MUCKAMORE ABBEY HOSPITAL INQUIRY

SITTING AT CORN EXCHANGE, CATHEDRAL QUARTER, BELFAST

HEARD BEFORE THE INQUIRY PANEL

ON TUESDAY, 6th JUNE 2023 - DAY 48

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WITNESS PAGE

DR. JOANNA DOUGHERTY

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1 THE INQUIRY RESUMED ON TUESDAY, 6TH OF JUNE 2023 AS
2 FOLLOWS:
3
4 MS. BRIGGS: Good morning, Chair, Panel. The witness
5 this morning is Dr. Joanna Dougherty and the Inquiry 09:59
6 will hear evidence from her on behalf of the Belfast
7 Trust regarding Module 2, evidence dealing with the
8 inter relationship between trusts regarding patients
9 admitted to Muckamore. And, as you may recall, she
10 will be speaking to June Champion's statement and 09:59
11 dealing with some of the issues that Ms. Champion
12 wasn't able to provide details about.
13 CHAIRPERSON: Understood, thank you.
14 MS. BRIGGS: The questions that I will be asking will
15 be focusing on paragraphs 195 to 210 which are found on 09:59
16 pages 08853 to 56.
17 CHAIRPERSON: Hang on. 195?
18 MS. BRIGGS: Paragraphs 195 to 210 and the page
19 references are 08853 to 56. I want to advise the Panel
20 and Core Participants that Dr. Dougherty has found 09:59
21 further materials which may be relevant to the Inquiry
22 and that those were provided to the Inquiry just before
23 the end of the day yesterday. These are including over
24 200 pages of material and, given the short time
25 available, we haven't been able to review the material 10:00
26 or indeed share it as appropriate with Core
27 Participants. As a result of that I will be unable to
28 deal with it in questioning today, but we have asked
29 Dr. Dougherty to make a further statement to the

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1 Inquiry exhibiting the new materials that she may be
2 asked to come again and give oral evidence at some
3 point.
4 CHAIRPERSON: Okay. Well in due course, once you have
5 had a chance to review that, the counsel team can 10:00
6 assess it and see whether we need to have her back,
7 hopefully not, but we'll see how that goes. All right.
8 Thank you very much.
9 MS. BRIGGS: Unless there are any further issues we'll
10 call the witness, Dr. Joanna Dougherty, please. 10:00
11
12 DR. JOANNA DOUGHERTY, HAVING BEEN SWORN, WAS DIRECTLY
13 EXAMINED BY MS. TANG AS FOLLOWS:
14
15 CHAIRPERSON: Doctor, thank you very much for joining 10:01
16 us. I met you very briefly in the room outside, so we
17 are very grateful for your presence to come and assist
18 us, specifically about the inter relationships between
19 the Trusts. I don't think you will be here that long,
20 but if it gets to about an hour we'll take a short 10:01
21 break. Okay, thank you.
22 1 Q. MS. TANG: Good morning, Dr. Dougherty. As you know
23 I'm Shirley Tang, one of the counsel to the Inquiry, we
24 met a short time ago. I'll be taking you through some
25 questions, as the Chair has just said, regarding the 10:02
26 inter relationships between The Trusts regarding
27 patients admitted to Muckamore. You have agreed to
28 speak to the topic which was previously in the
29 statement of June Champion, can I just check that you

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1 have a copy of that statement in front of you?
2 A. Yes, I do.
3 2 Q. You do. It can be brought up on the screen as well,
4 but obviously if you have a hard copy that's helpful.
5 I am going to be looking specifically at paragraphs 195 10:02
6 to 210, and those are on pages 53 to 56. Can I check
7 that you have had an opportunity to review those
8 paragraphs before coming here today?
9 A. I have.
10 3 Q. You have, thank you. When you and I spoke earlier I 10:02
11 advised you that we have received the additional
12 material that you found and believed to be relevant and
13 that we won't be dealing with it today because it needs
14 to be properly reviewed by the counsel team, but that
15 you may be asked to do a further statement and to 10:03
16 exhibit that new material with it at some point. So,
17 it's not possible to say whether you will have to come
18 and give further evidence at this point, but we will be
19 able to make that decision once we have reviewed the
20 material. 10:03
21
22 I am not going to ask you to formally adopt into
23 evidence Ms. Champion's statement because she has
24 already done that, but can I confirm that you are
25 content to speak to the evidence within the section of 10:03
26 inter relationship between The Trusts today?
27 A. I am.
28 4 Q. Thank you. Can I start about asking you a little bit
29 about your background, what's your current role and how

1 long have you been doing it?
2 A. I am currently a consultant psychiatrist in the Belfast
3 Trust. I work in the specialty of general adult
4 psychiatry, covering a service for patients who are
5 deaf with mental health difficulties and working in 10:03
6 South Belfast Recovery Community Services, so I'm
7 essentially a community psychiatrist.
8 CHAIRPERSON: Could I just ask you to keep your voice
9 up, we can probably bring the microphone a bit closer
10 but not too close because then it feeds back. Thank 10:04
11 you very much.
12 5 Q. MS. TANG: So can I just clarify, do you have an
13 expertise in intellectual disability or?
14 A. I don't have a specific expertise in terms of a
15 certificate of specialist training, but I have 10:04
16 previously worked in intellectual disability services
17 as a trainee.
18 6 Q. And would some of your current remit cover patients
19 with an intellectual disability or are they not
20 typically? 10:04
21 A. Not at present, no, not at present.
22 7 Q. Okay. How long have you worked within Belfast Trust?
23 A. I have worked as a substantive consultant in Belfast
24 Trust since 2011.
25 8 Q. Okay. And have you ever worked at Muckamore? 10:04
26 A. I have.
27 9 Q. You have. Was that in a consultant role or was that in
28 previous training roles?
29 A. That was in previous training roles, both as a senior

1 house officer and as a specialty registrar.
2 10 Q. At what point would you have started your specialist
3 reg training?
4 A. I started my specialist registrar training in 2007.
5 11 Q. 2007. Can you remember roughly when you might first 10:05
6 have spent some time at Muckamore in the course of
7 that?
8 A. Well my first period at Muckamore was as a senior house
9 officer, so that was just prior to embarking on my
10 specialist registrar training and that was also in 10:05
11 2007.
12 12 Q. Yes.
13 A. The second period I spent in Muckamore was as a
14 specialty registrar coming to the end of my training,
15 the completion of my training, and that was in 2011. 10:05
16 13 Q. 2011, thank you.
17 A. Apologies, 2010.
18 14 Q. 2010. Okay, thank you. Turning to the statement now,
19 I wanted to ask you a general question first of all,
20 and it's thinking about patients who were admitted to 10:05
21 Muckamore for potentially quite a long stay. Can you
22 let me know what the structures are between Belfast
23 Trust and the other trusts that a patient might be
24 admitted from where it is likely that they could be in
25 for quite a while? 10:06
26 A. In terms, sorry, just so I could clarify, in terms of
27 the patient being admitted, the point of admission.
28 15 Q. Yes.
29 A. So that has changed slightly over the last number of

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1 years. So, historically, I mean I'm sure The Inquiry
2 will be aware, Belfast Trust is commissioned to provide
3 in-patient services for the Northern Trust and South
4 Eastern Trust as well as the Belfast Trust. So,
5 traditionally, there would have been contact from the 10:06
6 community team or the out of hours GP in respect of the
7 patient, depending on the acuteness of the situation,
8 clinical situation. They would have made contact with
9 the hospital in-patient ward directly and requested
10 admission, so that was the process. We worked, in 2019 10:06
11 onwards, on a new process which had a slightly more
12 rigorous clinical structure and format to it called the
13 Blue Light process. That was adopted from the Care and
14 Treatment Review launched in England following the Good
15 Services for Patients With Learning Disability document 10:07
16 in 2015.
17 16 Q. You mentioned Blue Light, I was actually going to ask
18 you about that further in, but can you tell me what
19 Blue Light actually means?
20 A. So, Blue Light, the Blue Light process was, as I say, 10:07
21 adopted from the Care and Treatment Review which was
22 published in England in 2015. We took the Blue Light
23 section out of that, because the care and treatment
24 process wouldn't have been entirely relevant to our
25 patients, it is a very comprehensive funded process 10:07
26 involving commissioners as well as the clinical team.
27 But the Blue Light process was essentially a way of
28 structuring the clinical discussion before the patient
29 would be admitted to hospital. And it was quite a

1 rigorous discussion actually which really focused on
2 looking at what are the alternatives for the patient,
3 what is the least restrictive option for the patient in
4 terms of their management in an acute situation. So it
5 was generally for patients who were deemed to be at 10:08
6 risk of admission, their condition had deteriorated to
7 the extent that that was being considered for them. So
8 we had decided that the Blue Light meetings and using
9 the proforma were going to be what we would proceed
10 with going forward. 10:08
11 CHAIRPERSON: So was it a protocol?
12 A. Yes, essentially it was. It was a proforma. Around
13 that we had meetings that were set up really between
14 the community team, and some of the hospital staff
15 would have been involved as well. Unfortunately 10:08
16 actually before we could properly roll this out, what
17 happened was the hospital became closed to admissions,
18 essentially, we were unable to take patients in. So we
19 continued to pilot this within Belfast Trust really for
20 patients who were at the point of admission. So that's 10:08
21 how this really became rolled out across 2019, 2020 and
22 then, obviously, with the pandemic that changed really
23 our ability to further evaluate the process and how it
24 was working.
25 17 Q. MS. TANG: Can I clarify, when you say the hospital 10:09
26 became closed to admissions, was that a
27 pandemic-related closure or was that something specific
28 to Muckamore?
29 A. My understanding was that was particular to Muckamore

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1 because it occurred before the pandemic, to the best of
2 my recollection.
3 18 Q. Okay. This new process, is there a sense that it's
4 ideally designed to try and avoid an admission unless
5 it is absolutely necessary? 10:09
6 A. Yes.
7 19 Q. So, in terms of the discussions that the community
8 teams and the hospital staff would have, is that
9 something that outside potential placements or
10 short-term interventions are a feature of that 10:09
11 conversation?
12 A. Well, there were lots of, I suppose, specifics within
13 the conversation which would be expected by the use of
14 the proforma essentially or the template. So there
15 would be the very necessary clinical discussion around 10:10
16 the patient, their symptoms, their treatment plan, what
17 had worked previously, what their risks were, what had
18 been trialed in the community and what was available in
19 the community to them. There was a specific discussion
20 then of the risks of remaining in the community. There 10:10
21 was a discussion about the alternatives to hospital in
22 the community, what potentially the barriers would be
23 to continuing to manage the patient in the community
24 and what would the expected outcomes of admission be,
25 which I feel was very important actually. 10:10
26
27 So it was a more extensive discussion or the aim was
28 that it would be a more extensive discussion than
29 possibly was previously had, with a focus very clearly

1 being, the principle was that a hospital was the most
2 restrictive option and a clear demonstration of why we
3 weren't able in these circumstances to use less
4 restrictive options for the patient.
5 20 Q. So, in terms of the practical impact of that change of 10:11
6 approach, would you say there was -- could you see a
7 difference in the number of admissions before that
8 approach happened and after it?
9 A. Unfortunately because we -- the implementation
10 evaluation was hampered by the fact we had a situation 10:11
11 where we weren't able to admit patients. So we trialed
12 this within our community teams in Belfast Trust and it
13 certainly was successful in, I suppose, ending the
14 discussion that admission continued to be needed, and
15 we did have some figures on that as well. The 10:11
16 anecdotal feedback from community staff was also that
17 this was a helpful process. I think it was also to
18 help support the general multidisciplinary team
19 involved, rather than one person making a phone call
20 about admission and holding a lot of that and the 10:12
21 clinical, risk actually it was a more distributed
22 discussion.
23 21 Q. Can I just check with you, I have taken it from what
24 you have said that this was for learning disability
25 particularly this protocol, was it reflective of what 10:12
26 was happening elsewhere in adult mental health services
27 as well?
28 A. In adult mental health services, the gatekeeper for our
29 admissions would be the home treatment team. So

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1 actually all referrals from community consultants like
2 myself would go through the home treatment team and
3 there would be an extensive discussion as to whether
4 admission was suitable for the patient and what the
5 alternatives were in the community. It didn't employ 10:12
6 the Blue Light process per se but actually the home
7 treatment team itself or the option of being treated at
8 home was a less restrictive option, so there was that
9 natural filter actually or natural alternative prior to
10 the community consultant and hospital. So that was 10:12
11 helpful in itself, actually, in that respect.
12 22 Q. Just thinking about the community services and the
13 provision that there is in the various different trust
14 of origin areas, would you say that, over time, have
15 you noticed that patients have sometimes had to be 10:13
16 admitted because there wasn't community support for
17 them and there was no alternative to admission?
18 A. I suppose myself personally I was involved in the Blue
19 Light meetings, so naturally the aim of those was to
20 explore alternatives. I wasn't directly involved in 10:13
21 discussions whereby the patient required an admission
22 prior to that, because we introduced the Blue Light
23 meetings fairly quickly from recollection.
24 23 Q. So when, at what point in time, was it, did you say
25 2019 onwards that the Blue Light meetings took effect? 10:13
26 A. Yes.
27 24 Q. So prior to that could you say whether or not there
28 would have been times whenever a lack of community
29 provision might have led to admission?

1 A. Well I wasn't directly involved in those discussions.
2 Because previously I had worked in Muckamore as a
3 trainee, so we would have always discussed those cases
4 with the consultant or the referral within hours would
5 have gone to the consultant on the ward, to the best of 10:14
6 my recollection.
7 25 Q. Okay.
8 A. When I joined as clinical director in 2018, at that
9 point the discussions were going through the chair of
10 division at that stage. 10:14
11 CHAIRPERSON: Sorry, can we sort the microphones out
12 please. Sorry, thank you. Could I just go back to an
13 answer you gave. You were asked by Ms. Tang about was
14 there a position where patients sometimes had to be
15 admitted because there wasn't community support for 10:15
16 them. You said you were involved in Blue Light
17 meetings, so naturally the aim was to explore
18 alternatives, but I'm not sure that's an answer to the
19 question in fact. When you explored alternatives were
20 there sufficient alternatives to avoid admission? 10:15
21 A. Certainly in the Blue Light meetings that I was
22 involved within the Belfast Trust, yes, that was the
23 case. We did, we were able to avoid admission with
24 alternatives. We were also able to access our Trust
25 home treatment team for adult mental health services 10:15
26 for patients with mild to moderate learning disability.
27 That was extremely helpful, actually, particularly
28 during times when our bed numbers were reduced.
29 DR. MAXWELL: So are you saying you wouldn't have been

1 involved in Blue Light meetings involving patients from
2 the Northern Trust area?
3 A. I can't recall we actually had the opportunity to do
4 those. We had discussions in early 2019 with the other
5 trusts regarding rolling out this process. Then we 10:16
6 faced a situation where we were unable to admit
7 patients because of staffing issues and other factors.
8 I think that was an external decision to the best of my
9 recollection. So we didn't really have a chance to
10 pilot it as such. 10:16
11 DR. MAXWELL: So this pilot only happened for people
12 living within the geographical area covered by Belfast
13 Trust?
14 A. Yes.
15 DR. MAXWELL: I suppose the question then is: Do you 10:16
16 know whether patients from other geographical areas
17 were admitted to Muckamore because there weren't
18 community services available in those areas?
19 A. Well, unfortunately we had a period where we weren't
20 actually able to take admissions. So I wasn't involved 10:16
21 in-depth in those clinical discussions, if they
22 occurred. I do know that there were patients for whom
23 we were being asked for admission, we were being
24 consulted about that. But the situation at that time,
25 worsened by the pandemic of course, was that we were at 10:17
26 times unable to facilitate those requests.
27 DR. MAXWELL: So prior to the Blue Light meetings, so
28 going back to your whole experience of Muckamore, were
29 there some patients in some geographical areas who

1 couldn't access community services and therefore got
2 admitted whereas patients from different geographical
3 areas had access to community services which meant they
4 could stay at home?
5 A. I think I would probably have to give that question 10:17
6 some further thought, because I can't recall being
7 involved in those discussions with other trusts,
8 specifically that X is not available so the patient
9 needs to come into hospital. I just can't recall that
10 at this point, I'm sorry. 10:17
11 CHAIRPERSON: Thank you.
12 26 Q. MS. TANG: Can I ask you to look at paragraph 203,
13 which is on page 54 and goes over on to page 55, if
14 that could be brought up, please. I am going to read a
15 short section from that paragraph: 10:18
16
17 "When a patient is admitted to Muckamore, that patient
18 is no longer funded by the trust of origin and the
19 financial implications of that patient's admission to
20 Muckamore fall to be met by the Belfast Trust." 10:18
21
22 I appreciate as a clinician the financial flows may not
23 have been something that you're that close to, but is
24 it your understanding that the money doesn't follow the
25 patient unlike re-settlement where, if the patient is 10:18
26 leaving Muckamore, it would?
27 A. I'm sorry, I wouldn't have an in-depth understanding of
28 the financial position for patients.
29 27 Q. Okay. Can I ask you then to look at paragraph 205,

1 which is on page 55. I'll read a short bit from that
2 as well:
3
4 "Any incidents, complaints or safeguarding issues that
5 arise in relation to a non-Belfast Trust patient within 10:19
6 Muckamore are dealt with by the Belfast Trust. But, as
7 matter of good practice, the trust of origin should,
8 where reasonably possibly, be kept informed and the
9 processes within the Belfast Trust generally require
10 referral to the trust of origin for their 10:19
11 consideration."
12
13 Can you tell me what process, what are the processes by
14 which the clinical and social care teams from these two
15 trusts actually speak to each other or communicate? 10:19
16 A. Again I should probably mention a change in the way
17 things -- practice on the wards prior to 2019. We had
18 a traditional ward round system which would have been
19 whereby the multidisciplinary team came together weekly
20 to discuss the care of the patients on a particular 10:20
21 ward. At that it would be expected that there was
22 representation from, usually, social work colleagues,
23 from other trusts, the trust of origin, essentially.
24 That itself was a form or a means of communication and
25 update, sort of reciprocal really in terms of us 10:20
26 advising the social worker as to how the patient was
27 doing and what was expected for their treatment plan
28 going forward. Then towards the end of their time with
29 us in Muckamore and approaching discharge we would

1 expect that the social worker would give us feedback
2 then as to what the plans are in the community for them
3 to return.
4 28 Q. Would the trust of origin have been quite close to the
5 treatment planning itself or was that very much in the 10:20
6 initial stages of the admission up to the Muckamore
7 team?
8 A. Well, I should probably say we then changed to a PIPA
9 system actually which was a system of daily review and
10 task review. I don't know if you want me to discuss 10:21
11 that in-depth. But certainly as part of the process we
12 had formulation meetings which would have occurred
13 within a few days of the patient being admitted. The
14 Trust social worker would be invited to those,
15 sometimes the consultant as well, really to try and do 10:21
16 a comprehensive clinical formulation for the patient in
17 terms of their signs, symptoms and to propose --
18 CHAIRPERSON: Sorry, I am so sorry, my fault, when you
19 say the Trust social worker, do you mean the social
20 worker responsible for that patient? 10:21
21 A. Sorry, from the trust of origin, yes. So it really
22 would be a means of actually bringing together the two
23 teams, the community team and the in-patient team who
24 were involved in the patient's care, working together
25 and sharing information to try and build an accurate 10:21
26 and appropriate treatment plan for the patient. That's
27 to put it probably more simply.
28 29 Q. MS. TANG: So in terms of the clinical care and
29 progress of the patient hopefully through the hospital

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1 ideally back out into the community, I can see that
2 structure; how does the risk planning around a patient,
3 a particularly vulnerable patient, for instance, if
4 there are potential safeguarding issues, how does that
5 get fed into the treatment planning and management plan 10:22
6 for the patient when they are admitted?
7 A. So at the PIPA meeting we have daily report outs, so it
8 is essentially a daily mini ward round system. On the
9 daily report out, any safeguarding issues are
10 discussed, whether they have been screened in or 10:22
11 screened out, any incidents relating to the patient,
12 any factors in their care relating to restraint or
13 physical intervention, restrictive practices
14 essentially. Seclusion would also be discussed at that
15 meeting with the clinical team. 10:22
16 30 Q. So you say that happens now, can you tell us what might
17 have happened before 2019?
18 A. My understanding is that those, well I suppose it would
19 depend on the nature of the incident. They may have
20 been needed to be reviewed at the time, actually, with 10:23
21 the clinical team and I'm unsure as to whether they
22 were then also discussed at the weekly ward round.
23 I wasn't involved in those at that stage,
24 unfortunately, so I can't comment with any accuracy.
25 31 Q. So if a patient, when you were training, for instance, 10:23
26 if a patient was known to have potential to be
27 physically aggressive perhaps to staff or to another
28 patient, can you recall any of the risk planning that
29 would have gone on around a patient like that coming

1 in?
2 A. When I was a trainee?
3 32 Q. Yes or since you have been a consultant, if you have
4 been at Muckamore at any point?
5 A. I probably would have to have a think. Apologies, 10:23
6 I only prepared for the current time.
7 33 Q. Yes, I understand. Okay, we'll come back to that. Can
8 I ask you to look at paragraph 207, that's on page 56.
9 I'm reading from that, it says:
10 10:24
11 "Unfortunately the Belfast Trust has found that the
12 administrative complexities regarding trust of origin
13 funding and care management responsibilities have been
14 identified as creating organisational disincentives to
15 the strategic commissioning and delivery of services to 10:24
16 people where they wish to live now, irrespective of
17 where they were born or raised."
18
19 Are you able to tell me what's meant by that phrase?
20 A. I mean, I think this may be referring to just the 10:24
21 difficulties in developing community care to meet the
22 needs of the patients and to meet their wishes as well
23 which obviously varied from trust to trust, but there
24 were commonalties in the barriers and difficulties the
25 Trust faced in developing community options. I'm 10:25
26 sorry, I can't be specific with the financial end of
27 things, but certainly from a clinical perspective there
28 were lots of obstacles, and that was across each of the
29 Trusts.

1 34 Q. Can you tell me about the obstacles that you would have
2 seen from a clinical perspective?
3 A. Yes, I can. I actually chaired meetings with the
4 trusts, with the care managers from each of the three
5 trusts for a period of time. 10:25
6 35 Q. The three trusts being?
7 A. Northern Trust, Belfast Trust and South Eastern Trust,
8 the trust for whom we were commissioning the in-patient
9 services. So I held meetings with the Trusts really to
10 try and bring the clinical teams a little bit closer to 10:26
11 the care management function, for them to hear really
12 about the progress of the patient and also for us to
13 hear what the plans were for re-settlement and how that
14 was coming along. So I did hear quite a lot of
15 information in that respect. There were huge 10:26
16 challenges, huge numerous challenges, really a number
17 relating to, I suppose, achieving the appropriate skill
18 mix and skill level of staffing in provider services,
19 even actually having the capital build projects
20 available, trying to balance the mix of patients who 10:26
21 would live together comfortably and what the
22 adaptations might be needed to allow for that to
23 happen. So there were numerous, there were numerous
24 issues really and reasons, I suppose, why it was
25 difficult to resettle patients in the community in an 10:27
26 efficient manner. I got the sense very much - and this
27 is a very general statement - I appreciate that
28 actually the community services possibly were not
29 developed sufficiently in some cases to meet the needs

1 of highly complex patients, and that included, also, to
2 clinically meet their needs as well. We didn't, for
3 example, have the equivalent of home treatment teams
4 for learning disability available in community
5 services, unlike in adult mental health. 10:27
6 CHAIRPERSON: Sorry to interrupt, but does that come
7 back to what you were saying at paragraph 207, I just
8 want to see if we can unpick what's in that. Because
9 you were focussing, I understand, on the availability
10 of clinical care, but it says: 10:28
11
12 "Unfortunately the Belfast Trust has found that the
13 administrative complexities regarding trust of origin
14 funding and care management responsibilities have been
15 identified as creating organisational disincentives to 10:28
16 the strategic commissioning and delivery of services to
17 people where they wish to live now."
18
19 Now what that might be saying is, once people have been
20 admitted to Muckamore, the financial responsibility 10:28
21 effectively becomes Muckamore's, the disincentive is to
22 The Trust to take them back, the trust of origin to
23 take them back because then it's got to create a
24 community care setting for that individual patient.
25 Now you were focussing, I understand, on the clinical 10:28
26 difficulties, but is that actually what that paragraph
27 is saying or am I reading too much into it? And if you
28 don't want to say or you can't say then you tell us.
29 A. My apologies, I couldn't -- I probably couldn't be

1 specific beyond what I observed from a clinical
2 perspective and the logistical issues. I don't really
3 have insight into the financial.
4 CHAIRPERSON: No, I understand. I don't want to press
5 you on an area that you are not comfortable with, but 10:29
6 that would be one reading of that paragraph?
7 A. Yes. I am just not entirely up to speed with the
8 administrative complexities, so I suppose it would be
9 difficult for me to go into detail on those or give my
10 opinion. 10:29
11 CHAIRPERSON: All right. We may hear about that.
12 Sorry to interrupt you, Ms. Tang.
13 36 Q. MS. TANG: Thank you. You identified three potential
14 reasons why there were logistical difficulties trying
15 to resettle people out into the community, one of which 10:29
16 was skill mix and staffing. Can I just clarify is that
17 in the receiving organisation, whether it be an
18 independent sector setting or community provision?
19 A. Yes, that would be across, I suppose, the community
20 provision relating to residential provision for the 10:30
21 patients in a situation where they weren't going back
22 to family care.
23 37 Q. Is it your understanding that it was hard to recruit
24 enough people or that the very particular skills, that
25 they just didn't exist? 10:30
26 A. I think it was difficult to recruit and to retain staff
27 from my recollection. There is obviously a very
28 specific specialised skill mix required which often
29 does need a lot of experience actually working in this

1 area and working with patients with these types of
2 difficulties. So from my understanding or my
3 observation really of the outcome of the discussions
4 was that that was proving quite difficult to achieve.
5 38 Q. From a clinical perspective, presumably when someone is 10:31
6 being prepared for re-settlement I would imagine there
7 is a degree of assessment of this person's needs and
8 what package they will actually need; is it your
9 understanding that the skill shortages or the staffing
10 shortages were more common with every type of learning 10:31
11 disability patient or were there certain more complex
12 patients that they were particularly pronounced for?
13 A. I think actually for our group of patients for whom
14 re-settlement and significant delayed discharges were
15 consideration, there were a lot of commonalties in the 10:31
16 complexities. So they were a group who, by no means
17 homogenous, but certainly I think the skill mix of the
18 provider staff would have had to have been similar for
19 each of those patients really in many respects, aside
20 from perhaps differences in their physical needs. That 10:32
21 is part of the challenge as to why they were in
22 Muckamore Abbey for a considerable period of time.
23 39 Q. You had also made reference to capital builds, that
24 there might be delays in those being available for
25 patients? 10:32
26 A. Yes.
27 40 Q. How common would that have been?
28 A. I think that was discussed fairly regularly at the
29 meeting, just having the physical, the appropriate

1 physical space and securing the appropriate buildings
2 in a location which was going to be appropriate as well
3 with reasonable access to other services. I don't know
4 much about the detail of why that was, I just know that
5 that was a factor. 10:32
6 41 Q. Have you any sense of whether it was delays identifying
7 a place or whether it was securing funding to build new
8 places or?
9 A. I think it was, now to my recollection it was actually
10 getting physical space, it was actually either 10:33
11 purchasing or hiring or leasing or whatever process
12 they were using really to acquire. I think from
13 recollection there were a few new build schemes which
14 were being proposed as well to meet the needs of
15 patients, so really just securing appropriate housing 10:33
16 was a challenge.
17 42 Q. So, if you had to put a figure on roughly what
18 percentage of potential re-settlements might be
19 impacted by something like difficulty accessing space
20 for them to be resettled into, have you any sense of 10:33
21 what percentage might have been?
22 A. I probably would have to look at some data on that,
23 apologies. I don't know that I could give you a
24 ballpark. We were having, I suppose, discussions about
25 all the patients in hospital at that stage. Throughout 10:33
26 the course of my time holding those meetings, there was
27 quite -- there were a number of changes. And so,
28 because it happened over a period of time, I'm not sure
29 that I could give you an instantaneous point of

1 reference for the numbers in that respect. I would
2 have to actually sit down and look at some data,
3 apologies.
4 43 Q. Okay, if you could that would be helpful. Can I ask
5 you to look at paragraph 210 which is further down page 10:34
6 56. This is just to clarify the working arrangements
7 that are in place for the clinical psychiatrists.
8 Reading from that paragraph where it picks up:
9
10 "To date clinical psychiatrists which provide services 10:34
11 to the South Eastern Trust are still employed by the
12 Belfast Health and Social Care Trust."
13
14 Can I ask you does that mean that Belfast's clinical
15 psychiatrists are covering sessions in Northern and 10:34
16 South Eastern Trusts or how does that work in practice?
17 A. So Belfast Trust clinical management would have
18 recruited for both the Northern Trust and for the South
19 Eastern Trust for their community areas for the
20 provision of community psychiatry. Northern Trust, 10:35
21 I understand, took over the recruitment of their
22 psychiatrists prior to me taking up post as clinical
23 director, so that was some years ago. When I was
24 clinical director we continued to employ community
25 psychiatrists on behalf of the South Eastern Trust, as 10:35
26 we did for children's services as well.
27 44 Q. So would that mean that you and your consultant
28 colleagues who are providing that service to South
29 Eastern could be in Belfast, could be in Muckamore,

1 could be driving over to South Eastern Trust facilities
2 all in the course of a working week, or how does that
3 work in practice?
4 A. Well for in-hours care generally not because people had
5 quite specified job plans. So if they were a community 10:35
6 psychiatrist it was for the South Eastern Trust area or
7 part of the South Eastern Trust area or it was for the
8 Belfast community area. Out of hours was a different
9 matter because the consultants were covering the
10 service as a whole. 10:36
11 45 Q. How did out of hours, how did that actually work then,
12 what arrangements?
13 A. The consultants were on an on-call rota, so they were
14 providing cover for learning disability services and
15 for Muckamore Abbey Hospital as well out of hours. 10:36
16 46 Q. Would it have been common to be called out of hours to
17 Muckamore in your experience?
18 A. In my experience as a consultant I did cover a couple
19 of the on-calls myself due to staffing shortages. It
20 wasn't common that I was called in or called on site. 10:36
21 I may have been called about clinical issues,
22 certainly. But that would be the expectation of a
23 consultant psychiatrist on an on-call rota and that is
24 what makes it feasible to do the on-call and to do
25 weekly clinical work as well. 10:36
26 MS. TANG: Thank you. Those are all my questions, but
27 the Panel may have some questions for you, so if you
28 could remain where you are.
29 CHAIRPERSON: No, you are all done. Can I thank you

1 very much indeed for attending and coming to assist us.
2 A. Thank you.
3 CHAIRPERSON: Yes, I think you can go with the
4 secretary to the Inquiry. I don't think the next
5 witness is until 2 o'clock? 10:37
6 MS. BRIGGS: That's correct, Chair. The next witness
7 is coming at 2.00.
8 CHAIRPERSON: We can't sort of move that forward?
9 2 o'clock then. Okay, thank you very much indeed.
10 10:37
11 THE HEARING ADJOURNED UNTIL 2.00 PM.
12
13
14 THE HEARING RESUMED AS FOLLOWS:
15 14:03
16 MS. BRIGGS: Chair, members of the Panel, this
17 afternoon you will be hearing evidence from Marie
18 Heaney on behalf of the Belfast Trust regarding
19 Module 2I, that's the outline of provision for
20 community based services. She, like the witness this 14:03
21 morning, will be speaking to the contents of June
22 Champion's statement, the reference is 088-1.
23 Specifically, Chair, it's paragraph 234 to 258, that's
24 pages 66 to 72 of the statement.
25 CHAIRPERSON: Thank you, that's very helpful. 14:04
26 MS. BRIGGS: Thank you, Chair, unless there is anything
27 further at this stage we can call the witness.
28
29

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1 MS. MARIE HEANEY, HAVING BEEN SWORN, WAS DIRECTLY
2 EXAMINED BY MS. BRIGGS AS FOLLOWS:
3
4 CHAIRPERSON: Good afternoon. Thank you very much for
5 coming to assist the Inquiry. I don't think you are 14:05
6 going to be here for that long, but if we get to about
7 an hour then we will take a short break. But if you
8 need a break earlier, just let me know.
9 A. Thank you.
10 47 Q. MS. BRIGGS: Good afternoon, Ms. Heaney, we have met 14:05
11 this morning, I am one of the counsel team to the
12 Inquiry. And, as you know, I am going to be asking you
13 a series of questions related to the provision of
14 community based services in the Belfast Trust?
15 A. Okay. 14:05
16 48 Q. And you have agreed to speak to that topic which was
17 previously dealt with in the statement of June
18 Champion, do you have a copy of that statement in front
19 of you?
20 A. I do. 14:05
21 49 Q. And, specifically, the paragraphs which you are
22 speaking to at paragraphs 234 to 258, found at pages 66
23 to 72. Have you had an opportunity to read those
24 paragraphs before today?
25 A. I have, thank you. 14:05
26 50 Q. I'm not going to ask you to formally adopt that
27 statement into evidence because Ms. Champion has
28 already done so, but I am going to ask if you are
29 content to speak to the contents of that statement,

1 those paragraphs?
2 A. I am.
3 51 Q. I am also going to ask whether there is anything within
4 that that you would like to change at this stage?
5 A. Well apart from a small minor correction at paragraph 14:06
6 241. That paragraph reads:
7
8 "Residential care is the residential accommodation care
9 provided by the Belfast Trust, such as Cherry Hill,
10 Greystone or Shaws Avenue." 14:06
11
12
13 52 Q. I am going to stop you there just so it gets pulled up
14 on screen, Mrs. Heaney. It's page 68 paragraph 241?
15 A. Yes. 14:06
16 53 Q. If you just bear with us one moment please. Okay, it
17 should be on your screen now, Ms. Heaney?
18 A. It is indeed. It is to point out that those facilities
19 are in fact supported living facilities and there
20 should have been two different facilities in there, 14:07
21 80 Malone Road and SixEleven Ormeau Road, it was just a
22 slight error in the two paragraphs.
23 54 Q. Okay. So that is to say then the residential care
24 facilities are 80 Malone Road, SixEleven Ormeau Road?
25 A. Yes. 14:07
26 55 Q. And those facilities then named at paragraph 241, which
27 are Cherry Hill, Greystone Centre or Shaws Avenue, they
28 are in fact supported living?
29 A. Exactly.

1 56 Q. Okay.
2 CHAIRPERSON: Oh, I see, okay, yes. I may need some
3 assistance but later on with the distinction between
4 residential care and supported living. I've heard a
5 lot about them but it would help, I think, if somebody 14:07
6 just told us what the fundamental differences are, but
7 I'll leave that to Ms. Briggs to come to.
8 A. Okay.
9 57 Q. MS. BRIGGS: Thank you, Chair. Other than that
10 correction that you have made into the record now is 14:08
11 there anything else within the statement that stands to
12 be corrected at this stage?
13 A. No.
14 58 Q. Okay, all right. I am going to ask you first a little
15 bit about your own professional background, you retired 14:08
16 from the Belfast Trust in June 2020; is that right?
17 A. That's correct.
18 59 Q. And what was your role prior to your retirement?
19 A. From September '17 - 2017 - until the end of June '20
20 I was Director of Adult Social and Primary Care. That 14:08
21 Directorate covered mental health services, older
22 peoples' services and learning disability services.
23 60 Q. Did it also cover community services?
24 A. Yes. I mean, those particular areas cover both
25 hospital and community services. So, for example, 14:08
26 mental health, it would have included, Beechcroft was
27 the Children's Mental Health Hospital and the City
28 Hospital, Mental Health Hospital. So the related
29 hospitals, in order to deliver an integrated approach

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1 to care, community teams and their hospital opposites
2 would have been integrated as far as possible.
3 61 Q. Okay. Mrs. Heaney, prior then to September 2017 what
4 was your role, if any, within the Belfast Trust?
5 A. Well, I've worked all my career in various permutations 14:09
6 of trusts. Just prior to the director role, I was
7 Co-Director in Older People, Physical Health and
8 Sensory Impairment Services for five years from 2012 to
9 2017.
10 62 Q. What is your professional background? 14:09
11 A. Social work.
12 63 Q. Social work. Have you ever been involved with
13 Muckamore directly in terms of being placed within
14 Muckamore for a role?
15 A. No, not until my director role. 14:09
16 64 Q. I am going to take you now to June Champion's
17 statement, if we can go back to page 66, please. At
18 paragraph 234, it is the first paragraph there,
19 Mrs. Heaney, do you have that in front of you?
20 A. Yes. 14:10
21 65 Q. Okay. Ms. Champion there lists the persons whose
22 assistance she had when she compiled this section of
23 her statement and she names there Tracy Reid, Fiona
24 Rowan and Kim Murray. You aren't listed there,
25 Mrs. Heaney, so can we take it, can the Inquiry take it 14:10
26 that you didn't have any part in compiling and writing
27 this actual section?
28 A. No.
29 66 Q. You weren't consulted by Ms. Champion whenever this

1 section of the statement was being compiled?
2 A. I can't fully remember. I had been involved in
3 assisting the Belfast Trust with many sections and I
4 think I did contribute to this in terms of just
5 feedback. 14:10
6 67 Q. So you gave a feedback role after this was drafted?
7 A. After, yeah.
8 68 Q. Okay. At paragraph 236 then, just further down the
9 page, Ms. Champion says there:
10 14:11
11 "The community team which provides care for patients
12 who have been resettled from MAH sit within the
13 division of intellectual disability services, which
14 sits within its own larger directorate."
15 14:11
16 What is the name of that directorate?
17 A. At the moment it is the Directorate of Mental Health
18 and Learning Disability Services. When I was in post
19 it was a larger directorate, it included older people
20 and physical and sensory impairment services. 14:11
21 69 Q. Was that the directorate that you had responsibility
22 for as director?
23 A. Yes, that's correct.
24 70 Q. It was then subsequently renamed then after you left
25 the Trust; is that right? 14:11
26 A. Well, there was another director appointed. It was
27 split between, mental health and learning disability
28 became its own directorate and older people services
29 became a directorate in its own right.

1 71 Q. At paragraph 238, it's page 67, Ms. Champion explains
2 there that:
3
4 "The division of intellectual disability services is
5 broken down into smaller care delivery units. One of 14:12
6 those care delivery units has always been centered
7 around MAH. The other care delivery units have
8 centered around community based learning disability
9 services and corporate support."
10 14:12
11 Can you assist the Inquiry by providing some detail as
12 to the individuals who work within care delivery units,
13 what kind of staff would that be?
14 A. Okay. I mean if it would be helpful I could outline
15 the current structure within learning disability 14:12
16 services. I mean, obviously it has evolved over the
17 years since the inception of the Belfast Trust, but
18 currently there is what is known as a collective
19 leadership team. There is a director who is the most
20 senior person in that team. Then we would have a 14:13
21 divisional social worker, chair of division - it's
22 usually a doctor - divisional nurse, clinical director.
23 That team together are responsible and accountable for
24 the planning, governance, quality and safety, risk
25 management, implementation of all aspects of service 14:13
26 delivery as outlined by the Commissioner. So that is
27 the senior team.
28
29 Below them, I mean obviously they have related

1 professional leads, particularly psychology, and they
2 would have governance leads to assist them in data
3 collection and analysing data points. There is five
4 care delivery units currently: Muckamore Abbey
5 Hospital and Iveagh, which is the children's disability 14:14
6 hospital, are in that one care delivery unit. We then
7 have day services and day opportunities, that's
8 separate care delivery units headed by a service
9 manager. Below that we would have eight day centres
10 across Belfast who would provide day services in terms 14:14
11 of educational and therapeutic programmes for fairly
12 complex needs. We would commission 79 places in the
13 independent sector day supports through an annual
14 contract.
15 14:14
16 Day opportunities is a relatively new development based
17 on the back of Bamford. One of the objectives of
18 Bamford is to give people with a learning disability a
19 rich and meaningful life in a home of their own in
20 their own neighbourhood. So that was funded. Through 14:14
21 that initiative, I mean most of the services in
22 community learning disability are adult social care,
23 which is a huge element of health and social care
24 overall. So they would provide, they work with
25 10 other organisations to provide a very wide range of 14:15
26 educational, leisure, employment, personal development,
27 all sorts of programmes, it is a very wide and rich
28 programme.
29

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1 Then we have a residential and supported living care
2 delivery unit. We have a number of directly managed
3 statutory residential units which have been around a
4 long time, maybe from the 70s. They have evolved over
5 the years. We, probably over the last 25 years, have 14:15
6 developed a significant number of supported living
7 schemes. They are usually -- I mean, learning
8 disability is unique, it has a couple of Trust-owned
9 buildings for supported living, but mostly they are
10 owned by housing associations. We work in partnership 14:16
11 with housing associations. They have the expertise
12 around building an appropriate space for the particular
13 needs of either the individual or the group of
14 individuals. They pay rent, usually through housing
15 benefit, or, if they have their own means, it is a 14:16
16 means-tested benefit. They would use their benefits;
17 then to pay for their daily living costs. The Trust or
18 an independent sector organisation would provide 24
19 hour support based on each individual tenant's
20 identified needs. The whole focus of supported housing 14:16
21 is to promote independence, choice and dignity and move
22 away from any hint of institutionalisation.
23
24 So that is the main difference between the two models.
25 It is an attempt to try and give people a home of their 14:16
26 own, that they have agency and autonomy in their own
27 lives with the least interference but a watchful eye
28 from Trust staff or independent sector staff.
29 Both sets of services in this unit really cater to the

1 needs of people with very, very complex needs,
2 behaviourally, medically. I mean, the vast majority of
3 people with a learning disability in Belfast, like
4 other places, live in their own homes, in social
5 housing or with their parents, have nothing do with the 14:17
6 Belfast Trust or any other organisation and are
7 supported by other adult social voluntary groups,
8 education and so on.
9
10 The next service delivery unit is commissioned services 14:17
11 and re-settlement. Essentially that is the
12 commissioning, the Trust's commissioning team for
13 significant amounts of private and voluntary sector
14 organisations. So we will have a whole raft of nursing
15 homes that are designated for people with learning 14:18
16 disability or residential homes. In fact we purchased
17 about 133 residential homes, 162 places, I should say,
18 in nursing homes, domiciliary care. We provide
19 directly and through the independent sector about 152
20 places. Family placements also is a very bespoke 14:18
21 service for people with a learning disability where
22 they live with a family. It is a bit like foster care
23 in children, that's the nearest analogy, which is very
24 successful and so on.
25 14:18
26 Then the final service delivery unit is community
27 treatment and support. That is an emerging area of
28 service, it has grown since the inception of the Trust
29 incrementally as the Board has been able to purchase or

1 to provide funds for. That would be, well obviously we
2 have our core four multidisciplinary teams in Belfast,
3 north, south, east and west. When the Trust was begun
4 back in 2006/7 we had North and West Belfast Trust, we
5 had Community Trust, South and East and they had two 14:19
6 different models. North and West would have had
7 unidisciplinary teams, two social work teams and two
8 nursing teams. South and East, they had already made
9 them multidisciplinary. So there was a bit of -- they
10 were developed into four multidisciplinary teams. They 14:19
11 have grown. I mean, their core function is individual
12 assessment, care planning and review for individuals
13 who are accepted, who meet the eligibility criteria for
14 Trust services.
15 14:20
16 It also has a safeguarding team which is a team of
17 social workers that cover both Muckamore and the
18 community. Their primary role is under the adult
19 safeguarding policies and procedures. They are very
20 busy, there is a lot of work in that team. 14:20
21
22 We also have intensive support teams which are provided
23 by -- led by psychology. They are a team of staff who
24 provide very intensive support to residential units and
25 to nursing homes and residential homes and supported 14:20
26 living when issues arise. When some individuals may be
27 at risk of admission to hospital for example, or, you
28 know, where their behaviours, you need to be reviewed
29 and there has to be a multidisciplinary view in order

1 to prevent any escalation.
2 DR. MAXWELL: Can they support people in their own
3 homes as well?
4 A. Yes, absolutely. So this team is developing as it
5 moves ahead into a multidisciplinary therapeutic team 14:21
6 while retaining its core functions of assessment,
7 treatment and review. The evidence shows that the more
8 disciplines are involved in that process the better the
9 outcomes for the individuals. We also have our carers
10 lead in those teams and they manage transitions from 14:21
11 children's services and support carers with the carers'
12 assessments and carer grants. So those are the five.
13 72 Q. Thank you very much, Ms. Heaney.
14 PROFESSOR MURPHY: Could I just ask, sorry, where does
15 direct treatment sit? 14:21
16 A. Direct payments?
17 PROFESSOR MURPHY: Direct payments, sorry, where do
18 they sit?
19 A. They would sit in the core multidisciplinary teams.
20 The social workers usually supports family members who 14:21
21 want to really be more in charge, through a self
22 directed support model, more in charge of what they
23 want as opposed to any prescription from the Trust.
24 73 Q. MS. BRIGGS: Mrs. Heaney, thank you very much. You
25 have given us an overview of the care delivery units, 14:22
26 how they are broken down. What I had asked you was the
27 types of staff that work within care delivery units,
28 and you have given us an overview of that based on
29 what's in your answer, but just to break it down. As

1 I understand it based on your evidence the care
2 delivery units are staffed by a range of different
3 disciplines of staff; is that right?
4 A. Yes.
5 74 Q. Okay. They come from a range of professional 14:22
6 backgrounds?
7 A. Yes.
8 75 Q. Okay.
9 A. I mean, it started with nurses and social workers and
10 now it is fully multidisciplinary. Obviously those 14:22
11 teams can access more specialist services like perhaps
12 dietetics, addiction services, forensic services,
13 forensic psychiatry, forensic psychology, to understand
14 better the needs of particular individuals.
15 76 Q. Thank you very much. Has that always been the case 14:22
16 with care delivery units? You had mentioned how the
17 evidence is showing that involving a range of
18 professionals from different backgrounds, it benefits
19 the patients, has that always been the case that there
20 were such a range of individuals within care delivery 14:23
21 units?
22 A. No, I think that has been an evolution. As the
23 research and the understanding has grown and as
24 resources became available and working with the other
25 professions has evolved, but I think it is the aim to 14:23
26 increase that further.
27 77 Q. Yes.
28 DR. MAXWELL: When did that start evolving? You said
29 it started with nursing and social work teams, when did

1 Belfast Trust start adding to those teams?
2 A. I think, I can't be 100% sure, but looking back over
3 the statutory functions reports that I looked at in
4 preparation for that, it was probably around -- I mean,
5 there was always psychology. I mean, the day centres 14:23
6 I referred to always had access to a multidisciplinary
7 component, particularly psychology. But that
8 profession expanded over the last 10 to 15 years, so I
9 think it began to come into the community teams around
10 '9/'10, around that period of time. I can double check 14:24
11 that, if that's helpful.
12 CHAIRPERSON: Could I just go back to the beginning of
13 that answer which was talking about how you have
14 residential premises and also supported living.
15 A. Yes. 14:24
16 CHAIRPERSON: I just want to come back to the
17 distinction and whether there is a clear distinction or
18 whether it's a sliding scale of support. How would you
19 describe a residential living facility?
20 A. Well, a residential care facility generally has its 14:24
21 roots in a particular model of care, it is registered
22 with RQIA as a registered facility for a start. It
23 tends to have much more restricted accommodation. So
24 you might have en suite bedroom. I mean, I can
25 remember when there was five in bedrooms in residential 14:25
26 care many years ago. I mean, the accommodation
27 standards have developed over the years. But generally
28 you have an en suite bedroom, you generally don't have
29 access to cooking facilities. You would have communal

1 facilities for socialising in. Your meals would be
2 regimented in terms of breakfast, it is a bit like a
3 hotel.
4 CHAIRPERSON: More of an institutional?
5 A. It's very much. Now I know that there is a range of 14:25
6 levels of quality in residential care and some of the
7 top end ones are very --
8 CHAIRPERSON: Are very close, I imagine, to
9 residential?
10 A. -- close, exactly. But generally it is a regimented 14:25
11 routine. The needs of the institution predominate, you
12 know meal times, toileting regimes, for example. In my
13 experience in older peoples' facilities generally
14 social care staff or nursing assistants would be the
15 main staff. You don't go out unless you are able, you 14:26
16 know you are accompanied. So, yes, it is much more
17 restrictive, I mean that's the word I would use.
18 CHAIRPERSON: I understand that. But the people who -
19 so we have heard quite a lot about the difficulty of
20 recruitment, for instance, particularly to Muckamore - 14:26
21 is part of that because of the nature of the facility?
22 I mean, part of it will be because of the publicity and
23 what's been going on at Muckamore, but is it easier to
24 recruit people to work in supported living than it is
25 to a residential facility, or can you not comment? 14:26
26 A. I can't really comment, I don't have any statistics
27 about that. But I think there are challenges in
28 recruitment across all of those types of facilities.
29 I have not been aware that it's been easier in

1 supported living.
2 CHAIRPERSON: And in supported living will you also
3 have people who are specialised in learning disability?
4 A. Increasingly providers are wanting to recruit staff who
5 are trained in positive behaviour support, a different 14:27
6 skill mix. But historically they are social care
7 workers. The manager overall may be a nurse or a
8 social worker or someone who is qualified in learning
9 disability nursing or general nursing. Then they will
10 seek to bring in specialist training. But generally, 14:27
11 no, they would not be specialists.
12 CHAIRPERSON: Thank you.
13 MS. BRIGGS: Thank you.
14 CHAIRPERSON: Sorry, Ms. Briggs.
15 78 Q. MS. BRIGGS: No problem, Chair. Ms. Heaney, thank you 14:28
16 very much. I am going to go down at this stage to
17 paragraph 245 at page 69, the first paragraph on the
18 page there. It's written there:
19
20 "It is within the community teams unit that you will 14:28
21 find community key workers."
22
23 The Inquiry has heard evidence from the various trusts
24 about the role of the community key worker. On behalf
25 of the Belfast Trust what can you say about the 14:28
26 community key worker and their specific role?
27 A. In Muckamore or generally?
28 79 Q. Generally.
29 A. The key worker is really the individual who has

1 responsibility for accepting the referral. Sometimes
2 it's generally the social worker because they tend to
3 be, the basis of their training is collating care
4 assessments, co-ordinating care. They are responsible
5 really, they own, if you like, the individual. They 14:29
6 hold the record, they record all the assessments, they
7 are responsible for ensuring reviews occur. They are
8 responsible for taking advice from other members of the
9 multidisciplinary team. So they really are responsible
10 for that client. If any issues about that particular 14:29
11 individual, the key worker is the person responsible,
12 whether it's through transitions into adult services
13 from children's or re-settlement from a hospital like
14 Muckamore, they are the person responsible for going
15 into the hospital, attending ward rounds, gathering 14:29
16 information and making sure that there is a full
17 assessment of needs. You know they are required to
18 involve families in that process.
19 CHAIRPERSON: I was going to ask you about that,
20 presumably they would be a key contact for the family? 14:30
21 A. Yes.
22 80 Q. MS. BRIGGS: How long has the likes of a role of a
23 community key worker been in place, Mrs. Heaney, can
24 you speak to that?
25 A. Well originally it was the social worker who would have 14:30
26 been considered the key worker. I mean, nurses tended
27 to deliver therapeutic interventions, the relationship
28 would stop there. There was a community care reform,
29 it goes right back to 1990, called People First and it

1 is related to care management procedures and charging
2 arrangements and so on. That document really brought
3 in the concept of care management. It created the
4 purchaser provider, the commission provider split at
5 organisational level and at individual staff level. So 14:30
6 some trusts, there was a broad -- across the five
7 trusts there would have been similarities in how they
8 approached care management. Some trusts would have
9 appointed care managers and they were the key worker,
10 particularly for complex patients. So they were the 14:31
11 key workers, they generally had a social work or
12 nursing background and they have extensive
13 responsibilities around the individual that are laid
14 out in the care management procedures. It's generally
15 around case finding, assessment, review, quality 14:31
16 monitoring, consultation with families, involving the
17 multidisciplinary team where appropriate. So they have
18 extensive responsibilities.
19 81 Q. Thank you very much, Mrs. Heaney. I am going to go
20 down now to paragraph 251, it's on page 70. About half 14:31
21 way down that paragraph it is written:
22
23 "Each patient has a care manager from the community
24 team of the trust of origin."
25 14:31
26 Can you tell us similarly a little bit more about the
27 care manager and their role?
28 A. Yes. As I mentioned earlier, I mean the care manager
29 is the key worker. I think at a point in time social

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1 workers assumed, but as the demand and the needs grew
2 they became separate. So the care manager is the key
3 worker. Sorry, could you just repeat the question.
4 82 Q. Mrs. Heaney, that's very helpful. I was asking you
5 what a care manager is and I think your answer to the 14:32
6 Inquiry is that they are effectively the same as a key
7 worker?
8 A. Yes, yes, correct.
9 DR. MAXWELL: Can I just clarify that because you said
10 increasingly it became the social worker, but you've 14:32
11 said the key worker was sometimes a nurse?
12 A. In learning disability, I think before care managers
13 existed, which is quite a long time ago, the social
14 worker would have assumed the role of the key worker in
15 terms of the care co-ordination. Over time and with 14:33
16 the implementation of care management a new type of
17 worker was created, care managers. They assumed the
18 key worker role which was laid out in quite a lot of
19 detail. Now some trusts did not create the role of
20 care manager. In those teams it could be, it was a 14:33
21 care management role but it could be either a nurse or
22 a social worker. But they were not functioning as a
23 clinical nurse in that case, they would have been
24 functioning as a care manager.
25 DR. MAXWELL: Are you saying that the role of care 14:33
26 manager might be different in each of the five
27 different trusts?
28 A. I think they are the same, the models of how -- in
29 Belfast, for example, we appointed care managers as a

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1 separate profession, if you like, or a separate group
2 of staff, whereas I think maybe in other trusts they
3 had staff whose function was care management. But they
4 did the same work, they were key workers.
5 DR. MAXWELL: So patients potentially could have a key 14:34
6 worker and a care manager?
7 A. No, the care manager was the case manager, if you like,
8 for that individual, just different terminology.
9 DR. MAXWELL: Okay.
10 A. The function was key working. 14:34
11 83 Q. MS. BRIGGS: Mrs. Heaney, at the end of that paragraph
12 then it is written:
13
14 "Generally, however, patients from MAH require
15 placements within commissioned services." 14:34
16
17 I want to ask you a little bit about that, why is it
18 that patients from MAH generally require placements
19 within commissioned services?
20 A. Well, the key reason is that the vast majority of 14:34
21 services for people with a learning disability are
22 provided by the independent sector. I think going back
23 a long, long time ago the independent sector didn't
24 exist to the extent it does today. In my memory or in
25 my recollection the People First document created the 14:35
26 mixed economy of care with the transfer of social
27 security money from social security to the boards. So
28 they got a lot more money and that was when you saw the
29 significant explosion of independent sector providers

1 in the care market. I mean, the market was created,
2 that document created a care market. So commissioned
3 services refers to all of the voluntary and private
4 sector providers in supported housing, residential and
5 nursing home care and domiciliary care and shared 14:35
6 lives. I mean, we have seen extensive innovations from
7 those sectors in relation to learning disability in
8 recent years.
9
10 Statutory services reserve a small amount of services. 14:36
11 I mean in preparation for this I looked at the
12 expenditure and it was probably 90% external. I mean
13 there is a difference, you can interpret the figures
14 from a spend, what is spent on the activity, they are
15 slightly different figures. But the vast majority of 14:36
16 provision is within the independent sector; therefore,
17 well that team has expanded because they are
18 responsible for ensuring that the assessments of
19 people, particularly from places like Muckamore which
20 are deeply detailed and require intensive work in order 14:36
21 to marry up the individual with a service that can meet
22 their needs.
23 84 Q. When did that shift happen, Mrs. Heaney, away from
24 statutory services towards commissioned services being
25 the primary source of services for service users? 14:37
26 A. Probably since the 1970s. I mean, it's been an
27 evolutionary period over many decades, gradually the
28 outsourcing, as some people would say, into the
29 independent sector.

1 85 Q. Thank you very much. Page 70, please. I think we are
2 on it already, paragraph 253, which is at the bottom of
3 page 70. Ms. Champion there refers to the role of the
4 community integration co-ordinator and she says:
5 14:37
6 "The role of the community integration co-ordinator, of
7 which there are presently two, is to work to help
8 source and plan for accommodation and co-ordinate the
9 different professionals involved in planning that
10 placement." 14:37
11
12 What is the professional discipline of the person or
13 the two people in that role?
14 A. Certainly, to the best of my knowledge, certainly when
15 I was there there were learning disability nurses. You 14:38
16 would really need that qualification to undertake that
17 role. So to the best of my knowledge, I can't be --
18 I think I only remember one individual, but, if they
19 are, it would tend to be a learning disability nurse.
20 I mean, it is the only professional really who is fully 14:38
21 trained through their entire nursing training to
22 understand and respond to the needs of people with
23 complex learning disabilities and autism.
24 86 Q. Are they always an individual employed by the Belfast
25 Trust? 14:38
26 A. Yes. I mean, to the best of my memory, those posts,
27 the integration co-ordinators were funded by the Board.
28 They were employed by the Belfast Trust, but they would
29 have been very involved in creating that bridge really

1 between the community key workers and the hospital
2 multidisciplinary teams. So they would have been --
3 the individual I recall worked in Muckamore, understood
4 the institution, understood the needs of patients and
5 she would have helped the key workers and the hospital 14:39
6 teams come together and understand the discharge needs.
7 It is highly intensive work and very often can take a
8 very long period of time.
9 DR. MAXWELL: Did these two roles cover all the Trusts?
10 A. Yes. 14:39
11 DR. MAXWELL: So they weren't just dealing with Belfast
12 Trust?
13 A. No. Sorry, I meant to make that point. Particularly
14 for the three trusts who had patients, the main
15 patients in Muckamore, but also all the Trusts had 14:39
16 small numbers of patients in Muckamore, particularly
17 the forensic ward, but mainly Northern, South Eastern
18 and Belfast Trusts.
19 87 Q. MS. BRIGGS: It's mentioned in the statement there that
20 there is two presently, from your knowledge and your 14:39
21 recollection has it always been around that number or
22 have there been periods where there have been more or
23 less?
24 A. I don't believe there has been any more. I recall one,
25 but, sorry, I could be making a mistake, but there is 14:40
26 definitely two now. I thought at a point in time there
27 was just one.
28 88 Q. From your experience of working in the area, is two
29 sufficient, does it meet the needs of the numbers of

1 patients that have been in Muckamore?
2 A. Well I'm not quite sure. I mean, I think the
3 intelligence that I had gathered was that this work was
4 very intensive, took a long time. We had put a
5 proposal forward to intensify that team, to have more 14:40
6 members of staff. I think that did occur in that they
7 looked at the entire model, whether the hospital team,
8 the care management team or the co-ordinators in the
9 middle, if you like, and there was expansions across
10 those three areas as opposed to an expansion of the 14:41
11 community co-ordinators or the integration
12 co-ordinators.
13 DR. MAXWELL: How much authority do they have? So if
14 I was community integration co-ordinator and I was
15 putting together a complex package and I found some 14:41
16 independent providers to provide the physical location,
17 would I be able to speak to the intensive support team
18 and say: 'This person is going to need three months of
19 support during this transition out of Muckamore'?
20 A. In my experience it was very much a collaborative 14:41
21 process. They didn't have a specific positional
22 authority to make any particular demands. It was a
23 role that required deep understanding and significant
24 negotiation. That person would have been out in the
25 community looking at supported living facilities, 14:42
26 residential facilities. They would have been very
27 familiar with the pathways. They would have been
28 talking to the care managers looking at what support
29 was available in the community, particularly positive

1 behaviour support. They would have been looking at the
2 whole package. They really acted as the bridge
3 between -- because very often there were different
4 views. I mean, at a point in time in hospital the
5 needs could be very different. I mean, the research 14:42
6 shows that once people are settled in the community and
7 it is successful and you get over that time of
8 disruption and upset, that people's needs can settle
9 and they need a much lesser package. So there is
10 always that difference of opinion between hospital and 14:42
11 community teams around that.
12 CHAIRPERSON: Sorry.
13 DR. MAXWELL: Sorry, the second part of that, whether
14 they had the authority or not, you made the point that,
15 once people are settled in a more home-like 14:42
16 environment, their needs tend to --
17 A. Diminish.
18 DR. MAXWELL: -- diminish. The point about the
19 intensive support, I imagine there is a lot of pressure
20 on that service? 14:43
21 A. Yes.
22 DR. MAXWELL: Was there a capacity to give intensive
23 support for the transition to community living?
24 A. I think in the main, yes. But for some, for a smaller
25 amount of individuals it didn't work and it would have 14:43
26 needed more. I mean, I think to make a positive - I am
27 no expert at all in positive behaviour support - but in
28 my observations, you know, you may have needed a
29 positive behaviour specialist. They weren't always

1 qualified psychologists, they could have been well
2 trained individuals, really needed to embed themselves
3 in that facility for maybe weeks and that kind of
4 resource wasn't available.
5 CHAIRPERSON: But it means that the community 14:44
6 integration worker has knowledge, do they, of all the
7 potential facilities around each of the Trusts?
8 A. Yes.
9 CHAIRPERSON: Does that work in this - I have got to be
10 careful - does that work in this jurisdiction 14:44
11 particularly because, although it's a fairly large part
12 of the country, it has a relatively small population.
13 I was just thinking, if you try to transfer that to a
14 much bigger market, you wouldn't have that capability?
15 A. No, absolutely not. Because Northern Ireland is so 14:44
16 small and the learning disability community is very
17 small, my impression and my experience was that
18 everybody knew each other. So it would be very easy
19 for the integration co-ordinators to get access to
20 teams in other trusts and access to facilities. So 14:44
21 they were key members of the whole re-settlement
22 process.
23 CHAIRPERSON: You are saying they were, does that role
24 still exist?
25 A. Yes. 14:45
26 CHAIRPERSON: Yes. Despite that, we know that there
27 has been considerable difficulty still resettling a
28 cadre, as it were, of patients at Muckamore. So that's
29 despite that facility being available, or that

1 individual being available and with all of their help
2 they still haven't been able to resettle a limited
3 number of people?
4 A. That's right. I mean, I was looking at some data that
5 the Trust provided me with about the admissions and 14:45
6 discharges in Muckamore over the last, say since
7 2006/7, it is very interesting to look at how the
8 dependence on Muckamore has diminished as community
9 services have grown. So I think Belfast has nine
10 individuals left in Muckamore. All of them have very, 14:45
11 very complex needs. There is some forensic patients in
12 amongst that. The supply of bespoke housing or
13 vacancies with the level of service and the location of
14 the service hasn't just been there. Now I am informed
15 by colleagues who are working that they now have, in 14:46
16 fact all the Trusts have plans for whatever patients
17 they have left - we have nine, Belfast has nine - that
18 will be realised. So we are fairly, they tell me they
19 are fairly confident that those placements will occur
20 in the very near future. But it has been a long 14:46
21 journey to make sure that the accommodation, the
22 workforce, the supports. I mean, community services
23 cannot provide a comprehensive service unless they have
24 access to community treatment, intensive support all
25 the time to sustain a model of that. 14:47
26 CHAIRPERSON: Otherwise the re-settlement is just going
27 to fail, isn't it?
28 A. I mean as part of my role when I was in Muckamore or
29 I was in with the learning disability, we visited, the

1 East London Foundation Trust was recommended to me by
2 the Chief Executive, Dr. Jack at that time. I visited
3 London and they visited me, or visited Muckamore
4 rather. Also the consultant psychiatrist who worked on
5 the SAI, you know we learnt a lot about how other areas 14:47
6 responded, what their service response was. They felt
7 that the vast majority of the people in Muckamore did
8 not need to be in a tertiary facility and that they
9 didn't have them, that they had moved along the
10 continuum to very intensive community support, 14:48
11 community treatment with people with milder learning
12 disability accessing usual, normal mental health
13 services and not specialist mental health services or
14 specialist learning disability hospitals.
15 14:48
16 I mean, obviously I am no expert on that but it was
17 very influential on us really accelerating all of that.
18 They made the point that it wasn't necessarily in the
19 patient's best interest to be in Muckamore at all.
20 PROFESSOR MURPHY: Could you say something about 14:48
21 respite care because that's been a bit absent from your
22 account so far. You could argue that people end up in
23 hospital when the service is in crisis because there is
24 no respite care, so you have to resort to a hospital
25 care model? 14:48
26 A. Yes, you're absolutely right. I mean, Belfast Trust
27 does provide respite care. I think three of our
28 residential units have two beds each that provide
29 continuous respite care. There is some supported

1 living facilities that have registered beds within
2 their supported living as respite beds. So all of the
3 services, I mean carers can access carer grants, they
4 can access respite or they can get a direct payment so
5 they can organise their own respite to whatever suits 14:49
6 them. I mean I can't make a comment at this stage on
7 whether it's enough, but certainly there are well
8 developed respite services. The data is recorded and
9 reported to the Board or the SPPG as they are now. So,
10 yes, there are quite a lot of respite services. 14:49
11 PROFESSOR MURPHY: Thank you.
12 DR. MAXWELL: You mentioned a number of factors that
13 have to come together to make a successful
14 re-settlement, you need the physical environment, you
15 need the workforce and you need the community support 14:50
16 around the workforce in the physical space, so there
17 are still a number of people in Muckamore despite
18 people saying it will be closed way back in 2005/6/7,
19 whatever, what is the balance of the problem, is it
20 because there isn't enough physical space? Is it 14:50
21 mostly about the workforce? Is it actually about not
22 having the wraparound support services in the community
23 from the professionals?
24 A. It's a very pertinent question. To be honest I haven't
25 really considered that in an analytical way. I mean 14:50
26 I think all those factors, I mean workforce certainly
27 is a major current factor across all providers and
28 trusts in getting the right workforce. I suspect it's
29 been a very complicated evolution, and my involvement

1 was for a brief period of time so I couldn't give you a
2 comprehensive answer on that but I'm happy to consider
3 it further.
4 CHAIRPERSON: We will let Ms. Briggs carry on.
5 89 Q. MS. BRIGGS: Thank you, Chair. If we could go down to 14:51
6 page 71, paragraph 254, it's in the middle of the page.
7 Ms. Champion is there speaking to the role of
8 psychological services and she says, about half way
9 through there:
10 14:51
11 "That they provide the positive behaviour support plans
12 for the patient and often provide training to the
13 independent service provider in respect of that support
14 plan. Some independent service providers are
15 completely new staff teams and psychological services 14:52
16 often supplement specific training on how to support
17 the patient with managing their behaviours."
18
19 Is that training always provided prior to a
20 re-settlement placement starting or would there be an 14:52
21 ongoing role for psychological services in providing
22 ongoing training to staff as and when specific or new
23 issues might arise during the course of a
24 re-settlement?
25 A. In my experience it tended to be that, as part of the 14:52
26 community integration co-ordinator's role, that she or
27 he would be working very closely with the provider and
28 trying to establish what skills they had within
29 their -- (a) understanding the needs of that particular

1 patient, checking out with the provider that they
2 really understood and could respond to those needs,
3 that's part of her role. I mean, there was a period of
4 time where the provider would, you know, maybe weeks,
5 maybe months before the discharge date was agreed their 14:53
6 staff would be in the ward working or observing, not
7 working necessarily, but certainly observing and
8 learning and trying to understand the needs of the
9 patients and to develop the skills. I mean, it is the
10 responsibility of providers to actually make sure their 14:53
11 staff are trained, they are a regulated service. RQIA
12 would have an eye on their staffing and their training
13 and their skill mix. But increasingly you see evidence
14 of providers wanting to employ their own positive
15 behaviour support specialists and that seems a good 14:53
16 thing. So, sorry, I'm not sure that answers your
17 question.
18 90 Q. Ms. Heaney, it does answer the next question I was
19 going to ask which is: Is the primary responsibility
20 for training within an independent service provider, 14:54
21 does that rest on the independent service provider
22 themselves?
23 A. Yes, it's their primary responsibility. Increasingly
24 there is collaboration, it is in everybody's interest
25 that everybody is skilled up. 14:54
26 91 Q. You reference there the input of the community
27 integration co-ordinator in that process and you have
28 given evidence that they are a Belfast Trust
29 individual; is that right?

1 A. Yes.
2 92 Q. Then in terms of the role of psychological services,
3 which is dealt with here at paragraph 254, can you tell
4 us a little bit more about their role, would that be
5 providing and supplementing training prior to the 14:54
6 re-settlement happening or during that process?
7 A. There are positive behaviour support staff both in
8 Muckamore and, you know, within the community.
9 Sometimes they travel back and forward depending on the
10 needs of particular settings. I mean, psychological 14:54
11 services are core skill, the set of skills they bring
12 to the table are core to meeting the needs of people
13 with significant learning disabilities and autism. So
14 they do lead those teams. They are professionally
15 responsible and accountable, they are vital part of the 14:55
16 multidisciplinary team. So they would input into the
17 wards and input into the communities and they would
18 have a big role in the discharge planning. Belfast
19 tended to use an essential lifestyle planning tool
20 which was multidisciplinary. So, yes, they are a key 14:55
21 part of it.
22 93 Q. To clarify your evidence on the point, are they a key
23 part both before and during the re-settlement
24 process --
25 A. Yes. 14:55
26 94 Q. -- in terms of providing specifically training to the
27 independent service provider, or is that something you
28 are not sure about?
29 A. I'm not sure. I think maybe there has been particular

1 situations where we have called upon a psychology
2 support provider in terms of training but it is not a
3 general arrangement as yet.
4 95 Q. You've touched on it a little bit in your earlier
5 answer, but just to be clear: Do psychological 14:56
6 services have any formal role in providing positive
7 behaviour support plans and indeed training staff
8 within Muckamore away from the re-settlement process?
9 A. Yes. I mean, psychology is an embedded profession
10 within Muckamore. There is a team, in my experience 14:56
11 there was a team of PBS, usually nurses, specialist
12 nurses, who supported the wards in the formulation of
13 the diagnosis and in the development of the positive
14 behaviour plan in hospital and over time that was
15 extended to the community. I'm sure that question 14:56
16 could be answered better by the head of psychology in
17 Belfast, but that's my general understanding from my
18 experience.
19 96 Q. Yes, that's helpful, Ms. Heaney. Can you speak at all,
20 and if you can't do say, if they provide a role in 14:56
21 terms of training staff within Muckamore? You've
22 touched on the positive behaviour support plans, but in
23 terms of providing training to staff in Muckamore, do
24 they have a role in that?
25 A. I actually am not 100% sure. My guess would be - I am 14:57
26 not in the business of guessing - but I would be
27 surprised if they didn't, but I am not 100% sure.
28 97 Q. Thank you, Mrs. Heaney. Onto the last page then, page
29 72, paragraph 256. Ms. Champion says:

1 "There is now also a governance lead solely dedicated
2 to governance within commissioned services who sits
3 within commissioned services and re-settlement. As the
4 commissioner of the service the Belfast Trust should be
5 kept informed of any incident that occurs in the 14:57
6 provision of the service to the service user. The
7 governance lead ensures that the responsibilities and
8 duties of the Belfast Trust are fulfilled in respect of
9 commissioned services within intellectual disability
10 services and responds when there are quality issues to 14:58
11 seek assurances that issues are addressed and care is
12 safe."
13
14 So Ms. Champion here is speaking to the role of the
15 governance lead whenever there is a service user from 14:58
16 Muckamore who has been resettled within a commissioned
17 service, okay. In terms of the governance lead, that
18 role which she is talking about there in the paragraph
19 that I have read out, are they a Trust member of staff,
20 specifically Belfast Trust? 14:58
21 A. Yes.
22 98 Q. When it says in the statement that the governance lead
23 ensures that the responsibilities and duties of the
24 Belfast Trust are fulfilled in respect of commissioned
25 services, what does that actually mean, can you help 14:58
26 the Inquiry at all with that?
27 A. What that means is, I mean, sorry, just to be clear.
28 I mean, there is a range, I think I have indicated
29 earlier that there is a range of facilities, nursing

1 homes, residential homes, supported living facilities,
2 there is dozens and dozens of them, I have the data on
3 that. Most of those are group living settings. Now we
4 have a range of clients who live in their own homes
5 with their own front door, which is probably the ideal. 14:59
6 But we still have a lot of group living settings. In
7 those settings there are a high number of incidents.
8 The majority would be resident on resident. I mean, a
9 resident gets triggered, an argument breaks out, an
10 incident occurs, any permutation of types of incident. 14:59
11 All of those incidents and, if there is a safeguarding
12 element to those incidents, the regulated facility,
13 which is the care home or day centre, are required to
14 report that to RQIA if it is an incident and, if it's a
15 safeguarding incident, to the trusts. Now the role of 14:59
16 the governance manager will be to make sure that data
17 is collected, analysed and presented on a regular basis
18 so that trends and issues that may arise and actions
19 that may need to be taken. So that's what that refers
20 to. It is really to keep a close eye on nature and 15:00
21 volume of incidents in group living settings and to be
22 on top of the issues there.
23 DR. MAXWELL: So that's an analyst rather than a
24 service manager?
25 A. The governance, yes. I mean, they would be very 15:00
26 comfortable with data and presenting data.
27 DR. MAXWELL: So collecting and analysing?
28 A. Collecting and analysing data and then discussing it
29 with the team.

1 DR. MAXWELL: But they are not required to act on what
2 they find?
3 A. No.
4 DR. MAXWELL: That is somebody else's role?
5 A. That is somebody else. They are required to bring that 15:00
6 to the attention of the adult safeguarding team, for
7 example, or RQIA for example.
8 CHAIRPERSON: So they don't report to the Board?
9 A. No. They are internal Trust employee. They gather
10 data and intelligence for the Trust and make sure that 15:01
11 incidents are reported appropriately. So they would,
12 I mean they have their own, if you like, management
13 line within the governance structure of the Trust, but
14 they mainly relate to the service managers or the
15 service delivery units. They are there to make sure 15:01
16 that those service delivery units have the right
17 information at the right time and that it is analysed
18 appropriately and escalated appropriately if there is a
19 serious incident within the community.
20 99 Q. MS. BRIGGS: You mention in your evidence there, 15:01
21 Mrs. Heaney, that, if there is an incident, that the
22 commissioned service provider is required to report it
23 both to the RQIA and to the Trust, is there a specific
24 individual or post or position within the Trust that
25 they are required to report to or should report to? 15:01
26 A. The governance manager. Can I just clarify? Are you
27 talking about the governance manager?
28 100 Q. You said in your evidence earlier that independent
29 service providers, so commissioned service providers.

1 A. Yes.
2 101 Q. If there is an incident within their setting, that they
3 are required to report that to the RQIA and your
4 evidence was also that they are required to report it
5 to the Trust, what the Inquiry would like to know is 15:02
6 who the individual is, if there is a specific
7 individual or post within The Trust that they are
8 required to report to, who is that?
9 A. There are two governance managers currently in the
10 community, one for commissioned services and one for 15:02
11 core Trust services. They are part of the
12 administrative support, the corporate support referred
13 to in this. They have their own line management up to
14 the head of governance in the Belfast Trust. So they
15 are associated with the programme of care, the service 15:02
16 delivery unit, but they work on a day to day basis with
17 the teams. They are supporting the teams in the
18 gathering and analysing of data. They don't have a
19 professional role, they are support staff.
20 102 Q. So who is it -- sorry, go ahead, Dr. Maxwell. 15:03
21 DR. MAXWELL: So if I was working in a care home and
22 there was an incident, who in the Trust would I report
23 that to or how would I report it, would I do it
24 electronically, would I send a bit of paper on a fax
25 machine? 15:03
26 A. Well I may not be up to speed, but in my experience the
27 care homes report -- I mean, the regulator is
28 responsible. The incidents are reported to the RQIA as
29 the regulator, that's their primary. RQIA are

1 responsible for the governance of care homes. I think
2 there is a portal now, an electronic portal, I think it
3 is all electronic now, so the care homes report that
4 directly to RQIA. If there is an adult safeguarding
5 incident, my recollection is that they are required to 15:03
6 also involve the key worker of the Trust. So if
7 somebody is injured in a care home.
8 DR. MAXWELL: So it is through the key worker?
9 A. Yes, they collect the data.
10 DR. MAXWELL: The governance lead would get the 15:04
11 information via the key worker?
12 A. Yeah.
13 MS. BRIGGS: Thank you very much, Mrs. Heaney. I am
14 going to move on then to the final paragraph of the
15 statement, which is paragraph 258, the final paragraph 15:04
16 of this section of the statement, I should say. It
17 says there:
18
19 "When a patient from MAH is resettled, the patient's
20 clinical psychiatrist from the Belfast Trust continues 15:04
21 to care for that patient in the initial months of their
22 re-settlement, in an attempt to assist with continuity
23 of care. Other professionals from the Belfast Trust
24 such as care workers will also often be involved.
25 However, the trust of origin should, in theory, assume 15:04
26 responsibility for the patient's care upon
27 re-settlement."
28
29 I appreciate you haven't written this statement,

1 Mrs. Heaney, it is not your words, but perhaps you
2 could assist the Inquiry by telling us a little bit
3 more by what is meant by "in theory" then?
4 A. This arises in, I think, the care management circular
5 of 2010. It really refers to, say, for example, a 15:05
6 trust, an individual from Belfast, that's where they
7 were born and reared, that choses to move to a care
8 home, it only applies to institutions, to care homes.
9 It doesn't apply if an individual goes to live in
10 Ballymena and goes into a supported living facility or 15:05
11 a social home there, they are then resident in that
12 district, in that area, and can access primary health
13 care services, hospital services as any other citizen.
14 It's slightly different if it is a care home because it
15 is governed by the care management circular which means 15:06
16 that if a person goes to live in another care home, the
17 care manager continues the responsibility of the
18 funding, of the reviews, of the quality of that
19 placement. That's my understanding of what that refers
20 to. 15:06
21 103 Q. So is it to say that in practice, the current practice
22 would be that the clinical psychiatrist from the
23 Belfast Trust continues to care for the patient for a
24 number of months and there are other Belfast Trust
25 individuals such as care workers, but otherwise 15:06
26 responsibility lies with the trust of origin, is that a
27 fair summation?
28 A. Yes, that's correct.
29 DR. MAXWELL: That doesn't necessarily mean they have

1 to be under a psychiatrist, they are presumably
2 discharged from psychiatry services and they are having
3 other ongoing support?
4 A. It's not an area that I am aware of the detail.
5 I certainly, in my experience, have known psychiatrists 15:07
6 to travel, particularly maybe for the first or second
7 review. At some point I assume they are discharged,
8 but my psychiatry colleagues would need to...
9 DR. MAXWELL: An example you will know better, older
10 people, when they are discharged from hospital, don't 15:07
11 remain under the care of a geriatrician?
12 A. No.
13 DR. MAXWELL: It is actually the GP who takes over the
14 management of their care. I am wondering if that's the
15 same for people discharged from Muckamore, that unless 15:07
16 there is a pressing need they are discharged from
17 psychiatry and it is primary care who then are
18 responsible for them?
19 A. I am not 100% sure of that. I think because learning
20 disability is quite different, and for many years the 15:07
21 psychiatrist from Muckamore provided maybe so much
22 out-patient work right across the three areas that had
23 patients in Muckamore and a lot of the reviews -- so I
24 think it is slightly different. But, if it is helpful,
25 I will go back to the psychiatrists in Belfast just to 15:08
26 clarify the discharge criteria.
27 104 Q. MS. BRIGGS: Mrs. Heaney, before I pass over to the
28 Panel in case they have any further questions, I am
29 conscious that the questions that I have asked you have

1 been about the statement of Ms. Champion and I'd like
2 to give you an opportunity, if you want to, to add to
3 anything that's in that statement or indeed anything
4 that you have been asked to comment on this afternoon?
5 A. No, I am content with the statement. Obviously there 15:08
6 is a lot of detail there behind it, but in terms of an
7 overall statement, yes.
8 MS. BRIGGS: Thank you very much, Mrs. Heaney.
9 CHAIRPERSON: I think we've asked all the questions as
10 we have gone along, so can I thank you very much for 15:08
11 coming to assist the Inquiry.
12 A. Thank you very much.
13 CHAIRPERSON: Thank you. I think we are sitting
14 tomorrow at 10 o'clock?
15 MS. BRIGGS: We are. We are hearing again from 15:09
16 Mrs. Heaney and we are also hearing from Brona Shaw in
17 respect of Module 3 and Ms. Kiley will be dealing with
18 that evidence tomorrow.
19 CHAIRPERSON: Right, thank you very much.
20 15:09
21 THE HEARING WAS ADJOURNED TO WEDNESDAY, 7TH JUNE 2023
22 AT 10
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