56 or what information did that mean?

A. Yes, in practical terms they -- at the Chief Executive's meeting, and I think this would happen quarterly, a report would be tabled that detailed the use of seclusion. It gave dates of seclusion, it gave 14:56 anonymised patient information, so initials of a particular patient, so that you could look at patterns. It gave length of time somebody might be in seclusion, so they were quite detailed reports.

274 Q. And was there a direction of travel with the use of seclusion, was the goal to try and reduce it?

A. Very much so, indeed. And as the new hospital was developed we had many debates. And when I say we, this is a very wide group, because we had consultation with patients and families and our own staff obviously, about developing the new hospital. We had a lot of debate about, should there be a seclusion room or not? And one of the things that happened was we did have a seclusion room, but the idea was it would move from being a room that was used for seclusion to a quiet room. And in fact certainly in my personal experience, that's how it was used. Patients would -- I am very aware of a patient who used to ask to go to the seclusion room with her book and she liked the quietness of it. So we were trying very hard and doing a lot of work with our staff to move away from the traditional use of seclusion to making this a quiet space for patients. 14:57 14:57 14:58 14:58

CHAIRPERSON: Could I just ask on that, because we heard a little bit about the seclusion room, as you may know this morning; if that's right, if a patient does ask to go to the seclusion room, do the policies then apply. In other words, is somebody meant to look in on them every 15 minutes? Are you meant to ensure that all the requirements of an enforced seclusion would actually apply to that patient? 14:58 14:58

A. No, if a patient asked to go to the seclusion room, the door would be open for starters. So the patient would

be free to come and go and to use that room in the way they would use any other sitting room or leisure area in the hospital.

CHAIRPERSON: And presumably a record wouldn't have to be made? 14:59

A. No, no.

CHAIRPERSON: I see, thank you.

275 Q. MS. TANG: So we've talked a little bit about the information that was sent up to the Chief Executive and the executive team. In terms of the scrutiny and the 14:59 oversight that they typically applied, what can you recall of how that happened?

A. So are you meaning if a new policy was developed?

276 Q. Sorry, what I mean is in terms of -- supposing the report into the use of seclusion that was provided to 14:59 the executives, what do they do with that?

A. Well, it was debated at some length. I was asked to -- myself or the medical director would be asked to provide information about why -- particularly, it was very much looking at patterns, why would this 14:59 particular individual be receiving seclusion, maybe every day, and there would be questions asked about that.

We would certainly be expected to take that back to the 15:00 stat team and look at, does there need to be an analysis? Or is there something wrong with this patient? Is this person unwell? And so their behaviour is becoming increasingly difficulty, because

they have no way of telling us they are in pain.

So those questions would be asked. And at the next meeting or often, so something like that for seclusion it wouldn't wait to the next meeting, I would be asked, 15:00
or the medical director would be asked to report back quite quickly on what we were doing about this particular incident.

277 Q. I don't know if it would have been an appropriate area for targets or percentage reductions or anything in the 15:00
use of it, but do you recall anything like that ever being discussed?

A. No, we didn't have that for seclusion, no.

278 Q. Thinking about some of the other things that might have been captured as part of the governance, I believe you 15:01
had referred to complaints as well?

A. Yeah.

279 Q. Can you tell me a little bit more -- I think what I'm looking at particularly is, if a member of a family, for instance, complained about some of the care that 15:01
they had seen their loved one receive, what would happen next?

A. So if a family member complained they would be likely to complain to the ward staff initially. There was a complaints book on the ward, and a copy of the 15:01
complaint would come to the Assistant Director, usually via the sort of ward manager or senior nurse manager. And the Assistant Director would look at that complaint and think about was there a way to resolve this

complaint? And a complaint didn't have to be a written complaint to be taken seriously, I think that's maybe quite important.

So, the Assistant Director would think about what she needed to do to resolve this complaint. And again the complaint could be anything from somebody losing something to somebody being injured, a very serious issue. 15:02

Now, if it could be resolved locally, the Assistant Director would take steps to do that, but the complaint would be recorded. And the number of complaints again would come to both the Core Group meeting and to the governance groups, and reports would be produced right up to the Complaints Committee. 15:02

Now, if a complaint came -- for example, a complaint might come direct to the Chief Executive's office, a family member might contact. And complaints were not always replied to in writing, because if it was a complaint that a family member was quite happy to say was resolved on the ward, we wouldn't always write a letter, but many complaints were dealt with in writing back to the complainant, and those letters came directly from the Chief Executive's office. 15:03

280 Q. So, there was a layer of local scrutiny effectively of those complaints?

A. Yeah.

281 Q. Were there some that you could look at or was there any kind of weighting attached to say, right, we can deal with this ourselves we don't need to brief the executive team about this, what got the length of the executive team and what typically wouldn't. Have I made that clear I wonder? 15:04

A. Yes, I think you have made it clear, I am just thinking about how did we make those, how did we make those decisions.

15:04

I think if there was something that had a more strategic focus, so for example, if another trust complained that they couldn't get a patient admitted to hospital and were complaining about that, that would go to the Chief Executive. But if a family member was complaining that an item of clothing had been damaged or lost, we would try and resolve that locally. 15:04

282 Q. What about an injury to a patient?

A. Injuries were dealt with more through an incident reporting process rather than complaints. So if a patient was injured on a ward, or a family member reported that there had been an injury, an incident form was filled out on the ward. Incident forms came in triplicate, so one form went to the Assistant Director again, one form went into the patient's notes, and one form went to the electronic recording system, the EPEX system. 15:05 15:05

Now, again, the Assistant Director kept her copy of the

incident form until she was absolutely satisfied that all the investigations had been done that were relevant to this incident. A report of all incidents again was compiled and came to both Core Group and Governance Group. And overall for the learning disability programme, an overall report of incidents right across the Learning Disability Service, but broken down by facility came to the Assurance Group at Chief Exec level. 15:06

283 Q. And was there any kind of categorisation of those incidents, like serious, not so serious, near miss or... 15:06

A. In the beginning not so much, because again we were learning new systems. And at this time serious adverse incidents, which were we are all very familiar with now, hadn't yet been defined. You know there was a definition from the Department for that. But we did classify incidents as serious. We didn't ever classify an incident as not serious, but we would have classification of certain incidents. 15:06 15:07

There were certain incidents as well that the Chief Executive wanted to know about immediately. An example of that I can remember is, if a patient hadn't returned from home leave, that was something the Chief Executive would want to know about straight away, and that would be my responsibility to let him know. 15:07

284 Q. What about if a patient had slipped and fallen, for instance, or had somehow got injured, maybe had a

fracture or something like that?

A. Yeah, yeah. That's the sort of incident that the Assistant Director would be -- if a patient had a fracture, she would be wanting to know, well, who is taking them to hospital? What's the follow up? Do we need to send staff to the hospital to be with this patient while they get plastered or whatever happens? She would also be looking at, was there a reason for this? Did the patient trip, or was there a hazard on the floor that needs to be dealt with? And again that incident would be recorded and would come in the reporting system. 15:07 15:08

285 Q. That's very helpful. You've dealt with quite a few of my questions going forward, but I'm just going to check that I haven't overlooked anything. 15:08

I want to ask you specifically about if a family member of a patient had come to one of the ward staff, for instance, and said, I'm really worried about Patient X, he has lost an awful weight since he has been in here. Is that something that would have been viewed as an incident, or how would that have been responded to? 15:08

A. I think that would have been responded to. Now, it depended, a family member might say, I am complaining about what's happening here, and that would be dealt with as a complaint. There might be more a clinical focus on that rather than see it as a complaint and the family member would talk to the clinical team. There were weight measurements taken for patients. Obviously 15:09

I am not on top of the detail of that, but the nursing staff would have done that. And I think there would have been a monitoring system organised with the family and the patient to deal with that.

286 Q. Thinking back to some of the stipulations in the Department of Health's document; one of the things that trusts were asked to consider was to involve service users, their families and the local community in how they designed their governance systems. 15:09

15:10

Can you tell me a bit more about how in Muckamore particularly the Trust went about involving service users and families in how they measured good care?

A. So if I start with families first of all; we had regular meetings, during my time at Muckamore it was the society of parents and friends. And they were involved in the development of the EQC tool that I was telling you about. They had a lot of input into what they would like to see audited and measured. They also had regular meetings and they had -- they were able to get information as to how different audits had gone. 15:10 15:10

Patients had patients' forums on the wards, and again they were involved in the development of the EQC.

15:11

Patients were also involved, patients and staff and families, were involved as we developed the new buildings in the hospital, as we developed the new model for the hospital.

There were focus groups and consultation sessions, and independently facilitated focus groups for that.

The other very important issue with patients was the development of TILIS, and TILIS stands for "Tell It Like It Is" Peer Advocacy Group. 15:11

Now, what was really important with that was patients -- there was nothing that a patient couldn't talk about, there were guidelines for TILIS, there was absolutely nothing that was off the agenda. And patients themselves were trained how to make -- for example, they made a Powerpoint presentation and took it to politicians at Stormont. So they were very involved. And what that presentation was about was, what it's like to be stuck in hospital, what this feels like. So again an example of consultation and working with patients on the ward. 15:11 15:12

287 Q. You've described what sounds like quite a comprehensive governance system in North and West Belfast Trust. If you were to look back on it, were there things about it that you would have changed with hindsight? 15:12

A. I'm sure there is always things we would change with hindsight. But one of the things that struck me about North and West when I came to it was the strong culture around governance and quality. 15:12

The Chief Exec was very keen on quality initiatives and I have -- I'll maybe share it in a few minutes, I have

a list of quality initiatives that happened during my time in the Trust. So, there is nothing, we can always improve things, we can never be complacent, but there is nothing that I would say, there was a big gap there, in fact I would say it's an organisation that had a very strong culture around quality and governance.

288 Q. And if I -- if you were to reflect on the society of patients and friends, would you have said the working relationships were positive, or would there have been a challenge there or what... 15:13

A. Oh, yes, of course there was challenge there, but you would expect there to be challenge there and you would want challenge to be there. But I always felt we had a sort of mutual respect for each other, we did not always agree, especially when it came to resettlement, and I had many difficult meetings with the Society of Parents and Friends, but myself or the Assistant Director always attended their meetings when we were invited. But despite maybe, not disagreements, but different views, I do think there was a culture of respect. 15:14

We also supported the parents and friends with their administration, if they had letters to be sent out that was all done in the Muckamore office. So we saw them as a very important partner. 15:14

289 Q. I want to take you to a paragraph in the statement, it's paragraph 118, and that is on page 31 please -- sorry, yes, 118. The phrase is used in that paragraph,

I will just wait for it to come up, sorry. Yes, just the second line of that; it's in reference to some observations made in the English system about governing in silos. Does that phrase mean anything to you in the context of North and West Belfast? 15:15

A. Not so much in terms of North and West Belfast, because it was a much smaller organisation. I believe that made it easier to work across the silos rather than vertically in silos. And because you had often the same group of people in the management structure and in 15:15 the governance committees, information would be shared.

Also again I go back to the Chief Exec's leadership, and he very much emphasised the need for not to be governing in silos, that if something mattered in 15:16 children's services, I had a part to play in that as well, although it was, you know in management terms nothing to do with me, I couldn't walk away from that.

So I think there was a culture of trying to work across 15:16 the silos rather than in silos. But I have seen this many times, I am very old, I have been around a long time, and I have seen that many times.

290 Q. You've made reference to silos, and I guess what you may have been thinking about was the different clinical 15:16 areas or different programmes of care, some people might call them. Were you conscious of an alignment of the clinical and social care governance agenda with the financial and the performance agenda of the

organisation, how did that work?

A. Yes, yes, very much so. In our performance meetings, and often our performance meetings would be with the Commissioners, and at that time it was the Boards. And certainly the governance agenda would play as strong a part as the performance agenda, but that was because North and West would have pushed that. 15:17

Obviously the Board was more interested, understandably, in the performance agenda, but governance featured strongly at those meetings. 15:17

291 Q. Was the clinical and social care governance agenda ever in direct conflict with the financial agenda, such as save money, control costs, to your recollection?

A. Not in North and West. Of course there were difficult discussions, and certainly as, you know, increasing amounts of savings had to be made. But there was always a drive that the quality of care, you know the belief in clinical governance is continuous, improvement of services, that was always very important in North and West. So I am not aware of anybody ever saying you can't make that improvement because finances won't allow it. 15:17 15:18

292 Q. Okay. I have got to the end of my questions, but I want to give you the opportunity, you have made reference to some other details that you have to hand. Is there anything else you want to make us aware of at this point? 15:18

A. There are just some things I thought I would note. I

think the reason for that is to just provide some examples of that culture, that valued clinical governance and quality.

So for -- and these are specific to Muckamore; the hospital received four Charter Marks between 1997 and 2005, no 2007. And, you know, sometimes people think of a Charter Mark as being a bit of a tick box exercise. I think you might get away with it once as a tick box, but you will not get away with it four times. And to get the Charter Mark there was a self-assessment and then inspection from the Office of Public Service Reform from the Prime Minister's Office in London. So there were four Charter Marks. 15:19 15:19

Because of those Charter Marks, Muckamore was designated a best practice site for two years in 2005, by The Office of the First Minister and Deputy First Minister at Stormont. And that meant that other learning disability services were coming to Muckamore for learning exercises. And that was -- that was important in sharing across, not just from Muckamore to others, but back into Muckamore as well, so the best practice site worked very well. 15:20 15:20

I have told you about the little bookmark that everybody got. There was some benchmarking done both for admission services. I remember us looking at services in the north-east of England and in the south

of England as well.

293 Q. DR. MAXWELL: Do you remember which agency you used for the benchmarking?

A. Yeah, we spoke to, I can't remember the name of the hospital, you maybe familiar with it in the north-east of England, it's quite a big learning disability hospital, it may be closed by now. 15:21

PROFESSOR MURPHY: Northgate?

A. Northgate, yes, yes.

294 Q. DR. MAXWELL: So you contacted them direct rather than going through a benchmarking service? 15:21

A. Yeah, we didn't go through a benchmarking service, we did this ourselves. We contacted them and St. Andrews in Northhampton, another one. We also looked at benchmarking for resettlement, people went to visit the ESOL project in Scotland. And also we looked at Liverpool, who at that time Liverpool were providing some very interesting supported living services for people who challenge services, and we took a good look at that. So that was going on. 15:21

There was the development in the hospital of personalised care plans for nursing. It was called "All about me", and it was a much more personalised way of how nurses took their case histories and looked at their notes. 15:22

We developed a Patient Charter in 2004, that had standards that told patients what they could expect

from their staff. And that again was audited through the EQC tool that I have told you about.

I have mentioned TILIS already, which again was very important. 15:22

Hospital passports were developed for patients who might go from Muckamore into an acute hospital and maybe weren't able to speak or express their needs, and we developed a passport so that acute hospital staff would know how to communicate with somebody. 15:22

And finally one other document which I brought, but I know, you know, it's not in the evidence, this is called "The Big Plan", and this was -- now, this was in the time of Belfast Trust 2010 to 2013, it was the result of a consultation exercise about the future of learning disability services and a strategic plan for the future of services was developed. And The Big Plan was an easy read version of what the Learning Disability Service was going to do, not just in Muckamore, in fact there is very little about Muckamore in that, because we were fairly clear at that point what we were trying to do. But it is just another example of how we would, as matter of course, consult with patients and families. And that exercise that produced The Big Plan was done, the consultation exercise was with people with learning disabilities, their families, and our partners in the voluntary and 15:23 15:23

community sectors. So I think that's my list, thank you for giving me the opportunity to do that.

MS. TANG: Thank you for making us aware of those things, and the Inquiry will follow up, as appropriate, to bring in any materials. 15:24

A. Okay, thank you.

MS. TANG: Chair, those are all of my questions, I don't know if the Panel have anything for Ms. Somerville?

295 Q. PROFESSOR MURPHY: I have got one quick one; you were evaluating quality care measure, I seem to remember it being mentioned in some of our previous evidence, was it ever published, because I seem to remember there was discussion about it being published? 15:24

A. Yes, yes, I can't remember if it was ever published, it was certainly shared within Northern Ireland, but I'm not -- I don't remember whether we had a formal publisher, I'm not sure we did. 15:24

296 Q. DR. MAXWELL: Can I just ask you, you mentioned about being clear about where you wanted learning disability services to go, or where you wanted Muckamore to go when the Big Plan was published, and you talked about the new hospital. Would you say a little bit more about the planning of the new hospital and what you mean by the new hospital? 15:25

A. Oh, yes, yes. I'm really surprised this hasn't come before.

297 Q. DR. MAXWELL: Well, it may have come up, I would just like to hear it from you.

A. Okay. When I came to North and West in 2002, a business case had been developed and they were waiting for approval for this business case. And what the new hospital was, was for 35 assessment and treatment beds that would provide a regional assessment and treatment service, not long stay, but assessment and treatment service on a regional basis and 23 forensic beds.

A lot of work had been done at that time to assess the needs of all the existing patients in the hospital, and a plan had been developed for the sequence of ward closures for resettlement, so... 15:25 15:26

298 Q. DR. MAXWELL: So there was a clear plan --

A. Absolutely, yes.

299 Q. DR. MAXWELL: -- about what was going to close and when? 15:26

A. Yes.

300 Q. DR. MAXWELL: And this was pre-Bamford?

A. This was pre-Bamford, yes, this was 2002. This was 2002. When I got there I was given the plan and I could see this ward was going to close first, this ward was going to close next. That work had all been done. And patients had been moved into those wards some time before, I think maybe two years before that, around about 2000, so a lot of work had been done to separate out resettlement from the new hospital, which was going to be an assessment and treatment service and a forensic service. And that was crystal clear. 15:26 15:26

301 Q. DR. MAXWELL: And was that impacted at all by the

Bamford Review, or did that plan continue as it had been in 2002?

A. The plan continued. In Bamford we debated a lot about the number of beds, and certainly the view in Bamford was maybe we had too many beds, but Bamford wasn't going to reopen that debate at that time. And Bamford was focussing as well on the community treatment services and how they needed to be developed further to enable the number of assessment and treatment beds to close and work with partners in mental health services, so that people who could appropriately be treated in mental health services could access those services. 15:27 15:27

So in 2002, I believe, there was real clarity about what was going to happen. The business case for the new hospital was approved, and part of my job was to make that happen. 15:28

CHAIRPERSON: Sorry, where was it going to be, where was this new... 15:28

A. Where was it going to be?

CHAIRPERSON: Yes.

A. On the existing hospital site.

CHAIRPERSON: So in the estate of Muckamore?

A. Yes. 15:28

302 Q. DR. MAXWELL: So this is what is currently Cranfield Ward and --

A. Absolutely, Cranfield, and Six Mile is the forensic unit. And we were very clear about what we were doing.

We had, you know, as you would expect the usual planning groups. And as I said earlier focus groups of patients. And, you know, one of the things about planning the new wards where the patients were asked questions like, what would make it better if you are in hospital? And they had all sorts of ideas that we would never have thought of. So that's how the new hospital came about.

303 Q. DR. MAXWELL: And can I ask you about the associated workforce plan, because one of the things that has been clear is that as the function has changed from a long stay hospital to assessment, and as wards have closed, that has been unsettling for staff. So was there a workforce plan associated with this? 15:29

A. Yes, very much so. 15:29

304 Q. DR. MAXWELL: Can you tell us a little bit more about that workforce plan?

A. I haven't got all the detail of the workforce plan, but I would know somebody who would very happy to talk to you about the workforce plan if you want to do that. 15:29 But there was a workforce plan developed with the then Director of Nursing in North and West with the woman I keep referring to as the Assistant Director for Hospital Services, she was also a learning disability nurse. And there were two nurses in the, lead nurses 15:30 in the Board and a nurse at the Department. Those people all worked together and put a very detailed workforce plan, based on the resettlement plan and looking at, you know, what would happen to staff, some

staff may choose to move out of the hospital with patients, may need some retraining in order to do that and how that would happen. Others may want to stay in the hospital, and they estimated the number of vacancies that would be needed. They also used, I don't know if you are familiar with the Telford tool, they used that to look at workforce planning. 15:30

305 Q. DR. MAXWELL: So that was looking at the numbers of staff you would need. Obviously change is difficult for people, so if your ward closes and you go to work on another ward, that can be difficult. Was there an organisational development plan to help people with team building? 15:31

A. Yeah, yeah, there was quite a lot of work going on with the nursing, and again the Assistant Director in the Hospital Services led that. And talking to staff, talking, I remember being invited to a meeting with the ward managers talking about how they would like to see this managed, what they felt their own staff on the wards needed to be able to do that. So there was a workforce plan. And in the time that I was there, because there was a workforce plan, I don't ever remember difficulties in recruiting nurses. Muckamore was still seen as a good place to be, it was a place people wanted to come and work in. 15:31 15:32

306 Q. DR. MAXWELL: So up until the time you retired, which was 2011, there wasn't a difficulty --

A. No.

307 Q. DR. MAXWELL: -- there weren't substantial vacancies?

A. No, no, it was getting -- it was always getting more difficult financially as we made more savings, but...

308 Q. DR. MAXWELL: Did you have to reduce posts in order to meet your cost savings target?

A. Well, we reduced back office functions rather than the nursing. And if -- and, you know, savings became a real challenge, and because the resettlement process hadn't released the savings that we originally hoped it would, and if it had been done in the sequence that it was originally planned to do, might have released those savings, because that didn't happen savings were difficult. 15:32 15:33

But if, again I come back to the Assistant Director, if she told me -- at times we often had this conversation and she'd say, we can manage to lose a post here, we can manage to take a post out here, because of whatever reasons, but she would often say to me, but that's it, Miriam, I can't do any more. 15:33

And so at that point we would have that discussion with our colleagues in the finance teams. And I have to say I often felt that the community services were making sacrifices because we couldn't take it out of the hospital and keep people safe. And our view was, it needed to be safe until the very last patient left, it had to be as safe as it was when the first one was there. 15:33

DR. MAXWELL: Thank you.

CHAIRPERSON: Can you remember how many posts were removed?

A. I haven't -- I couldn't remember, I'm sorry.

CHAIRPERSON: Was it a significant number so far as you were concerned? 15:34

A. Were moved --

CHAIRPERSON: Yes.

A. -- or were -- for cost savings do you mean?

CHAIRPERSON: Yes.

A. No, it wasn't significant. It wouldn't be the right thing for me to make a guess. 15:34

CHAIRPERSON: Fine, I don't want you to speculate.

309 Q. DR. MAXWELL: You did say you did know somebody who might be...

A. The Assistant Director of Hospital Services, who is the nurse, was the lead nurse at Muckamore, she has -- I have spoken to her this week, she is very keen to present evidence. She has been talking to the solicitors collecting a statement, I think, for four or maybe five days, she has the history of all this. 15:34 15:35

310 Q. DR. MAXWELL: So she could tell us more about this?

A. She can absolutely tell you more about this.

CHAIRPERSON: All right, well, before you go you will be spoken to by the Inquiry staff, all right.

DR. MAXWELL: Very pleasantly. 15:35

A. Thank you.

CHAIRPERSON: Thank you, all done.

Ms. Somerville, can I thank you very much for coming

back, again, to assist the Inquiry.

THE WITNESS WITHDREW

CHAIRPERSON: Can I just mention that next week we will not now be sitting on Thursday to hear Mr. McGuicken. We have recently received a statement from him, no complaint about that, but having reviewed it, it will in due course be disclosed to all CPs, but having reviewed it we don't think it is necessary actually to call him back to give oral evidence. So we will only be sitting next week on Wednesday. All right. Thank you very much indeed, see everybody back at 10 o'clock on Wednesday. 15:35 15:35 15:36

THE HEARING ADJOURNED UNTIL WEDNESDAY, 14TH JUNE 2023 AT 10:00AM